National Rural Health Association

CMS Request for Information: Promoting Efficiency and Equity Within CMS Programs

Accessing Healthcare and Related Challenges

Provider Payment: Rural hospitals are an integral part of the health care system and are a critical component of communities across rural America. Recent years have presented challenges for rural hospitals and health care safety net. Rural health care providers are feeling the effect of the current 8% inflation rates. For prospective payment system (PPS) hospitals and skilled nursing facilities (SNFs), proposed and final payment adjustments in the IPPS, SNF, and OPPS rules have been helpful but inadequate to address the skyrocketing costs. NRHA is concerned that inflation, coupled with dwindling COVID-19 funds, will cause rural hospitals to close at staggering rates. The Federal Reserve Bank of Dallas recently estimated that health care inflation will almost double between mid-2022 and mid-2023. This increase will be felt by patients, providers, and payers including CMS. Currently, the number of rural hospitals that have closed since 2010 is at 140, with 4 closing in 2022 so far. When hospitals close, beneficiaries lose an access point to care. Many rural beneficiaries already travel long distances to seek care and more hospitals closing means even longer distances creating disparities between rural and urban populations.

Obstetric Care: A recent GAO study reported on the availability of obstetric (OB) services in rural areas. Over half of rural counties do not have OB services. Stakeholders interviewed by GAO indicated that Medicaid reimbursement rates and recruiting and retaining clinicians were the biggest factors affecting hospital-based OB services. Medicaid reimbursement rates are set by states; however, CMS should work with states to consider all flexibilities to support expanding eligibility, increasing reimbursement, and coming up with innovative solutions to address challenges. Medicaid covers almost half of all rural births, so hospitals are reliant upon this reimbursement which is less than private insurance rates. Without proper reimbursement for OB, more pregnant people will lose access to already difficult to reach care.

Medicare Advantage: Medicare Advantage (MA) poses a threat to rural health care accessibility. A major issue is the denial of prior authorization requests for medically necessary services which leaves rural beneficiaries without needed care. At a minimum, MA plans must cover the same benefits as traditional Medicare but plans often have flexibility that can hamper access to care. For example, MA plans must cover up to 100 days in a SNF, like in traditional Medicare. But the plans can decide when a beneficiary no longer needs SNF care as opposed to Medicare in which the medical professionals at the SNF make the decision. Another element is that beneficiaries frequently do not understand the differences between MA and traditional Medicare during enrollment. MA is often touted as an option that will give beneficiaries more benefits, like dental coverage. In reality, the MA plan may not have full coverage for those services or have much higher out of pocket costs. Rural beneficiaries also face more restrictive networks in MA plans in rural communities. With MA enrollment projected to reach half of all Medicare enrollment in 2023, and rural MA participation growing rapidly, CMS should act to ensure rural MA beneficiaries are receiving needed access to care and proper coverage.

Oral Health Services: NRHA would also like to reiterate its comments from the CY 2023 Medicare Physician Fee Schedule proposed rule regarding Medicare coverage for dental services. Rural seniors are less likely to visit a dentist than their urban peers. CMS must interpret § 1862(a)(12) of the Social Security Act more broadly to cover dental services that are integral to an otherwise covered medical service. CMS should cover any related dental services that would improve Medicare patient outcomes for covered medical

services for certain chronic diseases that disproportionately affect rural beneficiaries, like diabetes and heart disease. Paying for dental care related to covered chronic disease services would help lessen rural health disparities.

CAH CoPs. NRHA stated in its comment on the proposed CAH updated CoPs that Indian Health Service (IHS) hospitals should be clearly excluded from the CAH distance requirements. CMS follows this policy at developed at the sub-regulatory level. CMS did not address our policy proposal in the final rulemaking because it was not in the proposed rule. However, NRHA again stresses the importance of codifying this sub-regulatory guidance in regulations to give clarity and consistency to providers and access to beneficiaries in rural areas.

Recommendations for how CMS can address these challenges through policy and programs include:

Provider Payment: For prospective payment system (PPS) hospitals and skilled nursing facilities (SNFs), proposed and final payment adjustments in the IPPS, SNF, and OPPS rules have been helpful but inadequate to address the skyrocketing costs. NRHA's suggestions on these payment rates were reflected in our comments on all 3 proposed rules found at https://www.ruralhealth.us/advocate/executive-branch.

Medicare Advantage: Medicare Advantage (MA) poses a threat to health care accessibility. NRHA wants to echo its comments made in response to CMS' MA request for information from August. CMS must take action against misleading marketing tactics by MA plans. CMS should monitor why beneficiaries leave MA plans and enter traditional Medicare to understand the impact that deceptive MA practices have on enrollment and unenrollment trends.

Telehealth: Telehealth flexibilities throughout the PHE have been a path to increased access to care for rural beneficiaries. As discussed in NRHA's responses to the questions below, CMS coverage of audio-only telehealth services is critical for maintaining such access.

Site Neutral Payment Adjustment: NRHA applauds CMS' finalized policy to exempt rural sole community hospitals from the Physician Fee Schedule (PFS) site neutral payment adjustment. As we requested in our OPPS proposed rule comment, Medicare Dependent Hospitals, Low Volume Hospital, and Rural Referral Centers should also be exempted from this policy. The same reasoning that led CMS to believe that SCHs should be exempt also apply to these rural hospitals. Factors other than the payment differential can be attributed to the volume of services in provider-based clinics at rural hospitals. This would maintain access to care in rural areas by ensuring rural providers are paid for services provided at off-campus departments at rates comparable to those paid at on-campus departments.

340B: Relatedly, rural SCHs are excepted from the Medicare OPPS 340B payment cuts, but CMS revisits this exception on an annual basis. Leaving rural SCHs uncertain from year-to-year whether CMS will maintain this exception makes it difficult to effectively plan and maximize limited resources. Moreover, urban SCHs, MDHs and RRCs are subject to the adjustment. CMS said that it would monitor for negative impacts on other hospitals. Urban SCHs, MDHs and RRCs share many of the same characteristics as rural SCHs, and also should be protected while CMS examines the impact.

DPU beds: Beds associated with Distinct Part Units (DPU) in a PPS hospital should not count in the 100-bed threshold that qualifies a PPS hospital to operate swing beds within their acute care operation.

Currently, if a rural PPS hospital wants to operate a swing bed program, it must have 100 staffed beds or less. Under current rules, DPU beds count in the total. NRHA asks that CMS remove DPU beds from total bed count of a rural PPS hospital in order to determine swing bed participation. Since DPUs have their own associated reimbursement programs and are accounted for separately within those payment structures, there is no risk of double payment by the Medicare program. Exempting DPU beds would increase the number of swing bed programs and thus increase access for rural beneficiaries.

Rural Emergency Hospitals (REHs). NRHA was pleased with the final conditions of participation and payment policies for REHs. However, NRHA urges CMS to work alongside Congress to make certain improvements in the program to encourage participation. REHs are one tool for struggling rural hospitals to maintain emergency and outpatient care rather than close, losing a point of access to care for beneficiaries. CMS should work with HRSA and Congress to reopen the 340B statute and include REHs as eligible providers. Many NRHA member hospitals have indicated that conversion to REH status without 340B savings would not be feasible. Second, CMS should work with Congress to add the 5% payment increase to non-OPPS services like laboratory services. NRHA also would like to see CMS work with Congress to allow inpatient psychiatric DPUs in addition to SNF DPUs. Patients requiring acute psychiatric care beyond the ability of the emergency department are difficult to transfer in rural areas because available psychiatric beds are lacking.

Understanding Provider Experiences

Workforce: Rural providers are especially impacted by the workforce shortages facing the health care industry. NRHA has heard throughout the COVID-19 pandemic that rural providers are unable to offer competitive wages as health care costs continue to grow. This issue is worsening as inflation is rising at unprecedented rates. Provider burnout has been extensively reported since the COVID-19 pandemic began. For rural providers, staff shortages and provider isolation are main drivers. Workforce flexibilities play a role in alleviating burnout. NRHA members have expressed that they have tried using alternative scheduling models, scribes, and telehealth to further ease burnout. However, these are interim solutions. Burnout leads to professionals leaving rural facilities or the health field altogether, worsening the workforce shortages that already exist.

Emergency Medical Services: Another rural provider issue is the lack of emergency medical services (EMS) in rural areas. This creates a dangerous situation for patients and complicates workflows and care for providers and facilities. NRHA has heard that critical access hospitals and small rural hospitals are forced to retain patients that require a higher level of care because EMS does not exist or have the capacity to move patients. This exacerbates the staff workload issues previously discussed because they must keep and serve patients that should be transferred. Further reimbursement models or incentives are needed for non-emergent transportation, particularly for sending and receiving facilities with high Medicaid populations.

Medicare Advantage: From a provider perspective, MA growth is harming the rural health infrastructure. Practices such as utilization review process, underpayment of claims, and directing services are causing financial hardship for rural hospitals. As an a example, MA plans are damaging for critical access hospitals, which are a vital component of the rural health safety net. CMS pays CAHs 101% of reasonable Medicare costs, but MA patient days are not included in this calculation. Again, we are likely to see MA enrollment reach 50% of all Medicare enrollment in 2023. This adds up to a large loss of reasonable cost

reimbursement payments that CAHs would otherwise see if beneficiaries chose traditional Medicare. NRHA believes that MA patient days and outpatient revenue should be considered as Medicare on hospitals' cost reports when calculating CAH payments. Instead, as it stands, MA plans can choose how to pay CAHs in their networks but out-of-network CAHs must receive what traditional Medicare would be paid for the services.

Split or Shared Services: Nonphysician practitioners (NPPs) are critical members of the rural health workforce. Their training and expertise allow them to perform medical staff level duties, where appropriate, and create more efficient workflows in rural facilities. We appreciate that CMS has delayed implementation of the new split or shared services policy until January 1, 2024. However, we reiterate our comments from the CY 2023 PFS proposed rule that this new policy will harm rural providers. Requiring that NPPs or physicians bill for the service if they provide just over half of the care is inconsistent with the plain meaning of a "substantive portion." We do not believe that "over half" is an appropriate definition of "substantive portion" for the purpose of billing split or shared services. This policy is troublesome for rural providers as NPPs often provide the majority of care for rural patients and providers will consequently receive less payment under PFS for split or shared visits. NRHA suggests that CMS reconsider relying upon time for defining "substantive portion" and revert to a narrower definition. For example, CMS should amend the definition so that the practitioner that is involved in medical decision making (MDM) may bill for the split or shared service.

Recommendations for how CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations include:

Workforce: One pain point for rural long term care providers is the requirement that temporary nurse aides (TNAs) must become certified nursing assistants (CNAs) within four months. CMS waived this requirement through June 6, 2022, due to the PHE. The nursing workforce shortage, especially support staff such as CNAs, has been well-documented. Rural long term care providers would greatly benefit from CMS retaining a version of this waiver. NRHA suggests that CMS may make an exception to the requirement for rural facilities specifically to allow TNAs 12 months to become certified as CNAs with proof of coursework towards certification.

Graduate Medical Education: The geographic maldistribution of primary care physicians is a problem in the United States. Rural areas particularly lack access to primary care physicians and other shortage specialties compared to urban and suburban areas. Medicare is the only stable national source of GME funding, in comparison to other grant funding such as HRSA-run programs and Medicaid GME funding. Rural hospitals operate on narrow margins and cannot commit to ongoing residency training costs without a predictable source of funding. Physician rotation in rural residencies programs in CAHs and rural PPS hospitals has been proven to dramatically improve workforce shortages in rural and frontier locations.

CAHs are only allowed to put direct GME on cost reports, which is roughly one-third of typical total GME payments. They are not eligible for reimbursement for the costs of indirect medical education (IME). In addition, other hospitals cannot claim the residents' time spent in a CAH, so there is no reimbursement for IME costs. SCHs are restricted from rebasing their hospital specific rate to include IME when they start a new training program. CMS has the authority to allow a CAH to choose annually whether it wishes to be considered a hospital or a non-provider for GME purposes only. It also can allow reimbursement for SCHs to include IME expenses, regardless of the mode of payment under which they are reimbursed. CMS

should allow both of these options in order to increase training in rural areas and therefore a greater likelihood of rural practice.

Advancing Health Equity

Telehealth: NRHA suggests that CMS address its termination of audio-only telehealth coverage under Medicare. This policy disproportionately impacts rural Medicare beneficiaries given broadband limitations and therefore hinders access to care. Ending audio-only coverage after the PHE ends is a health equity issue for rural beneficiaries. Rural populations tend to be older, sicker, and poorer than their urban counterparts and thus benefit from audio-only care for several reasons. Rural seniors, particularly those that are very sick, struggle with traveling long distances to appointments and use telehealth when appropriate instead. However, telehealth in rural areas can be challenging given the lack of broadband infrastructure. For rural beneficiaries without strong internet connection or access, audio-only provides a convenient alternative to audio/video appointments or in-person appointments. Audio-only telehealth services are also easier to facilitate with rural seniors that may struggle using audio/video technology on a computer or smart device. Further, NRHA is concerned that when the PHE ends, HIPAA compliant platforms will be required again for telehealth and these platforms may be difficult for seniors to navigate. Without an audio-only option this may serve as a barrier for rural beneficiaries.

Food Security: Following the release of the National Strategy on Hunger, Nutrition, and Health, CMS should act on health and chronic disease issues that contribute to health disparities in rural America. To an extent, food as medicine interventions and access to nutritious food can prevent chronic diseases. CMS beneficiaries need access to food as medicine solutions, like produce prescription programs, through pilot or demonstration programs.

Medicaid Beneficiary Eligibility: The end of the Federal Medical Assistance Percentage (FMAP) temporary increase and Medicaid continuous enrollment requirement are health equity issues. The Families First Coronavirus Response Act stipulated that states that receive the FMAP increase cannot unenroll beneficiaries during the PHE. CMS must work within its authority to ensure that beneficiaries are not wrongly unenrolled. Beneficiaries face losing coverage after over two years of continuous coverage and the foundational patient-clinician relationships that were built during that time. Uninsurance is a driver of health disparities that is a barrier to achieving health equity for all CMS beneficiaries and CMS and states must work together to minimize erroneous unenrollment.

NRHA applauds CMS for its proposed rulemaking on streamlining Medicaid and CHIP as many provisions will ensure state Medicaid offices exhaust all options before unenrolling beneficiaries. But this isn't a final rule, thus it may not apply when the PHE unwinds. CMS must bolster its outreach and communications to states to educate both state offices and beneficiaries. For example, when the PHE ends, beneficiaries may not be aware that they should update their address if they moved. As it stands, if a beneficiary doesn't respond to mail regarding their Medicaid enrollment status, they may be unenrolled.

The effects on underserved and underrepresented rural populations when community providers leave the community or are removed from participation with CMS programs include:

Rural communities face a lack of access to health care generally, which has been exacerbated by the PHE. This can be partially attributed to workforce concerns. Every provider that leaves a rural community creates a larger ripple effect than in urban areas because of the shortage of rural providers. Using Health

Professional Shortage Areas (HPSAs) as a measure, rural areas have the biggest share of HPSAs compared to non-rural or partially rural areas. For each HPSA category – primary care, dental, and mental health – rural areas account for almost 2/3 of all HPSAs. This especially problematic for dental and mental health services which are severely lacking for rural. For those that do have full dental coverage, they may not be able to access a nearby provider. As mental health concerns have grown during the PHE, rural residents face more difficulties finding providers in their communities that can provide treatment, especially psychiatrists. When providers leave communities, there is less access to care which leads to worse health outcomes. This phenomenon is more serious in rural areas that perennially face provider shortages.

When a rural hospital closes, it can disrupt both the health care and the economy of a community. The health care sector can supply as much as 10% of the jobs in a rural area. Rural hospital closures reduce access to emergency care, as well as primary care given that emergency departments are a major source of primary care in rural areas by default. Further, hospital closure exacerbates gaps in access to specialty care. Beyond health care, studies show links between hospital closures, lower overall employment, and per capita income at the county level. A hospital closure can eliminate a hundred or more jobs immediately, a significant loss in communities with small populations. In some cases, the local hospital is one of the largest employers in the community. Hospital closures can also make it more challenging for rural communities to attract employers, having a broader impact on the health of the community and its residents.

Keeping care local is incredibly important for rural beneficiaries. Rural residents travel longer distances on average to seek health care. When a local provider leaves a community, residents either forsake care or travel further. Transportation may not be accessible for all rural residents if they are forced to travel. Public transportation is often not an option in rural areas. On top of that, elderly residents may not be able to drive and residents with lower socioeconomic status may not have a car.

Recommendations for how CMS can promote efficiency and advance health equity through policies and programs include:

Telehealth: NRHA believes that CMS does not need to wait for Congress to allow audio-only post-PHE. NRHA disagrees with CMS' reading of Section 1834(m)(2)(A) and believes that it is a narrow interpretation. CMS interprets the provision to require that "telehealth services be so analogous to in-person care such that the telehealth service is essentially a substitute for a face-to-face encounter." This is an unnecessarily restrictive reading of the statute. The statute only provides that Medicare reimbursement for telehealth must be equal to the amount the provider would have been paid if the service were furnished in-person. The statute is silent on whether the services must be "so analogous" to in-person care so that it's "essentially a substitute" for an in-person visit.

NRHA urges CMS to adopt a broader reading of § 1834(m)(2)(A) such that audio-only services are retained beyond 151 days post-PHE. NRHA suggests that CMS allow audio-only for telehealth visits for circumstances in which a beneficiary does not consent to audio/video technology or is not capable due to broadband or other connectivity resource issues. Providing audio-only options can lessen health disparities, increase access, and incentivize care seeking for rural populations.

Food Security: CMS should support rural providers in performing food insecurity screenings and related referrals through incentives or quality reporting programs. Last, CMS should develop codes that ensure rural providers can receive Medicare reimbursement for SDOH and health equity services that currently

are not captured through existing billing codes. Presently, rural providers aren't incentivized to perform these services because they aren't reimbursed accordingly. Also, if CMS helps to develop data infrastructure for SDOH data elements, CMS must also support rural providers that lack resources.

Dental care: NRHA applauds CMS for its expansion of covered dental services for Medicare beneficiaries in the CY 2023 Physician Fee Schedule rule. NRHA urges CMS to continue this expansion by considering the comments that it received on other types of clinical scenarios where the dental services may be inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services. For example, CMS should cover dental services related and integral to the clinical success of diabetes or heart disease services. These two chronic diseases disproportionately affect rural populations and rural Medicare beneficiaries should have related dental expenses covered.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

Rural patients and providers benefited greatly from the PHE blanket waivers.

CAH 96 Hour Rule: Critical access hospitals (CAHs) have benefited from the 96-hour rule exemption. The 96-hour rule 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. In the 2018 Inpatient Prospective Payment System (IPPS) final rule, CMS made the 96-hour rule a low priority for medical review records, but the regulation still causes confusion and interferes with the best judgement of physicians and other health care providers. While a legislative fix is needed to remove this requirement, NRHA urges CMS to continue treating enforcement of this rule as a low priority post-PHE.

Swing Bed Admission: Direct admission into swing beds for patients that do not require acute care but do not meet SNF requirements. This would allow patients who show signs of declining health to get the care they need before they deteriorate further or get sicker, thus needing inpatient services. Preventatively allowing patients in swing beds would ultimately achieve savings for health systems, CMS, and patients.

Workforce: Several workforce waivers have been beneficial for rural providers. For example, NPPs were able to offset physician workloads because Medicare patients did not need to be under the care of a physician. This allowed for more efficient workflows. Physicians are not required to be physically present in hospitals and CAHs during the PHE so long as they were available by phone or radio communications. Removing minimum personnel qualifications for NPPs and deferring staff licensure, certification, or registration to state law has allowed CAHs to ease workforce shortages by using all available clinicians.

Provider-based Rural Health Clinic Payment: Provider-based RHCs affiliated with hospitals that have less than 50 beds are exempted from the payment limits established in the Consolidated Appropriations Act (CAA), 2021. Since April 2020, CMS has allowed those hospitals RHCs to go beyond the 50-bed limit without an impact to RHC payment to account for the surge in patients due to the PHE. Our members have expressed a desire to retain this flexibility for the subset of provider-based RHCs with less than 50 beds in case of a future surge. NRHA acknowledges that this surge should be limited to other PHEs or surges due to cold and flu season, otherwise the less than 50 bed designation would be moot.

RHC NP Supervision: RHCs have benefitted from the physician medical supervision of nurse practitioners (NPs) waiver. The waiver has allowed RHCs to use NPs to the fullest extent of their training and license

and also freed up time for physicians to tend to other duties. NPs should continue to be able to practice without physician medical supervision as this has been a valuable workforce flexibility.

Audio-only telehealth services: Continuation of audio-only service capacity as described above.

CRNA Supervision: Certified registered nurse anesthetists (CRNAs) have not required physician supervision of their services during the PHE. We recommend that CMS retain this waiver. Permanently waiving supervision requirements can help improve health equity and access to care. CRNAs are the predominant anesthesia providers in underserved areas, and they also provide obstetrical services, surgical services, trauma stabilization, and pain management. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography, insurance type, and the distribution of anesthesia provider type. The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries. The waiver proved invaluable for rural providers as it has helped to alleviate some workforce challenges in rural areas.

Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

NRHA recognizes that many of these waivers would require congressional action to be made permanent outside of the PHE. However, many waivers have been crucial during the PHE and would address rural health disparities by expanding access to care. We encourage CMS to work with Congress on a path forward to make permanent any of the waivers that require legislative action. NRHA priority waivers and flexibilities include:

Expanded ability for swing beds for patients who do not require acute care but do not meet SNF requirements as discussed above.

Telehealth Waivers for RHCs, FQHCs, and CAHs: Making telehealth waivers for RHCs and CAHs permanent is critical to maintain that access in rural areas. For RHCs and FQHCs specifically, allowing all practitioners to bill for telehealth as allowable within their scope of practice must continue after the 152nd day after the PHE ends. RHCs, FQHCs, and CAHs are essential rural safety net providers and rural beneficiaries must retain access to telehealth through these providers. Additionally, if RHCs and FQHCs are permanently authorized as distant site providers, CMS should reevaluate their reimbursement and coding methodologies for telehealth services to pay RHC/FQHCs their all-inclusive rates and count them as face-to-face encounters.

Temporary nurse aides (TNAs): Waiving of requirement that TNA's must become certified nursing assistants (CNAs) as described above.

Rural SNF Physician Visit Requirement: Many SNF waivers expired in 2022. One waiver that helped reduce workloads and mitigate against rural workforce shortages was the physician visit requirement waiver at 42 CFR § 483.30(c)(3). This waived the requirement that all required physician visits be made by the

physician personally. Waiving this allowed NPPs to make physician visits. NPPs are allowed, under § 483.30(c)(4), to make all other required physician visits after the initial visit. It follows that at the option of the physician, NPPs could continue to make the initial visit as well. Relatedly, the 42 CFR § 483.30(e)(4) waiver expired but it previously allowed physicians to delegate any task to NPPs, which was crucial in lessening physician workloads and utilizing NPPs as effectively as possible.

Workforce: All hospital and CAH workforce flexibilities previously discussed, including CRNA supervision and physician physical presence. Given the pressing shortage of rural practitioners, rural facilities need maximum flexibilities for workforce outside of the PHE. CMS should also make permanent the waiver of physician supervision over NPs in RHCs. The expanded list of practitioners able to bill Medicare for telehealth should be made permanent as well. Allowing other practitioners like occupational therapists to use telehealth expands access for rural beneficiaries that may not otherwise seek the care that they need.