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Submitted electronically via http://www.regulations.gov.

Ms. Allison Beattie, Assistant Deputy General Counsel, HHS:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to the Office of the Secretary, Department of Health and Human Services, request for information (RFI) to assess the temporary deregulatory actions in response to COVID-19.

The Department of Health and Human Services (HHS) presented a request for information (RFI) pertaining to measures that have been taken in response to the COVID-19 Public Health Emergency (PHE). The request for information presents 382 regulatory actions; given our interest and expertise in rural issues, the Panel will comment on 17 of them. We are commenting in the context of the second *key* question (a) (b) and (c). Our principal recommendation for these specific regulations is that they be continued beyond the end of the PHE to at least such time that evidence is available as to their efficacy and contribution to achieving enhanced access to high quality services for rural residents.

We are grouping regulations into four categories:

1. Changes that enhance service availability for rural residents by allowing service site expansion;
2. Changes that enchance access to high quality care through telehealth;
3. Changes that addresss workforce needs; and
4. Changes that help meet unusual needs during a pendemic (surge capacity).

Service site expansion

The following will provide the panel's opinion related to service site expansion; specifically defining how these regulatory acts affect rural residents. The following will address inpatient hospital services and critical access hospital (CAH) status and location.

Action 118: Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital

This rule is quite reasonable during the PHE as a means of dealing with hospital capacity pressures. However, it may also be a natural experiment, testing more efficient and effective means of assuring access to hospital services, particularly in hard-to-serve places (rural and underserved). While we do not recommend continuing the rule without evidence of its efficacy, we do recommend an analysis of its use to reach previously underserved populations in rural and urban locations. In particular, use by rural PPS hospitals should be reviewed.

Action 165: CAH Status and Location

Comments made about Action 118 for PPS hospitals apply here for CAHs. During the PHE, this rule allows CAHs to respond to a surge in demand. On a more permanent basis, a transition to a "hospital without walls" may be a model for securing access in rural places from a base facility. An assessment of the effects of the rule should include financial impacts on the CAHs; would this approach enhance financial stability, thereby assuring local access to essential services?

Using telehealth-facilitated services

The following will address the panel's views on telehealth-facilitated services. The COVID-19 pandemic demonstrated the importance of telehealth in rural areas, and there are still challenges that must be considered following the pandemic.

Action 113: Telephone Evaluation and Management (E/M) Services Codes

Allowing use of these codes for both new and established patients may be a means of expanding access to services to areas otherwise hard to reach. This is particularly true in areas with limited access to high-speed broadband that will benefit from service delivery with telephone technology.

Actions 121 and 140: Requirements for Opioid Treatment Programs (OTP); Opioid Treatment Programs (OTP)—Furnishing Periodic Assessments via Communication Technology

Opioid abuse exacerbates the mental health workforce shortage, especially in rural areas and specifically among specialists. Requirements for treatment services persists, and the use of communication technology should be continued, after the pandemic. Telehealth services would enable increased access to mental health services, in response to the opioid epidemic, in rural and other underserved areas. This is particularly true in areas with limited access to high-speed broadband that will benefit from service delivery with telephone technology.

Action 123: Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) Telehealth

According to the CARES Act, RHCs and FQHCs are authorized to give distant site telehealth services to Medicare patients during the COVID-19 PHE. Medicare is now allowing telehealth communications even

without interactive audio and video telecommunications systems. Expanding allowable services further opens access to essential services in rural locations.

Action 125: Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Our comment regarding action 123 applies to Action 125 as well.

Effective use of workforce

The following will present the panel's views on effective use of workforce. Workforce capacity and the appropriate usage of the workforce has proven to be very important in combatting the pandemic.

Action 127: Home Health Orders from APPs

This action may enhance access to home health services by sustaining such services through allowing additional (other than MDs) qualified personnel to care for patients and certify their eligibility. This could be a means of providing services in areas of health professions shortages.

Action 145: Scope of Practice: Supervision of Diagnostic Tests by Certain Non-Physician Practitioners

Allowing non-physician practitioners to conduct diagnostic tests under supervision allows qualified professionals, practicing at the top of their licensure, to care for patients that might not otherwise receive services. This also may allow for residents of rural and underserved areas to have increased access to healthcare services.

Action 146; Scope of Practice: Pharmacists Working Incident to a Physicians' Service

Expanding the role of pharmacists as part of a care patient team by allowing them to provide services incident to those provided by the billing physician or NPP may expand access to such services in communities lacking the presence of the physician or NPP. The need for such access extends beyond the time of the PHE.

Action 192: Responsibilities of Physicians in Critical Access Hospitals (CAHs)

The requirement that the physician must be physically present in the CAH to give direction, consultation, and supervision was waived in response to COVID-19. Due to physician shortages in rural areas, allowing physicians to treat patients via telecommunications technology after the pandemic ends would increase access to care in rural and underserved areas where residents are affected by physician shortages. For services provided by CAHs, using telecommunications may also relieve the CAH of an unnecessary cost.

Action 194: Physician Supervision of NPs in RHCs and FQHCs

Allowing physicians to supervise NPs staffing RHCs and FQHCs by using by using telecommunications technology is a means of allowing cost-effective approaches to assuring medical direction for clinic activities. The logic underlying this waiver applies without the presence of a PHE. In rural and underserved areas, it would increase access to healthcare, and address physician shortage issues in these areas, but the general requirements are there due to general qualifications of NPs.

Action 195: Staffing Requirements for RCHs and FQHCs

The flexibilities of staffing requirements, in response to COVID-19, allow the facilities to mix staff, though there are still some requirements on who must be present. These staffing flexibilities would allow rural and underserved areas to staff facilities without having to meet specific staffing requirements that would prevent facilities from operating, and therefore, would increase access to healthcare. Consideration should be given to extending this waiver to allow RCHs and FQHCs maximum flexibility to serve the needs of rural residents in shortage and underserved areas.

Action 215: Eligibility for Telehealth

Expanding the types of professionals providing distant site telehealth services, clearly needed during the PHE, is means of addressing long-standing issues of access to routine care. The allied health professions specified in the waiver are essential providers for Medicare beneficiaries in recuperation or those with chronic conditions. Providing services to them close to their residence, including rural places that may not have sufficient demand to support locating allied health practices, is a benefit of telehealth communications technology that should be considered beyond the current pandemic-induced needs.

Surge Capacity

We encourage CMS to develop blueprints for future waivers during public health emergencies based on the experiences of institutions receiving waivers through the following actions. We recommend the waivers not be extended beyond the PHE, but that they be ready for any future need to surge capacity quickly in rural places.

Action 166: Hospitals Classified as Sole Community Hospitals (SCH)

Action 167: RHC and FQHC Temporary Expansion Locations

Action 196: CAH Staff Licensure

The above information presents the panel's response to the RFI. The panel presents a focus on the impacts the regulatory actions had on rural health. The panel appreciates the opportunity to offer comments on this RFI.

Sincerely,

The Rural Policy Research Institute Health Panel

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