National Rural Health Association

January 22, 2025

Robert F. Kennedy, Jr.
Secretary Designate
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Designate Kennedy,

The National Rural Health Association (NRHA) looks forward to working with you in your role as Secretary of Health and Human Services behalf of more than 60 million rural Americans across the country.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals (CAHs), doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

NRHA is proposing several policy opportunities to help enhance access to care in rural communities.

I. First 100 Day Potential Wins
- Rescind overreaching nursing home staffing mandate
- Hold Medicare Advantage plans accountable
- Clarify Rural Emergency Hospital payments under Medicaid

II. Year One Focus Areas
- Extend current site neutral payment policy exemptions to Medicare-Dependent Hospitals
- Allow Sole Community Hospitals and Medicare-Dependent Hospitals to receive indirect medical education payments
- Modernize the Rural Health Clinic Program
- Support rural EMS services
- Improve rural innovation at Centers for Medicare and Medicaid Services' Innovation Center
- Address outdated Medicare cost report policies
- Establish a Rural Hospital Network Initiative
- Allow Rural Emergency Hospital participation in the National Health Service Corps
- Reinstate the 340B waiver to regarding child site start date

NRHA would welcome the opportunity to meet with you to discuss these proposals further.

First 100 Days Potential Wins

NRHA has identified three critical actions for the Department to take as a part of the incoming Administration's first 100 days in office. If implemented, these changes would reduce administrative burdens and ease unnecessary government oversight, while promoting health and health care access for rural residents.

Rescind the overreaching nursing home staffing mandate. NRHA urges the Trump Administration to swiftly put forth a notice of proposed rulemaking to rescind the Minimum Staffing Standards for Long-Term Care Facilities rule. The Biden Administration put in place regulations that threaten rural long-term care providers and beneficiaries. Estimates show that this rule will cost $43 billion over 10 years, borne by the long-term care facilities.[1] The Minimum Staffing Standards for Long-Term Care Facilities rule finalized last spring will close rural nursing homes and worsen existing rural nursing home deserts.[2] The finalized staffing ratios are impossible for the majority of rural nursing homes to meet and will significantly impact rural beneficiary access to long-term care. A federal mandate for nursing staff levels will not create qualified and interested workers where they do not currently exist in rural areas. If rural nursing homes cannot meet these stringent standards that are set to go into effect in 2027 and 2029, they will be forced to close. Further, NRHA members have expressed that it is extremely difficult and burdensome to qualify for the exemptions allowed under the rule.

Hold Medicare Advantage plans accountable. Rural Medicare Advantage (MA) enrollment is nearing the 50% mark and rural providers are feeling the effects ranging from increased administrative burden to undue financial implications.[3] **NRHA asks that the Administration work alongside its colleagues in Congress to ensure that:**

1. *MA plans pay rural hospitals and rural health clinics (RHCs) at Traditional Medicare rates if the facility is not under contract with the MA plan.* Regulations on MA payment state that services furnished by providers without a contract with an MA plan must accept as payment in full the amount that it could collect if the beneficiary were enrolled in Traditional Medicare. Further, sub-regulatory guidance on MA payment to out-of-network providers states that MA plans are generally required to pay at least Traditional Medicare rates for Medicare covered services.[4]

2. *MA plans do not use prior authorization processes to delay and deny care for rural patients.* Even when a rural provider is able to receive payment equivalent to their Traditional Medicare rate, getting timely payments is difficult. For example, when a provider bills for a service, a plan may deny the claim after the beneficiary received the service despite previously receiving prior authorization. NRHA members note that this happens most often for inpatient stays. To help combat some of these abuses, particularly for inpatient care, NRHA encourages HHS to finalize provisions in the contract year 2026 Medicare Advantage and Part D proposed rule around concurrent and retrospective coverage reviews.[5]

3. *MA plans make timely payments to rural providers.* NRHA members have voiced that payment-related challenges with MA plans have negatively impacted their patients, staff, and facilities. Payment challenges are heightened for providers with special rural designations and payment systems, like CAHs and RHCs because of unique cost-based reimbursement structure.

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[1] https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08273.pdf page 3
[2] https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf
[3] https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf
[4] 42 C.F.R. § 422.214(b) (2023); https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.
[5] In particular, NRHA urges CMS to finalize proposals in "*V. Clarifying MA Organization Determinations To Enhance Enrollee Protections in Inpatient Settings"* of the proposed rule to prohibit plans' ability to revoke coverage decisions on inpatient admissions and provide timely notice and appeal rights to beneficiaries during concurrent reviews.

Clarify how Rural Emergency Hospitals should be paid under Medicaid. The Rural Emergency Hospital (REH) designation was created in January 2023 and serves as a lifeline for rural hospitals that may otherwise close. REHs receive an enhanced outpatient prospective payment system (OPPS) rate from Medicare in exchange for ceasing inpatient services, providing 24/7 emergency department care and optional outpatient services, and meeting identified conditions of participation (COPs). Since the designation began, 32 rural hospitals have converted and maintained local access to care in their communities.[6] The legislation that created the designation did not define REH services under Medicaid.[7] As such, CMS under the Biden Administration has held that REHs should be paid at the lower, clinic services rate. NRHA disagrees with this decision as REHs are clearly hospitals providing emergency and outpatient services, and they must be paid as hospitals. **NRHA urges the Administration to issue federal policy guidance through a State Medicaid Director Letter or Informational Bulletin allowing states to pay REHs at hospital rates under Medicaid.**

First Year Focus Areas

Centers for Medicare and Medicaid Services (CMS): NRHA identified several areas of improvement that CMS can implement through annual Medicare rulemaking cycles in order to support rural providers and beneficiaries. Rural hospitals are at a crisis point, **with nearly half operating on negative margins,**[8] and therefore needing relief from burden regulatory policies.

Extend current site neutral payment policy exemptions to Medicare-Dependent Hospitals. The current Medicare site-neutral payment policy applies to off-campus hospital outpatient departments established after the date of enactment of the Bipartisan Budget Act of 2015, with the exception of rural Sole Community Hospitals (SCHs). **NRHA urges CMS to allow rural Medicare-Dependent Hospitals (MDHs) to also receive an exemption from the burdensome site neutral policies.** The same considerations that justified the exemption for SCHs apply to MDHs[9] as they face challenges in maintaining service volumes and meeting healthcare needs. In fact, off-campus hospital outpatient departments of MDHs may see higher volumes because they serve as the only point of access to care for their communities.

Allow SCHs and MDHs to receive indirect medical education payments. SCHs and MDHs can be paid the federal inpatient prospective payment system (IPPS) rate or a cost-based hospital-specific rate that is based on a hospital's costs from a specified year. SCHs and MDHs paid under the federal rate receive both direct graduate medical education (DGME) and indirect medical education (IME) payments, whereas those SCHs and MDHs paid under their hospital-specific rate only receive DGME payments. This policy stifles rural physician training as SCHs and MDHs are well-situated to host rural residency programs yet are financially disincentivized from establishing programs. NRHA believes that **CMS should allow IME payments to SCHs and MDHs paid under their hospital-specific rate through the upcoming fiscal year 2026 IPPS rulemaking cycle in order to strengthen physician training in rural areas and provide additional viability to critical rural hospitals.**

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[6] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/

[7] The Consolidated Appropriations Act of 2021, which created the REH designation, only amended the Medicare statute in the Social Security Act at 42 U.S.C. § 1395x(kkk) and did not make corresponding changes to the Medicaid statute.

[8] Michael Topchik, et al., *Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory,* Chartis (2024), 2, https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf.

[9] https://www.cms.gov/files/document/hcfr-14-2-97pdf

Modernize the RHC Program. CMS must modernize RHC regulations to bring the program in line with the current realities of providing care in a rural area through the calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) rulemaking cycle. These include:

1. *Redefine "a facility which is primarily for the care and treatment of mental diseases" as it pertains to how much behavioral health care RHCs can furnish.* In the CY 2025 PFS final rule, CMS declined to define the term "mental disease", which is found in the RHC statute.[10] **"[A] facility which is primarily for the care and treatment of mental diseases" should be defined as clinic types that provide behavioral health care only**, including certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. Doing so would allow RHCs that predominantly provide primary care to increase the provision of much needed behavioral health services.

2. *Make telehealth flexibilities permanent.* In the CY 2025 PFS, CMS used its authority to extend RHCs' and federally-qualified health centers' (FQHCs) ability to furnish telehealth services through 2025, regardless of a congressional extension of Medicare telehealth flexibilities. CMS finalized a policy to continue to allow RHCs and FQHCs to bill code G2025 for telehealth visits. **NRHA asks that CMS make telehealth capabilities at RHCs and FQHCs permanent.** RHCs have been hesitant to make investment in telehealth infrastructure and technology given the uncertainty of their distant site status, stifling the growth of telehealth in rural areas where it is most needed.

3. *Establish payment parity for RHC and FQHC telehealth services.* Unlike all other provider types, RHCs and FQHCs do not receive the same reimbursement for in-person and telehealth visits. In addition to the policy above, CMS proposed an alternate policy option that it did not finalize which would have added telehealth visits to the definition of an RHC or FQHC visit. **NRHA urges CMS to revisit this policy in the CY 2026 PFS proposed rule.** By adding telehealth services to the definition of an RHC or FQHC visit, these providers will be paid their specific Medicare rates rather than the lower telehealth rate that they currently receive. NRHA members have found that costs to provide telehealth visits are similar to or the same as in-person, including staffing costs, a system or platform for the telehealth visits, space for the provider to meet virtually with the patient, and all overhead costs associated with the brick-and-mortar clinic. As such, payment parity is paramount to help RHCs and FQHCs make the necessary investments in telehealth to expand rural access to care.

4. *Allow same-day billing for annual wellness visits.* Medicare Annual Wellness Visits (AWVs) are important tools to increase beneficiaries' awareness and use of preventive care. Yet RHCs are not able to bill Medicare for AWVs in conjunction with a medical visit provided on the same day. As a result, RHCs are not incentivized to furnish AWVs because they either provide the service without adequate reimbursement or ask a beneficiary to return for an AWV on another day. Additionally, registered nurses cannot provide AWVs at RHCs whereas they can in other outpatient settings. This policy creates another barrier for beneficiaries seeking preventive care at RHCs. Therefore, **NRHA asks CMS to allow RHCs same-day billing for annual wellness visits under Medicare.**

Support rural EMS services. NRHA encourages CMS to **amend the Medicare Ground Ambulance Data Collection Survey to encourage hospitals to report overhead costs associated with ground ambulance services.** In the Bipartisan Budget Act of 2018, Congress required CMS to set up the ground ambulance data collection system (GADCS) to gather data to evaluate ambulance payment

[10] 42 U.S.C. 1395x(aa)(2)(ii) ("The term "rural health clinic" means a facility which […] is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases").

rates. This was done in conjunction with Congress extending the existing ambulance add-ons, including the rural add-on payments, that have been in place for a number of years now. In many parts of the country, particularly in rural areas, adequate ambulance services would not exist without the efforts of the local hospital to operate them. The current ground ambulance survey instrument goes into some detail to address ambulance services operated by entities with other services, but it doesn't adequately address all the costs hospitals incur when operating services. Rather than clearly stating that hospitals should use a process similar to the Medicare cost report (also created by CMS), it seems CMS does not encourage the same approach for the GADCS, which could result in a significant understatement in such costs when the GADCS results are reported. This could lead to comparisons showing rural hospital-based ambulance costs are less than urban costs, and Congress may end up eliminating the add-ons rural hospitals currently get and desperately need to retain ambulance services.

Improve rural innovation at CMS' Innovation Center. The CMS Innovation Center (CMMI) has historically excluded rural providers from participating in new, innovative payment models. This has been done both explicitly, as well as implicitly by not considering the barriers to participating in value-based models that rural providers face. CMMI should help ready rural providers for the transition to population health. **Efforts from the 2024 Rural Health Hackathon must be built upon to ensure that rural providers are integrated into value-based initiatives**. Further, strides made to include rural providers in CMMI demonstrations, such as ACO Primary Care Flex, must be continued. In order to facilitate rural providers into such models, CMS should explore reinterpreting the statutory "cost savings" mandate as rural providers in value-based care often take longer to achieve cost savings. For example, frontier hospitals need support tailored to their unique circumstances, like low patient volumes and isolation. CMS should allow for regulatory flexibilities that would assist with the long-term viability of frontier healthcare. Top priorities for consideration include waiving CAH length of stay requirements and 3-day prior hospitalization for skilled nursing facility (SNF) services. Conditions could be put in place to allow any frontier facility to qualify for eligibility.

Address outdated cost report policy. Medicare cost report methods date back to 1965 and have remained largely unchanged since. Allocation of Administrative and General (A&G) costs to subsidiary units reduces Medicare cost reimbursement for cost-based providers like CAHs and RHCs. Cost report allocation is the foundation of all strategic initiatives in a CAH. Often subsidiary services are non-or low margin services, yet critical services required for population health initiatives such as home health agencies, nursing homes, meals on wheels programs, early childhood intervention, supportive home care, assisted living, childcare, senior housing, and geriatric psychiatric services. **NRHA asks that HHS form a working group on cost report modernization to kickstart efforts towards cost report improvements much needed to support rural provider viability and beneficiary access.**

Health Resources and Services Administration. NRHA suggests the following programmatic changes related to rural health at the Health Resources and Services Administration (HRSA).

Support rural provider networks. The Federal Office of Rural Health Policy (FORHP) at HRSA **should establish a Rural Hospital Network Initiative.** Independent rural hospitals and other independent rural providers lack the size and scale to compete effectively in a health care environment in which size and scale are integral to succeed against competitors, achieve efficiencies, effectively collect and use data, recruit and retain workforce, reduce patient bypass, negotiate with payers, and make the transition to value-based care. The existing Rural Network Development Program authority within FORHP should be refined and improved to help support networks or

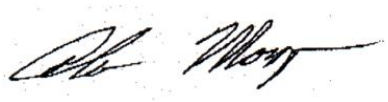
independent rural providers. This would allow facilities help to move beyond a focus on reimbursement as the sole way to reduce rural hospital closure or mergers and instead provide a sustainable path forward for small, independent hospitals. A network of independent rural providers would foster collaboration and equip rural hospitals with the resources needed to remain open, expand service lines, and better meet patient needs.

National Health Service Corps. The National Health Service Corps (NHSC) is a valuable program for rural providers and patients as it expands access to care in high-need areas, like rural communities. NRHA asks that HRSA add REHs as NHSC-eligible sites. REHs are one option for financially vulnerable hospitals to remain open; currently 32 rural hospitals have converted to this designation.[11] As the REH program grows **NRHA believes that they must be able to retain their eligibility as a NHSC site as they transition from a CAH to REH status**. The nature of the REH designation and services align with the purpose and goals of the NHSC. NHSC eligible site guidelines prohibit all inpatient hospitals, except CAHs and Indian Health Service hospitals, from participating in NHSC. REHs meet this guideline as they may only furnish emergency department and outpatient services. REHs would not change the composition of the NHSC program as they are not inpatient hospitals and are focused on maintaining local access to primary care.

340B Program. HRSA must **reinstate the 340B waiver to allow hospitals to provide 340B drugs to patients at an off-site outpatient facility (a "child site")** even if the covered entity's child site is not yet listed on the most recently filed Medicare cost report and registered with HRSA's Office of Pharmacy Affairs (OPAIS). Cost reporting and OPAIS registration may not occur until almost two years after a child site opens, thus this policy deprives covered entities of the ability to purchase 340B drugs at these sites for an extended period of time after opening, even though the Medicare program may consider these sites part of the hospital immediately upon opening. The 340B Drug Pricing Program is a lifeline that allows rural safety net providers to stretch scarce federal resources and keep their doors open to provide vital services to their communities.

NRHA appreciates your consideration of our rural health priorities. We look forward to working together to improve rural health and health outcomes across the country. **We would welcome a meeting with your team to discuss these priorities further.** Please contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel (amckinley@ruralhealth.us) to schedule a meeting.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[11] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/