

June 16, 2022

The Honorable Ron Wyden  
Chairman  
U.S. Senate Committee on Finance  
Washington, D.C., 20510

The Honorable Mike Crapo  
Ranking Member  
U.S. Senate Committee on Finance  
Washington, D.C., 20510

The Honorable Richard Neal  
Chairman  
Committee on Ways and Means  
Washington, D.C., 20515

The Honorable Kevin Brady  
Ranking Member  
Committee on Ways and Means  
Washington, D.C., 20515

Dear Chairman Ron Wyden, Ranking Member Mike Crapo, Chairman Richard Neal, Ranking Member Kevin Brady, Members of the Senate Finance Committee, and Members of the House Ways and Means Committee:

The Rural Health Clinic (RHC) program is intended to increase access to primary care services for individuals in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities located in rural, underserved areas. The majority of RHCs are provider-based and are owned and operated as an essential part of a hospital, nursing home, or home health agency participating in the Medicare program. Independent, or free-standing, RHCs are clinics owned by a clinician or clinical entity. As of March 2022, there are 5,092 RHCs, with 3,323 (65.3 percent) being provider-based and 1,769 (34.7 percent) being free-standing.

Understanding the essential role free-standing and provider-based RHCs play in rural health care, NRHA recommends the Senate Finance Committee and House Ways and Means Committee take the following actions to uphold this critical designation.

**Ensure program integrity by upholding the RHC designation**

**Provide a statutory fix to ensure the provider-based RHC designation remains a viable option for small, rural hospitals and the communities they serve.**

Through passage of the Consolidated Appropriations Act (CAA), 2021, reimbursement for both free-standing and provider-based RHCs changed. Free-standing RHCs and provider-based RHCs are reimbursed by enhanced payments known as an all-inclusive rate (AIR) for medically necessary primary care and preventive health services. The AIR was subject to an upper payment limit for all services, except those provided by provider-based RHC in a hospital with 50 beds or less, in order to provide access to care at rates that reflected costs associated with care, including the allocated hospital overhead.

Section 130 of the CAA increased the AIR RHC upper payment limit to \$100 starting on April 1, 2021 and increasing each year to \$190 in 2028. NRHA fully supported this much needed change for free-standing

RHCs reimbursement as it is more reflective of current costs. While the Section 130 payment change will allow the broader RHC program to have a more viable long-term Medicare reimbursement policy, the change has significant implications and unintended consequences on the provider-based RHC program in small rural hospitals. Any provider-based RHC certified after December 31, 2020, will be subject to the same payment limits as freestanding facilities, meaning no new provider-based RHCs can receive cost-based reimbursement. Provider-based RHCs in existence as of December 31, 2020, would be grandfathered-in at their current AIR and would receive their 2020 AIR plus an adjustment for the Medicare Economic Index (MEI) or their actual costs for the year.

Not only does NRHA have concerns about future of new provider-based RHCs in rural hospitals, but the current methodology for existing provider-based RHCs is problematic. Since annual rural hospital cost increases outpace MEI increases, small rural hospitals that own and operate RHCs will see a continued deterioration of financial performance, jeopardizing the ability to sustain these small, rural safety net clinics to provide care in the long run.

To address the concerns about the future viability of the provider-based RHC program in small rural hospitals, NRHA recommends Congress implement a quality measure reporting program in exchange for enhanced reimbursement. On average, RHCs have been less involved in quality measure reporting initiatives than other Medicare designations. Through adaptation of this proposal, Congress will receive data on the RHC program that has been historically unavailable. Additionally, this will keep the provider-based RHC program stable for the creation of additional RHCs affiliated with small rural hospitals to meet future need. To do so, **NRHA recommends Congress passes legislation similar to the [H.R. 5883, the Rural Health Fairness in Competition ActS](#).**

#### **Ensure continued access to the RHC designation by updating the CFR to reflect the removal of “urbanized area” in the U.S. Census Bureau’s definitions.**

NRHA has concerns about unintentional consequences regarding a recently finalized rule from the United States Census Bureau which removes the term “urbanized area” and “urbanized cluster” and moves to a single definition of an “urban area.” The current RHC statute and Code of Federal Regulations (CFR) specifically uses the term “urbanized area” for RHC eligibility, which no longer exists within the Census Bureau definition. Complicating the issue further is that the U.S. Census Bureau’s new singular definition of “urban area” includes geographic areas with 5,000 people or more, which is not a logical threshold for the RHC program moving forward.

NRHA is working with the Centers for Medicare and Medicaid Services (CMS) to see if they have the authority to reinterpret the RHC eligibility with a modified definition. However, NRHA asks Congress to consider changing the RHC statute **from “not in an urbanized area...” to “not in an urban area of 50,000 or more as defined by the U.S. Census Bureau...”** in order to protect the status quo of the policy.

#### **Preserve and enhance telehealth flexibilities for RHCs**

**Continue telehealth flexibilities beyond the extension of the public health emergency (PHE) plus 151-days passed by Congress in the CAA, 2022.**

At the onset of the COVID-19 pandemic, RHCs and Federally Qualified Health Centers (FQHC) were granted telehealth distant-site status under Medicare for the first time through Section 3704 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. In March 2022, those flexibilities were continued for 151-days beyond the duration of the existing COVID-19 PHE through the CAA, 2022. NRHA was pleased to see this initial extension, as we believe it signals congressional interest in making these flexibilities permanent.

While distant-site status for RHCs under Medicare is needed change, the current payment methodology for these services is also inadequate for several reasons. The reimbursement for telehealth services is currently a flat rate of \$92.00 per telehealth visit, far below the RHC upper payment limit. Further, the singular code given to RHC telehealth services does not accurately capture the full scope of work being provided.

Not having a true reflection of the work being provided at RHCs via telehealth is problematic for cost reporting issues, but worse yet, the significant disparity in reimbursement for telehealth creates incentive concerns. NRHA has heard from members who operate RHCs that the ability to invest in telehealth simply is not there under current reimbursement methodologies. Members have also expressed significant concerns about investment in telehealth technologies with uncertainty surrounding the long-term availability of telehealth services at RHCs.

NRHA recommends that Congress modify the existing provisions in a future telehealth extension to ensure RHCs can continue utilizing telehealth technologies, and that rural patients can take part in telehealth services at the same rate as their urban counterparts. **NRHA is supportive of the language included in [S. 1512](#) / [H.R. 2903](#), the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, to permanently expand telehealth distant-site status and update reimbursement so it is on par with their in-person reimbursement rate.**

#### **Support the President's proposal for behavioral health activities at RHCs**

**NRHA urges Congress to provide full funding for the President's Fiscal Year (FY) 2023 budget request for a new Behavioral Health Initiative at RHCs by appropriating \$10 million to the Federal Office of Rural Health Policy (FORHP).** The President also proposed **modernizing Medicare mental health benefits by allowing RHCs to bill for Licensed Professional Counselors (LPC) and Marriage and Family Therapists (MFT) services.** Not only will recognizing LPCs and MFTs help address the workforce crisis in rural communities, but RHCs will be able to utilize the Behavioral Health Initiative to bring behavioral health professionals to rural underserved populations. With these changes rural, underserved communities will be able to invest in critical behavioral health services.

#### **Provide RHCs with modernizing provisions, bringing the program into the 21st Century**

In addition to the above proposals, further modernizations are needed for the RHC program including:



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1. Modernize physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with State and local law relative to practice, performance, and delivery of health services.
2. Allow RHCs the flexibility to contract with physician assistants and nurse practitioners, rather than solely employment relationships.
3. Remove outdated laboratory requirements.

All three of these provisions were included in Senators Barrasso and Smith's 116<sup>th</sup> Congress legislation, [S. 1037, the Rural Health Clinic Modernization Act](#). NRHA maintains that by addressing, and updating, these provisions RHCs will be able to provide better services in the 21<sup>st</sup> Century.

Thank you for your consideration of these requests. NRHA looks forward to working with Members of the Committee to ensure that RHCs remain viable for their communities. If you have questions on the needs of RHCs, please contact Josh Jorgensen ([jjorgensen@ruralhealth.us](mailto:jjorgensen@ruralhealth.us)).

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan".

Alan Morgan  
Chief Executive Officer  
National Rural Health Association