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NATIONAL RURAL HEALTH ASSOCIATION

December 28, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

Dear Secretary Azar,

On behalf of the National Rural Health Association (NRHA), we appreciate the opportunity to provide formal comments on the Department of Health and Human Services (HHS) request for information (RFI) regarding regulatory changes amidst the ongoing COVID-19 public health emergency (PHE). NRHA applauds the work HHS has done to loosen regulatory barriers allowing providers greater flexibilities in combatting the ongoing PHE—it has been truly impactful, and NRHA hopes many of these important flexibilities can continue beyond the duration of the PHE.

NRHA is a national nonprofit membership organization with more than 21,000 members, and the association's mission is to improve the health of rural Americans and provide leadership on rural health issues through advocacy, communications, education, and research. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common goal of protecting rural health.

The COVID-19 pandemic has ravaged rural America disproportionately compared to their urban counterparts. The temporary waivers provided by HHS in response to the pandemic has allowed rural providers great flexibility in their ability to serve patients and many should be extended into the future. NRHA believes if HHS takes the following stabilizing actions, rural providers will be better equipped to rebound from the COVID-19 pandemic and able to provide sustained services to rural patients.

Eliminate the 96-hour Condition of Payment Requirement for critical access hospitals (CAH). During the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) suspended these rules for the duration of the PHE. NRHA believes CMS should eliminate this onerous regulation entirely.

The CAH 96-hour rule created a condition of repayment that requires a physician to certify that a patient can reasonably be expected to be discharged or transferred within 96 hours. CAHs already must meet a separate condition of participation, which requires that acute inpatient care provided to

patients not exceed 96 hours per patient on an average annual basis. CMS, in its 2018 IPPS final rule, made the 96-hour rule a low priority for medical record reviews, but the regulation still causes confusion and interferes with the best judgement of physicians and other health care providers.

Eliminate physician supervision requirements to allow providers like advanced practice registered nurses (APRN), physician assistants (PA), nurse practitioners (NP), and certified registered nurse anesthetists (CRNA) to practice to the fullest extent of their licensure. During the COVID-19 pandemic, CMS waived certain physician supervision requirements which provide patients in rural areas easier access to care. NRHA believes CMS should permanently eliminate these burdensome barriers.

Permanently removing these barriers will increase competition, network adequacy, and make much needed reforms to the health care system. In every population, but particularly among the rural and medically underserved areas, growing the number of highly educated advance practice providers enhance health care access and improve quality of care. Removing these artificial and burdensome barriers will greatly improve the availability and access to health care in rural America. As COVID-19 continues to ravage rural America, these flexibilities allowing providers to serve patients without burdensome barriers has greatly increased access to care for patients, especially in rural facilities like CAHs, rural health clinics (RHC), and federally qualified health centers (FQHC).

Continue, beyond the duration of the PHE, direct supervision flexibilities via telecommunication technologies. During the COVID-19 pandemic, in order to help limit exposure to the disease for patients and providers, CMS waived in-person supervision to allow for patient monitoring via interactive technology. NRHA believes CMS should continue these flexibilities beyond the PHE to provide flexibility for patients, especially for rural patients.

As COVID-19 began to spread across the United States, it became increasingly evident that Medicare's 60 million beneficiaries—an older and sicker population—were among the highest risk populations for COVID-19. With so much uncertainty, mundane hospital visits became a risk for this vulnerable population. The flexibilities provided to patients and providers, such as virtual direct supervision, decreased opportunity for infection. Through the 1135 waiver authority, CMS gave the opportunity for providers, patients, and policy makers to observe and examine the added benefits of telehealth services. NRHA understands that there are some services that simply will not be able to be provided via telehealth but added flexibility and options on direct supervision is an area where CMS can greatly increase the quality of care in rural America.

NRHA encourages CMS to allow for the continuation of telehealth services to provide every day, low-acuity care, like disease management, behavioral and mental health care, and evaluation visits. Allowing for the continuation of these services to be provided via telehealth would particularly increase quality of care in rural areas. In some rural communities, Medicare beneficiaries must travel long distances to receive mundane, everyday care. This includes disease management for diseases such as diabetes, asthma, and hypertension, as well as for behavioral and mental health care.

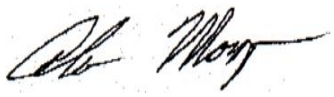
Continue the expansion of telehealth flexibilities, especially for RHCs and FQHCs. As mentioned above, the true silver lining of the COVID-19 pandemic in rural America has been the

expansion of telehealth services for rural providers. In line with that, allowing RHCs and FQHCs to furnish telehealth services has greatly increased access to care for patients in rural America. NRHA urges CMS to continue building on the flexibilities given to providers at the start of the pandemic to ensure continuation of care and accessibility to services from the comfort of their home. While the expansion of telehealth services to rural America has been welcomed, it is imperative that CMS reevaluate the payment methodology for RHCs and FQHCs. At their current level, the one-size-fits-all reimbursement for telehealth services is not conducive to long-term stability. NRHA asks CMS to create a model of payment for telehealth services for RHCs and FQHCs that encourages utilization of this technology and one that accurately depicts the services provided at those facilities.

Additionally, continuing the use of audio-only equipment to furnish telehealth services beyond the duration of the PHE is imperative. In some rural communities, there is still insufficient access to broadband services. We appreciate recent actions by the Trump Administration to create a taskforce between the United States Department of Agriculture (USDA), the Federal Communications Commission (FCC), and HHS to advance rural broadband specifically to improve the deployment of telehealth services. Unfortunately, however, we recognize that the deployment of broadband to every rural community and every rural Medicare beneficiary will take significant time, if possible, at all. While broadband continues to be built out overtime, it is critical to allow Medicare beneficiaries to continue receiving the care they need via audio-only services. Further, even as broadband becomes accessible across rural America, the elderly population Medicare services sometimes has issues utilizing technology past a telephone. The audio-only aspect is critical for this population to continue receiving high-quality access to care.

Thank you for the chance to offer comments on the 1135 waiver process. We look very much forward to continuing our work together to ensure our mutual goal of improving quality and access to care, especially in rural America. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org or 202-639-0550.

Sincerely,



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