

June 4, 2026

William N. Parham, III  
Director  
Division of Information Collections and Regulatory Impacts  
Office of Strategic Operations and Regulatory Affairs  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard Baltimore, MD 21244

**RE: CMS-10952A-D; Self-Attestation for Recertification of CORFs, OPT/SLP, and RHCs Providers and PXR Suppliers**

*Comment submitted electronically via regulations.gov.*

Dear Mr. Parham,

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) information collection request on self-attestation for recertification for rural health clinics (RHCs).

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, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA thanks CMS for its continued focus on reducing regulatory burdens for rural facilities. RHCs are important provider types in rural communities that increase access to outpatient services. NRHA has routinely supported removing administrative burdens from RHCs in order to focus limited resources and staff on activities that enhance access to care.

Nonetheless, NRHA believes that the RHC survey and certification processes run by State Survey Agencies (SSAs) is a critical accountability and patient safety tool. Like many rural facilities RHCs may face staff turnover and limited resources, making compliance with RHC regulations, including any annual changes made through rulemaking or guidance issued by CMS, more difficult to keep up with. The in-person survey process provides both an opportunity for RHC staff to work collaboratively with surveyors to ensure compliance and an accountability mechanism because a surveyor may come to the RHC at any time.

As such, NRHA cautions against the change from an initial certification survey and subsequent self-attestations. A self-attestation process may lead to less compliance among RHCs. The current initial certification and periodic recertification surveys is a reliable process to keep RHCs compliant with regulations and therefore guarantee that the best care possible is being delivered.

**As an alternative to removing in-person surveys, CMS should consider amending RHC regulations to remove unnecessary burden.** NRHA supports the following deregulatory actions:

### Behavioral health.

In the calendar year 2025 Medicare Physician Fee Schedule (MPFS) proposed rule, CMS considered, but did not move forward with, defining “facility for the care and treatment of mental diseases” as it pertains to the services that RHCs can provide. To simplify the RHC survey process and provide clear guidance for RHCs, NRHA urges CMS to define “facility for the care and treatment of mental diseases” in future rulemaking as “a facility primarily for the care and treatment of mental diseases” as clinic types that provide behavioral health care only, including certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. There is precedent for this approach as RHCs also cannot be “rehabilitation agencies” which is a term that CMS defines elsewhere.<sup>1</sup> This straightforward approach would make the survey process around meeting this requirement easy to implement and cite. So long as the RHC provides primary care services there should be no citation for providing any level of behavioral health care because any RHC providing primary care could not qualify as one of the facilities listed above.

**CMS should include this language in subsequent interpretive guidance and in 42 C.F.R. § 491.2 as follows:**

*Facility for the treatment of mental diseases* means a certified community behavioral health clinic, community mental health center as defined in 42 C.F.R. § 410.2, standalone opioid treatment program as defined in 42 C.F.R. § 8.2 and certified under § 8.11, or a facility that only provides intensive outpatient services as defined in 42 C.F.R. § 410.44.

### State Operations Manual (SOM).

SOM Appendix G provides comprehensive sub-regulatory guidance to RHCs on compliance with regulations and the survey and certification process. CMS has pursued several regulatory changes through the MPFS in the past few rulemaking cycles; however, Appendix G has not been updated to reflect some of these changes since 2024. Appendix G is the main resource that RHCs use to understand and comply with regulations, making timely updates critical. Should CMS transition to a self-attestation process, frequent Appendix G updates are even more important because RHCs will not have an in-person survey component to help staff understand and fulfill regulatory requirements.

### Telehealth.

In past rulemaking cycles, CMS considered amending the definition of an RHC to include visits conducted via telehealth, which would effectuate payment parity. Currently, unlike any other Medicare fee-for-service providers, RHCs do not receive the same amount for providing care via telehealth compared to in-person. NRHA urges CMS to pursue this proposal for RHC telehealth visits. Amending the definition of a visit for RHCs would be administratively simpler and more straightforward. Adding telehealth services to the definition of a visit would make billing for such services less burdensome on these providers. We ask that CMS seriously consider this change as it aligns with the provider burden reduction goals of the administration.

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<sup>1</sup> Outpatient Rehabilitation Providers, CMS.gov, Centers for Medicare and Medicaid Services, <https://www.cms.gov/medicare/health-safety-standards/certification-compliance/outpatient-rehabilitation-providers#:~:text=Rehabilitation%20Agency%20%2D%20An%20agency%20that,a%20team%2C%20specialized%20rehabilitation%20personnel.>

Since Medicare telehealth flexibilities have been implemented, rural beneficiaries' usage has been lower than urban beneficiaries.<sup>2</sup> One element of this disparity may be that some rural providers, like RHCs, have not been able to support telehealth services because of the added costs associated with furnishing them. Prior to the PHE and the subsequent extensions of telehealth flexibilities, many RHCs and FQHCs did not provide telehealth services because they could not serve as distant site providers and billing for the originating site facility fee was challenging and an administrative burden compared to the payout.<sup>3</sup>

Congressional proposals.

NRHA asks that CMS work closely with Congress to pursue burden reduction measures. H.R. 5199, the *Modernizing Rural Physician Assistant and Nurse Practitioner Utilization Act*, would simplify scope of practice rules for Nurse Practitioners (NPs) and Physician Assistants/Associates (PAs) working in RHCs. Currently, there are two different scope of practice rules for these practitioners. While many states allow full practice authority for NPs and PAs, outdated statutory language requires that these practitioners working in RHCs must be supervised by a physician Medical Director. The conflict in scope of practice rules creates an added layer of administrative burden for RHCs.

NRHA thanks CMS again for the chance to weigh in on this ICR. We look forward to working with the agency to continue to support rural providers and ease administrative burdens. For further information, or to discuss further, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain ([ccoehran@ruralhealth.us](mailto:ccoehran@ruralhealth.us)).

Sincerely,



Alan Morgan  
Chief Executive Officer  
National Rural Health Association

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<sup>2</sup> GOVERNMENT ACCOUNTABILITY OFFICE, *Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks* 13 (2022) <https://www.gao.gov/assets/d22104454.pdf>.

<sup>3</sup> OFFICE OF MINORITY HEALTH, CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Examining Rural Telehealth During the Public Health Emergency* 32 (2023) <https://www.cms.gov/files/document/examining-rural-telehealth-jan-2023.pdf>.