February 5, 2021

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
United States House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi, Leader McCarthy, Leader McConnell, and Leader Schumer:

Last year, the Rural Health Action Alliance (RHAA) announced its formation to work toward equitable access to health care in rural America (link). Together, we seek to advance federal policies to improve health outcomes and disparities that exist for rural and underserved populations. Entering the 117th Congress, the undersigned organizations urge Congress to increase access to COVID-19 treatments and vaccines, increase workforce funding, expand coverage for appropriate uses of telehealth technologies, make certain temporary waivers permanent, and ensure rural providers and the people they serve receive and have access to equitable resources.

The undersigned organizations are extremely concerned with the current trend of COVID-19, particularly in rural America. According to a recent *Daily Yonder* article, the number of COVID-19 cases in rural America declined in recent weeks, but the deaths stemming from the coronavirus continues to occur at record levels (link). Sadly, rural deaths have topped 60,000 due to COVID-19. Additionally, it has become clear that rural America is facing an uphill battle on vaccine deployment compared to their urban counterpart (link). To help curb the devastation caused by COVID-19 and help deploy the vaccine to all corners of the United States, the undersigned members of the RHAA call on Congress to build upon the December appropriations and COVID-19 relief package to pass more, needed relief for rural providers. The undersigned organizations ask Congress to:

1. Support additional resources for vaccination distribution in rural areas.

The latest relief package included funding through the CDC for vaccination distribution, however there was no mention within the text for the geographical disadvantages facing rural America in accessing the vaccine (link). We urge Congress to use the next COVID-19 relief package to specify these distinct disadvantages and provide a rural carveout in any additional vaccine deployment funding. As the vaccination rollout continues, we are concerned about reports that communities are being left behind. With COVID-19 vaccination administration efforts struggling, we support efforts to increase the pool of eligible health professionals who can

vaccinate, such as optometrists. There are untapped health professionals who are fully trained and ready to help, especially in communities that need it most.

2. Provide additional resources to support the health care workforce in rural America.

The ongoing COVID-19 pandemic has greatly exacerbated health care workforce shortages in rural America. We ask Congress to invest sufficient funds to workforce programs like the National Health Service Corps and the Nurse Corps Loan Repayment Program to help providers for the duration of the public health emergency (PHE). These programs are necessary to increasing the health care workforce in rural areas.

3. Support additional funding for, and a rural set aside within, the Provider Relief Fund.

The Provider Relief Fund (PRF) has been a valuable life source for rural providers amidst the COVID-19 pandemic. We call on Congress to provide robust funding for the PRF in the next COVID-19 package. Within the most recent COVID-19 relief package, Congress provided $3 billion in new funding and backdated reporting requirements for PRF dollars to June 2020. While we are supportive of the work Congress did in the last package, more funding is needed within this critical program to help providers as COVID-19 caseloads continue to surge in rural America. Specifically, we ask that Congress support the 20 percent set aside particularly for rural providers. As rural providers care for 20 percent of, or 60 million, Americans, having this same allotment set aside will be an asset for rural providers as they face mounting caseloads.

4. Fix a critical technical error to the Rural Health Clinic program from the latest COVID-19 relief package.

The latest COVID-19 relief package included language amending the reimbursement for rural health clinics (RHC). The text increases the freestanding RHC limit to $100 beginning April 1, 2021, taking it to $190 in 2028. Additionally, the text subjects all "new" RHCs, both freestanding and provider-based, to the new per-visit cap, eliminating the exemption of payment limit for new provider-based RHCs in hospitals with 50 beds or fewer. Unfortunately, the legislative language change is effective retroactively, to December 31, 2019. This means any existing provider-based RHC certified after December 31, 2019, is subject to dramatic decreases in reimbursement. We believe this was a mistake within the text and urge Congress to make a technical correction so that provider-based RHCs created after December 31, 2019, are not unfairly punished.

5. Make permanent important telehealth flexibilities.

The undersigned members call on Congress to permanently extend certain telehealth flexibilities first designated to providers within the CARES Act and the 1135 waiver process, when the care can be fully performed via technologies available. Providers must be authorized to utilize telehealth after the expiration of the COVID-19 PHE so that patients have continued access to health care, which is especially important in rural communities. We were disappointed that Congress did not extend these important flexibilities, including audio-only services, beyond the duration of the PHE in the last COVID-19 relief package and urges Congress to act on this

quickly in the 117th Congress to provide stability for providers. Additionally, it is also critical to initiate an evaluation of patient outcomes related to expanded telehealth services during the pandemic.

6. Improve telehealth reimbursement methodologies for rural health clinics and federally qualified health centers.

Under current telehealth flexibilities, the reimbursement model for RHCs and Federally Qualified Health Centers (FQHC) does not accurately capture claims data and the repayment methodology. We call on Congress to update the repayment methodology and coding to accurately report the work being done via telehealth at RHCs and FQHCs. As Congress works to extend telehealth flexibilities in the next COVID-19 relief package, we ask that RHCs and FQHC be paid their full all-inclusive rate (AIR) for distant site telehealth visits. Further, we ask that telehealth visits be treated the same as in-person visits for cost reporting purposes. These changes would simplify and improve telehealth for RHCs and FQHCs and increase their ability to provide critical services during the COVID-19 pandemic.

7. Review temporary waivers and permanently remove unnecessary regulations.

The Centers for Medicare & Medicaid Services (CMS) exercised regulatory flexibilities to help providers contain the spread of COVID-19. In March 2020, dozens of temporary waivers from certain regulations were issued through the end of the PHE. Many of these temporary waivers allowed providers to practice at the top of their profession and increased patient access to health care. The temporary waiver of these outdated barriers has shown that these burdens only limit patient care, and therefore should be permanently removed. We call on Congress to review these temporary waivers and to permanently remove all unnecessary regulations.

8. Continue Medicare sequestration relief.

Included within the latest COVID-19 relief package was continued relief from Medicare sequestration until March 31, 2021. Since the passage of the Budget Control Act of 2011, providers have been subject to an arbitrary two percent sequester on Medicare payments. Extending the relief through the end of March is welcomed, but we believe it needs to be continued further. This provision has provided sustained relief for providers and has helped many rural providers keep their doors open during the PHE. Simply sunsetting this relief during the height of the pandemic will be detrimental to providers' bottom line and could result in more rural closures. The undersigned organizations urge Congress to continue this relief past March 31, 2021, to provide stability for rural providers.

9. Increase funding for state Medicaid programs, increase FMAP.

We urge Congress to increase the FMAP increase in the Families First Coronavirus Response Act (FFCRA) above 6.2 percent. Currently, the FMAP increase is set to expire at the end of the PHE. Congress should extend the length of time that states can receive these additional funds since the economic impact of COVID-19 is likely to last much longer than the PHE declaration.

The undersigned members of the RHAA hopes you and your colleagues will consider these ideas as you work to finalize the text of the next COVID-19 relief package. The RHAA stands ready to be a resource to Congress and the Administration as you continue your work. Please don't hesitate to reach out to Josh Jorgensen (jjorgensen@nrharural.org) if the RHAA can be a resource.

Sincerely,

National Rural Health Association
American Association of Nurse Anesthetists
American Podiatric Medical Association
American Nurses Association
American Psychological Association
National Association of Rural Health Clinics
American Optometric Association
National Organization of State Offices of Rural Health
National Association of Pediatric Nurse Practitioners
National League for Nursing
American College of Nurse-Midwives
American Physical Therapy Association
American Association of Nurse Practitioners