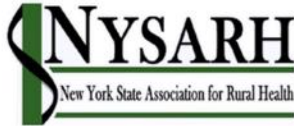

June 1, 2020

Dear Representative:

Hundreds of rural hospitals and rural health care providers are on the brink of closure.

We applaud the provisions in the Coronavirus Aid, Relief, and Economic Security (CARES) Act and in the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) that provided a temporary lifeline to rural health care providers. However, such relief is short-lived as rural providers continue to lose 50-80% of their revenue. The current rural hospital closure crisis will catastrophically escalate if more is not done. It is imperative to provide stabilization for rural providers as they face the pandemic head on and prepare to start regular procedures.

As you know, before the COVID-19 pandemic, rural health care providers were extremely vulnerable, with nearly half of all rural hospitals operating at a financial loss. Now, these hospitals are facing grave cash shortages. In fact, recently, the twelfth rural hospital in 2020 closed their doors, at a time when their community needs them the most. If Congress allows the hundreds of vulnerable rural hospitals to close, hundreds of thousands of rural patients will lose access to local emergency health services.

NRHA and NYSARH call for the following actions to ensure stabilization is provided to keep rural provider's doors open:

1. **Implement New Payment Models to Stabilize Rural Health Care by Adopting Recommendations of the Bipartisan Policy Center: The fragile state of rural health care must be stabilized during the COVID-19 pandemic and beyond.** It is unacceptable for rural communities to continue losing their access to care. A recent Bipartisan Policy Center report highlighted NRHA supported ideas for new models. There needs to be a rightsizing of health care services to fit the unique needs of a rural community. Rural transformation models such as the Rural Emergency Outpatient Hospital designation, Rural Emergency Acute Care Hospital (S.706), global budget model, Rural Emergency Health Center (H.R. 5808), and new CMMI projects are needed to establish sustainable payment structures for rural communities.

2. **Include *the Save Our Rural Health Providers Act* (S. 3823 / H.R. 7004) to establish a 20% Rural Carveout in the $100 Billion Provider Fund.** Priority should be granted to facilities that have been significantly affected by COVID-19 preparation, facilities that care for a disproportionately high percentage of Medicare and Medicaid patients, facilities that care for populations with above average senior populations or comorbidities that are particularly vulnerable to complications from COVID-19, and for areas with limited access to health infrastructure and high uninsured populations.

3. **Include *the Rural Hospital Closure Relief Act of 2019*** (S. 3103 / H.R. 5481) **in any future relief package**. This legislation allows the most vulnerable rural hospitals (rural PPS hospitals) to convert to Critical Access Hospitals (CAHs). Rural PPS hospitals have been most rural hospitals closed in the last decade and the CAH designation is a tried and proven equitable reimbursement structure that will keep rural health providers open.

4. **Ensure Rural Emergency Medical Services (EMS) relief.** EMS services in rural America were struggling prior to the COVID-19 pandemic and are now in crisis. An increase in funding of the SIREN Act, and a 20% add-on payment to the rural and "super-rural" Medicare extender provisions is needed.

5. **Provide Equitable Medicare Payments for Rural Providers.** S. 3665 would establish an appropriate national minimum (0.85) for the Medicare Area Wage Index (AWI) to ensure rural hospitals are paid for the care they provide. Last year, the Trump Administration made significant changes to the AWI, which provided higher Medicare payments for many rural hospitals, and this legislation will build upon that.

6. **Permanently Suspend Medicare Sequestration.** In the CARES Act, the Medicare sequester was suspended for the duration of the pandemic. This change needs to be made permanent to allow for rural hospitals to continue providing care to their communities. The 2% Medicare payment reductions due to the sequester are devastating for rural providers who are operating on slim margins.

7. **Permanently Keep Telehealth Changes.** Section 3704 of the CARES Act authorizes Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE. Also, now distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice, expanding the access to care for rural communities that lack an adequate workforce.

On behalf of the NYSARH membership, we implore you to take these important actions to stabilize rural health care providers.

Sincerely,
Sara Wall Bollinger
NYSARH