National Rural Health Association

A View from the Hill: Rural Health Policy Updates

ICAHN 2022 Annual Conference

Carrie Cochran-McClain
Chief Policy Officer

November 10, 2022

National Rural Health Association

NRHA

Your voice. Louder.

NRHA is a national nonprofit membership organization with more than 21,000 members, made up of a diverse collection of individuals and organizations with the common goal of ensuring all rural communities have access to quality, affordable health care.

Our mission is to provide leadership on rural health issues.

National Rural Health Association

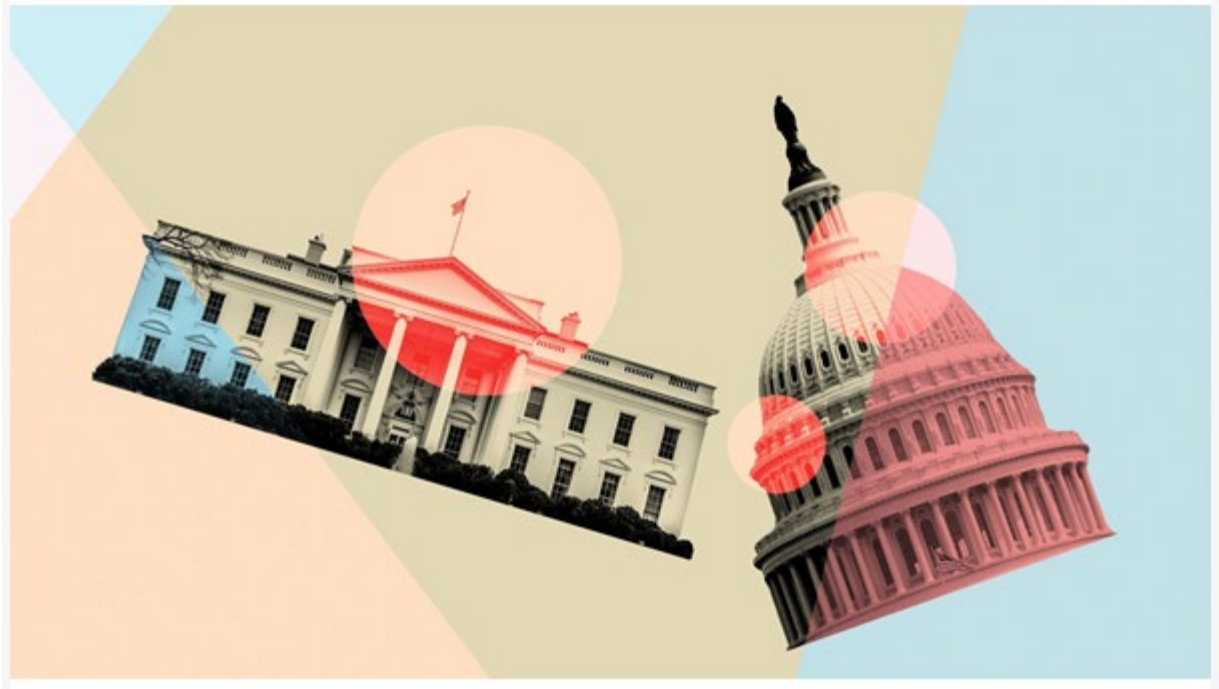
What We Fight for on Behalf of Rural

- Investing in a Strong Rural Health Safety Net
- Reducing Rural Healthcare Workforce Shortages
- Addressing Rural Declining Life Expectancy and Inequality

National Rural Health Association

Agenda

- The Rural Health Context
- View from the Hill
- Rules, Rules, Rules
- Advocating for Rural Health

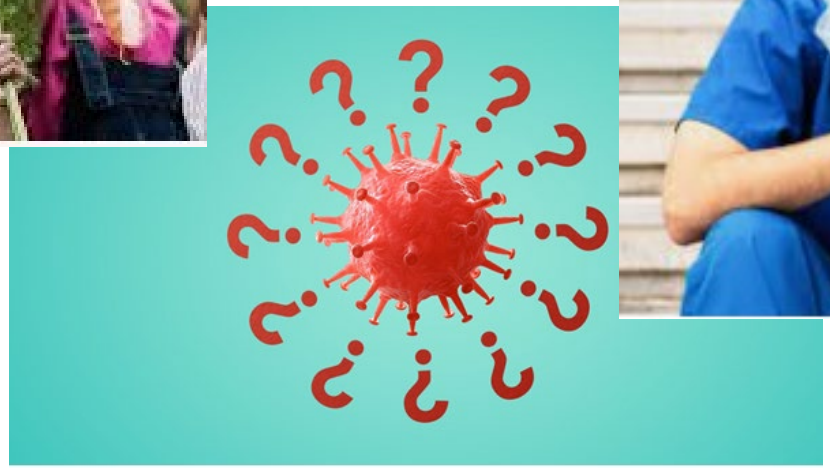


So… where are we?
Setting the Rural Health Context

NRHA
Your voice. Louder.

National Rural Health Association

What's Happening in the USA?



National Rural Health Association

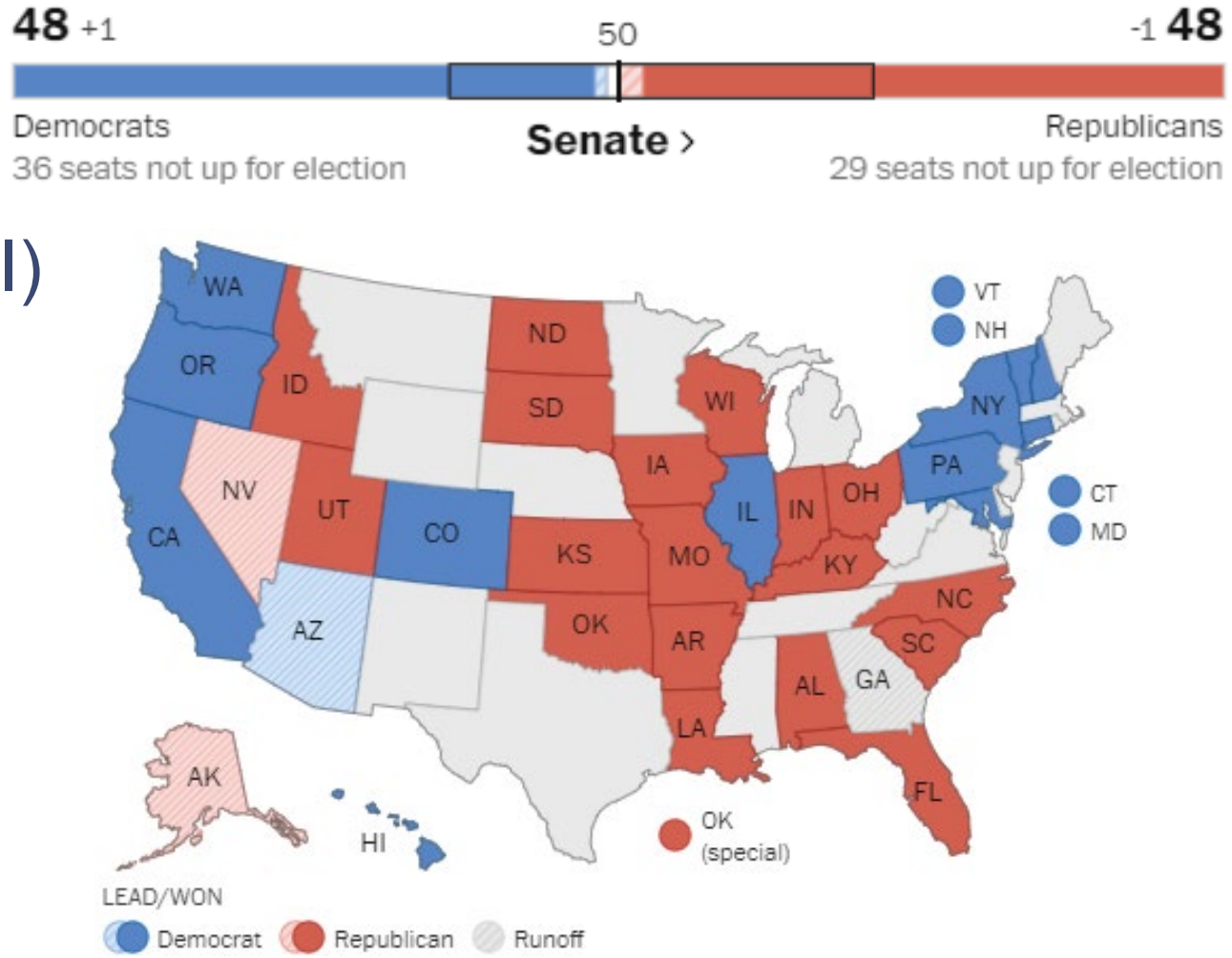
The more things change, the more they stay the same

- The 118th Congress is shaping up to look very similar to the 117th Congress.
- Polling indicating a Republican wave coming to Washington was significantly off.
- Republicans may still secure one or both chambers of Congress, but what that means for the 118th Congress is slim majorities in both chambers no matter who is in control.
- Single-party governing appears out of the question, and bipartisanship will have to commence to pass legislative priorities.

The US Senate

Of most competitive races:

- Called for the GOP (NC, OH, WI)
- Called for the Demos (CO, NH, PA)
- Undecided???
  - Republicans ahead Nevada
  - Democrats ahead in Arizona
  - Runoff coming in Georgia on December 6th



National Rural Health Association

The House of Representatives

- 218 votes to control the House
- Appears the House of Representatives will be in Republican control
- This majority of five to ten votes will require Democrat support to legislate

Race	Votes in	NYT win prob.	NYT est. of final vote
Ore. 6	56%	66% Dem.	D +2.8
Nev. 3	80%	64% Dem.	D +2.2
Nev. 1	80%	62% Dem.	D +2.5
Wash. 8	58%	61% Dem.	D +2.3
N.M. 2	>95%	59% Dem.	D +0.2
Calif. 13	42%	53% Dem.	D +0.8
Calif. 27	46%	56% Rep.	R +1.4
Ore. 5	69%	57% Rep.	R +1.5
Calif. 22	31%	57% Rep.	R +1.5
Colo. 8	94%	59% Rep.	R +1.4
Colo. 3	>95%	68% Rep.	R +0.7
Ariz. 1	65%	73% Rep.	R +4.4

↑ 206 DEM. WON OR FAVORED

10 TOSSUPS

219 REP. WON OR FAVORED ↓

National Rural Health Association

Gubernatorial Results

Ariz.	Hobbs +0.23
Fla.	DeSantis wins
Ga.	Kemp wins
Kan.	Kelly wins
Maine	Mills wins
Mich.	Whitmer wins
Nev.	Lombardo +5
N.M.	Lujan Grisham wins
N.Y.	Hochul wins
Ore.	Kotek +1.9
Pa.	Shapiro wins
Texas	Abbott wins
Wis.	Evers wins

National Rural Health Association

Where was health care on the ballot?

- South Dakota appears to have expanded Medicaid through a ballot initiative bringing non-expansion states from 12 to 11.
- Arizona approved a measure to reduce the maximum amount of interest creditors can charge on medical debt.
- Oregon moving to make health care a right in state constitution.
- Other key issues on the ballot include abortion and drug policy.

National Rural Health Association

What does Tuesday mean for rural health?

Divided government likely coming to Washington.

- Control of the Senate stay Democrats & House likely swings to Republicans.
- Limit use of tools like reconciliation, but both parties will have to be involved in all legislating.

Bipartisanship to accomplish legislative success.

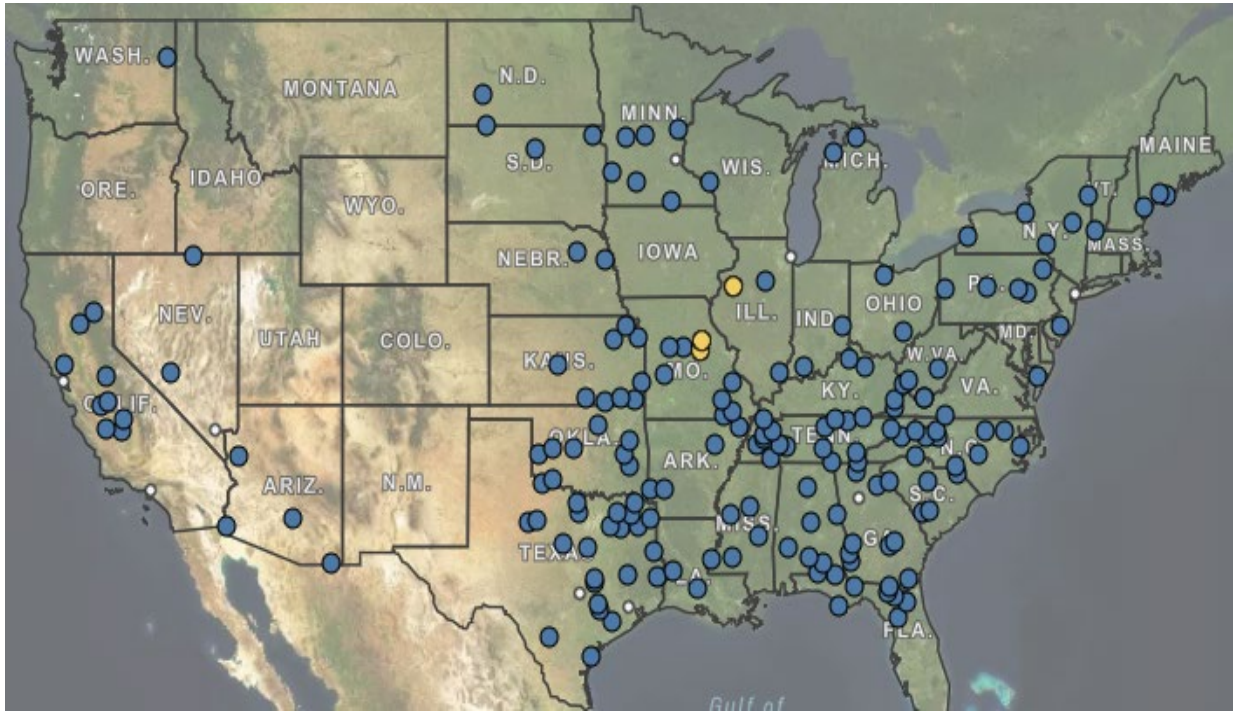
- Farm bill must be done in 2023.
- Mental health is still a priority for both parties.
- Decreased regulations/ extension of flexibilities provided during PHE.
- Enhancing the RURAL HEALTH safety-net.
- Other? Telehealth, Cybersecurity,

View from the Hill: Updates from Congress

NRHA
Your voice. Louder.

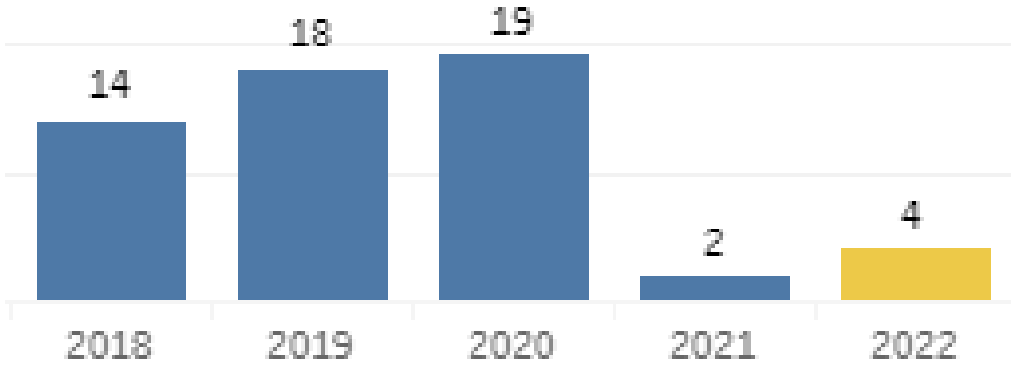
National Rural Health Association

Rural Hospital Viability



As of 2022

Closures 2018-2022



Source: Sheps Center, UNC
https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

National Rural Health Association

Red Sky in Morning, Sailor's Warning

Negative Operating Margin	Medicare Sequester	PAYGO	Rural Hospital Staffing
45%	**$228.5M**	**$900M+**	**96.2%**
Excluding relief funds	2% cut July-Dec 2022	4% cut 2023	said nursing #1 need

What left for this fall?

Key Dates

- November 8 – Midterm elections
- November 14 – Congress returns from recess
- December 5-9 – NRHA advocacy week!
- December 6 - Georgia run-off election (if necessary)
- December 16 – CR expires prompting either CR or omnibus
- January 3 – End of 117th Congress, beginning of 118th Congress
- Early January- Debt ceiling

National Rural Health Association

Will Congress pass a year-end package?

- If Tuesday had prompted a 'red wave' as some predicted, there was a higher likelihood that Republicans would want to move consideration of a year-end package next Congress.
- That did not happen. Conventional wisdom now indicates that an omnibus bill will be considered before year-end.
  - This means that non-appropriations provisions can ride along typical budgetary provisions.

FY 2023 Appropriations

- Limited action on the FY 2023 appropriations process thus far.
- Continuing resolution (CR) likely pushing consideration and debate of the appropriations bills until mid-December.
- At this time, NRHA is pleased with the numbers released by House and Senate appropriators.
- Because of the lack of top-line budgetary numbers, Republican engagement has been limited at this time.
- NRHA expects a massive year-end package to move both appropriations bills, and other non-budgetary provisions.

FY 2023 Appropriations

	FY 2022 Enacted	President's Budget	NRHA Request	HAC FY 2023 Bill	SAC FY 2023 Bill
RHC Behavioral Health Initiative	New request	$10 million	$10 million	$5 million	$5 million
Rural Hospital Flexibility Grants	$62 million	$58 million	$68 million	$68.5 million	$62 million
State Offices of Rural Health	$13 million	$13 million	$14 million	$13 million	$12.5 million
Rural Residency Planning & Development	$11 million	$13 million	$13 million	$13 million	$12.5 million
National Health Service Corps	$122 million	$210 million	$210 million	$155.6 million	$135.6 million

Funding bill likely an Omnibus

Appropriations revisited!

- NRHA feels good about where the numbers are falling so far in the FY 2023 bills.
- However, because this is the last train leaving the station, we're urging inclusion of non-appropriations provisions.

What are we pushing for in this year-end package?

- Removal of the ARPA PAYGO sequester and repeal of Medicare sequestration for rural hospitals;
- Medicare extenders: Ground ambulance add-on payments, Conrad 30 J-1 Visa, LVH/MDH designations, Home Health add-on;
- Extension of telehealth beyond 151-day extension, with rural friendly tweaks;
- 340B protections, setting the tone for more advocacy in the 118th.

Status of our Requests

- **Telehealth**
  - Two-year extension of telehealth flexibilities under current statute passed the House of Representatives in July.
  - Singling a timeline in mind?
  - NRHA urging an extension be accompanied by rural friendly tweaks (RHC/FQHC payment parity) and the continuation of audio-only telehealth.
- **Medicare extenders**
  - LVH/MDH, which is set to expire on September 30, is included in the CR text until December 16.
  - Five years seems most likely.
  - NRHA signed a letter urging ground ambulance plus up payments to be continued at a higher rate.
- **Sequestration**
  - NRHA feels confident the ARPA PAYGO sequester will be waived, but significant advocacy is needed on the Medicare front.
- **340B**
  - Long-term request. Hoping for some action before year-end to prepare us for the 118th

Focus on Critical Access Hospitals

- **Flexibilities and Waivers**
  - Telehealth flexibilities for CAHs provided through the 1135 waiver process continued within this year's OPPS proposed rule.
  - NRHA tracking on the end of the PHE, and waivers associated with it. This includes the 96-hour rule. Representatives Smith and Sewell are leading legislation to remove the rule, and a letter to better understand CMS' intent with the rule moving forward.
- **Coinsurance Fairness for Beneficiaries at CAHs**
  - NRHA is supportive of legislation to amend the coinsurance requirements for beneficiaries at CAHs so that they aren't required to be billed 20 percent of cost, rather 20 percent of reasonable costs as beneficiaries are able to at Rural PPS Hospitals.
- **Necessary Provider Status**
  - NRHA is supportive of reinstating Necessary Provider status, which sunset in 2006.

Rules, Rules, Rules: Regulatory Activities

NRHA
Your voice. Louder.

Recent Requests for Information (RFI)

- HHS RFI on Environmental Justice Strategy and Implementation Plan
- CMS RFI on Medicare Advantage
- Substance Abuse and Mental Health Services Administration RFI on Mental Health and Substance Use Wellbeing and Climate Change
- CMS RFI on Promote Efficiency, Reduce Burden, and Advance Equity within CMS Programs

CMS 2023 Final Rules

- **Medicare Enrollment & Eligibility**: NRHA summary
- CY 2023 Medicare **Home Health Prospective Payment System**: NRHA summary
- CY 2023 **Medicare Physician Fee Schedule**
- CY 2023 Medicare **Outpatient Prospective Payment System and Rural Emergency Hospital** policies
- REH Final Rules! NRHA **summary** circulated

Medicare Physician Fee Schedule

Medicare Shared Savings Program changes

- Advance investment payments - $250,000 one-time payment and additional quarterly payments
- Slower transition to performance-based risk for new, inexperienced ACOs
- All ACOs may remain in Level E of the BASIC track
- Quality performance – health equity upward adjustment & new sliding scale
- Reduced cap on negative regional adjustments

Medicare Physician Fee Schedule

- Medicare payment for dental services “inextricably linked to, and substantially related and integral to” another covered medical service
- Auxiliary personnel (i.e., LMFTs, LPCs) may practice under general supervision
- Medicare payment for OTP services at mobile medication units
- RHCs new care management codes for BHI and CPM
  - 12-month consecutive cost reports are used for establishing payment limit for certain provider-based RHCs
- Audio-only telehealth will not be extended beyond the 152nd day post-PHE

Outpatient Prospective Payment System

- Slight conversion factor update – 3.8% – like in IPPS final rule
- 340B drugs will be reimbursed at the ASP 6% rate
- Permanently continuing “hospitals without walls” policy, including for CAHs
- Nonphysician practitioner may provide general, direct, and personal supervision of diagnostic tests
- Rural sole community hospitals (SCH) are exempt from the site-specific Physician Fee Schedule rate for off-campus departments
- Continuing SCH 7.1% payment adjustment
- Payment adjustment for OPPS and IPPS hospitals that bought domestic made, NIOSH-approved N95 masks

CAH Conditions of Participation

485.610(c)(2): Primary roads for determining the driving distance of a CAH and its proximity to other providers is defined as:

- A numbered Federal highway, including interstates, intrastates, expressways, or any other numbered Federal highway **with 2 or more lanes each way**; or a numbered State highway with 2 or more lanes each way.
  - *Change from proposed rule*: One lane Federal highways are not primary roads

- REHs will not count in CAH distance determinations because they are outpatient only and do not serve the same purpose.

REH Payment Policies

- REH services: All covered outpatient department services under OPPS
  - REH services are paid the **OPPS rate plus 5%**
  - Non-REH services (i.e., lab services, SNF, rehab) are not paid additional 5% (statutory barrier)
  - REHs can use OPPS claims processing system with an REH identifier
  - **REHs are not paid under OPPS**; just using the rate + claims processing
- Monthly facility payment: REHs will receive $272,866 /month in CY 23
  - About **$4,000 more per month** compared to proposed rule because CMS attributed the low-volume payment to all CAHs in the methodology
  - Increased each year by the hospital market basket percentage
- Clarification that REHs may **operate provider-based rural health clinics** (RHCs) and can **maintain their excepted status** upon the hospital's conversion

REH Conditions of Participation

- Largely finalized CoPs as proposed, many mirror CAH CoPs
- CMS defines an REH as (42 CFR § 485.502):
  - An entity that operates for the purpose of providing emergency department services, observation care, and other outpatient services in which the annual per patient average length of stay does not exceed 24 hours.
  - *Change from proposed rule:* Includes instructions on how to calculate a patient's length of stay
- Laboratory services (§ 485.518): Must offer lab services necessary for immediate treatment and diagnosis of patients 24/7.
  - *Change from proposed rule*: Included language that lab services offered should be consistent with the REH's patient population.
- Staffing (§ 485.528): ED must be staffed 24/7.
  - *Change from proposed rule*: ED must be staffed 24/7 by an individual(s) competent in the skills needed for emergency care and that can receive patients and activate appropriate medical resources needed by patient

Advocate With Us!

NRHA
Your voice. Louder.

December Advocacy Week

- We invite everyone to join us for a virtual Hill week from **December 5 – 9, 2022**
- The goal is to meet with as many offices as possible and lift up our year end priorities and appropriations requests
  - One last push to ensure the rural voice is heard and included in the year-end package
  - Similar to PI, state contacts will facilitate and help set up meetings
- For those interested, you can register **here**
- There will be a planning call during the week of **November 28**

Year-End Leave Behinds

- **NRHA year-end asks leave behind**
  - High-level overview of the biggest issues we hope to see resolved before the new Congress.
  - Includes our specific requests on each issue.

NRHA Advocacy Year End Asks

Since 2010, 139 rural hospitals have shuttered their doors, including dozens since the onset of COVID-19. When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin exits, affecting the larger community. Coming out of the pandemic, it is critical Congress uses every tool to equip rural providers with the stability they need to keep their doors open. Currently, there are more than 450 rural hospitals operating on margins similar to those that closed. Unless Congress takes decisive action, NRHA is concerned we could see a tsunami of closures. To equip providers with the tools and resources they need, NRHA recommends Congress takes the following actions:

2. Critical Rural Medicare Extenders

NRHA supports legislation to extend the Medicare Dependent Hospital (MDH) and Low- Volume Hospital (LVH) designations, the Conrad 30 J-1 Visa waiver program, and increased Medicare payments to rural areas for ground ambulance services.

The MDH and LVH designations are set to expire on September 30, 2022. Currently, there are 139 MDHs and 545 LVHs nationwide that are integral parts of the rural health safety net. These designations allow hospitals to receive additional Medicare payments due to their low volumes and heavy Medicare population.

Request: NRHA urges support for *S. 4009/H.R. 1887,* the *Support Rural Hospitals Act, H.R. 8747* the *Assistance for Rural Communities Hospitals Act, or H.R. 8565* the *Rural HELP Act of 2022* to continue these lifeline programs.

FY 2023 Appropriations Requests

- **FY 2023 appropriations requests leave behind**
  - One page summary of our 6 requests including funding levels
  - Includes a table of our requests and allocations

National Rural Health Association

FY 2023 Appropriations Request

It is critical that Congress fully funds the rural health safety net before the end of the calendar year. Long-term continuing resolutions (CR) are disruptive to day-to-day operations and cause uncertainty for programs rural providers rely on. In order to provide stability, NRHA urges Congress to pass a full-year, Fiscal Year (FY) 2023 appropriations bill as soon as possible.

Although current spending for rural health discretionary programs is relatively small, it plays a crucial role in strengthening health care systems in rural communities. To ensure rural providers can remain in their communities and supply the care needed, NRHA urges Congress to support the following funding requests to improve rural health care access and affordability:

Increase funding for the Medicare Rural Hospital Flexibility (Flex) Program to $73.5 million in FY 2023. Flex Program grants are used by states to implement specific rural strategies to support small rural hospitals and ensure access to primary care in rural communities.

FY 2023 Appropriations Requests & Allocations					
Discretionary Funding Program	FY 2022 Enacted	NRHA's FY 2023 Request	President's FY 2023 Budget Request	HAC FY 2023 Allocations	SAC FY 2023 allocations
Federal Office of Rural Health Policy Programs					
Rural Health Research & Policy Development	11	12	11	11	11
Rural Health Care Services Outreach, Network & Quality Improvement Grants	86	90	90	91	90
Rural Hospital Flexibility Grants	62	73	58	68.5	62

Current advocacy campaigns

Urge Congress to Extend Relief from Medicare and PAYGO Sequestration

Urge Congress to pass Save America's Rural Hospitals Act

Urge Congress to Include Rural Friendly Provisions in PREVENT Pandemics Act

Urge Congress to Extend Critical Medicare Programs

Urge Congress to Invest in Rural Health

National Rural Health Day

- NRHA is planning a social media campaign
- We would love stories/testimonies from members on why you all love rural health!
  - A brief quote (4-5 sentences)
  - Short video (under a minute)
  - Why you love rural health/chose to work in rural health
- The submissions will be posted on our social media every day leading up to NRHD (November 17)
- Please email any submissions to Grace Girard (ggirard@ruralhealth.us)

2022 NRHA Advocacy Goodies

- Sign up to receive **NRHA's Rural Roundup** & **NRHA Today**.
- Engage with NRHA Advocacy online!
  - Social media: **Twitter**, **Facebook**, **LinkedIn**, **Instagram**
- Contact your NRHA Government Affairs Team
- Email: **Carrie Cochran-McClain**, **Josh Jorgensen**, **Alexa McKinley**, **Grace Girard**, **Kristen Batstone**

NRHA's 34th Annual Rural Health Policy Institute

February 7-9, 2023 in Washington DC


NRHA
Your voice. Louder.

NRHA
Your voice. Louder.

REH Appendices

REH Conditions of Participation

- Largely finalized CoPs as proposed, many mirror CAH CoPs
- CMS defines an REH as (42 CFR § 485.502):
  - An entity that operates for the purpose of providing emergency department services, observation care, and other outpatient services in which the annual per patient average length of stay does not exceed 24 hours.
  - *Change from proposed rule:* Includes instructions on how to calculate a patient's length of stay
- Basic requirements (§ 485.504): Must meet the above definition, have a provider agreement in effect, and meet all CoPs
- Governing body (§ 485.510): Must be legally responsible for conduct of the REH (or a responsible individual)

REH Conditions of Participation

- Medical staff (§ 485.512): Must be made up of MDs or Dos and operate under medical staff bylaws approved by the governing body
  - Other appropriate practitioners may be granted medical staff privileges
  - Bylaws describe organization of medical staff, required staff qualifications, etc.
- Provision of services (§ 485.514): Must have written policies developed by professional staff, including at least one MD/DO
- Emergency services (§ 485.516): Must comply with CAH CoPs at § 485.618
  - Emergency services available 24/7
  - Practitioner on call and available within 30 minutes
  - RN may conduct certain medical screening exams

REH Conditions of Participation

- Laboratory services (§ 485.518): Must offer lab services necessary for immediate treatment and diagnosis of patients 24/7. CMS does not prescribe what services must be offered.
  - *Change from proposed rule*: Included language that lab services offered should be consistent with the REH's patient population.
- Radiologic services (§ 485.520): Mirror CAH CoPs on radiologic services. Hospitals should already be in compliance upon conversion.
- Pharmaceutical services (§ 485.522): Align with rules for CAHs. Hospitals should already be in compliance upon conversion.

REH Conditions of Participation

- Additional outpatient services (§ 485.524): REH can provide services typically furnished at a physician's office. These must align with health needs of the community as assessed by the REH.
  - Can offer surgical services
  - Anesthesia must be administered by doctor or CRNA/anesthesiologist's assistant with supervision
- Infection prevention and antibiotic stewardship (§ 485.526): Must have a facility-wide infection prevention and control and antibiotic stewardship programs. Must appoint at least one infection preventionist and at least one antibiotic stewardship program leader.
  - Reporting requirements from end of PHE through April 30, 2024, on seasonal flu and COVID-19 information; COVID-19 vaccination through Nov. 2023

REH Conditions of Participation

- Staffing (§ 485.528): ED must be staffed 24/7.
  - Must meet CAH requirements at § 485.631, which includes staffing, responsibilities of doctors, NPP responsibilities, and review of clinical privileges and performance.
  - *Change from proposed rule*: ED must be staffed 24/7 by an individual(s) competent in the skills needed for emergency care and that can receive patients and activate appropriate medical resources needed by patient
- Nursing services (§ 485.530): Must have nursing services available 24/7.
  - Director of nursing must be an RN that is responsible for operation of nursing services
  - All nursing services must be furnished and supervised by RN
- Should read these two provisions in conjunction with each other

REH Conditions of Participation

- Discharge planning (§ 485.532): Must have discharge process in place.
  - Discharge planning evaluation not required for all patients
- Patient's rights (§ 485.534): Closely align with those for hospitals at § 428.13, however some are less restrictive.
  - Patients must be notified of their rights.
  - Patients have the right to make decisions about their treatment.
  - Restraints and seclusion should only be used to protect patients, staff, and others from harm when other less restrictive means have proven ineffective. Must discontinue use as soon as possible.

REH Conditions of Participation

- Quality Assessment and Performance Improvement Program (§ 485.536): Closely mirror hospital and CAH QAPI CoPs.
  - *Change from proposed rule*: REHs must measure, analyze, and track staffing as a quality indicator. This is in addition to adverse patient events included in the proposed rule.
  - REHs part of a multifacility system can participate in a unified and integrated QAPI program
- Agreements (§ 485.438): Must have transfer agreement with level I or II trauma center. Not precluded from agreements with other facilities
  - Must be licensed by the state and verified/licensed as level I or II trauma center

REH Conditions of Participation

- Medical records (§ 485.540): Medical record CoPs mirror those for CAHs at § 485.638
  - Must maintain a records system
  - A designated member of the professional staff is responsible for the records
  - Must maintain confidentiality
  - Retain records for 5 years (or longer if required by statute)
- Emergency preparedness (§ 485.542): Same as CAH CoPs for EP
  - Emergency preparedness plans, policies and procedures, communication plans, and training and testing programs must be reviewed and updated at least every 2 years.

REH Conditions of Participation

- Physical environment (§ 485.544):
  - Must meet the provisions applicable to Ambulatory Health Care Occupancies and must follow the Life Safety Code for fire safety
  - Must meet the applicable provisions and must proceed in accordance with the 2012 edition of the Health Care Facilities Code for building safety
  - Secretary may waive any provisions that would cause undue hardship
- SNF distinct part unit (§ 485.546): Must be separately licensed and meet SNF CoPs at 42 CFR subpart 483.

Misc. REH Provisions

- Provider enrollment (§ 424.575): Hospitals convert to an REH by submitting a **Form CMS-855A change of information application** instead of a CMS-855A initial enrollment application.
  - No application fee.
  - Automatically lose CAH/subsection (d) hospital designation upon conversion.
  - Converting from REH to CAH/hospital requires CMS-855A initial enrollment form.
- Physician self-referral law
  - *Change from proposed rule*: Not finalizing REH exception for ownership/investment interests from proposed rule.
  - REHs can qualify for **rural provider exception:** services are provided in a rural area and at least 75% of services are furnished to residents of rural areas