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North American HMS

Federal Office of Rural Health Policy Update

Lindsey Nienstedt
Public Health Analyst
Federal Office of Rural Health Policy

HRSA
Health Resources & Services Administration

National Association of Rural Health Clinics Policy Summit
Federal Office of Rural Health Policy Update

June 10th, 2026

Lindsey Nienstedt
Public Health Analyst, Policy Research Division
Federal Office of Rural Health Policy (FORHP)

Vision: Healthy Communities, Healthy People

Whom We Serve

The Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services (HHS), provides health care to people who are geographically isolated and economically or medically vulnerable.

- **More than 32 million people** in rural and underserved communities
- **About 59 million pregnant women, infants, and children**
- **Nearly 602,000 people** with HIV
- **More than 522,000** people through rural health programs
- **About 90% of patients** with incomes at or below 200% of the federal poverty level
- **1 in 8 children**

Data in this slide deck reflects HRSA's most recent publicly available information.

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

FORHP Overview

Established in Section 711 of the Social Security Act

The Federal Office of Rural Health Policy (FORHP) collaborates with rural communities and partners to support community programs and provide technical assistance to improve health in rural America.

Voice for Rural

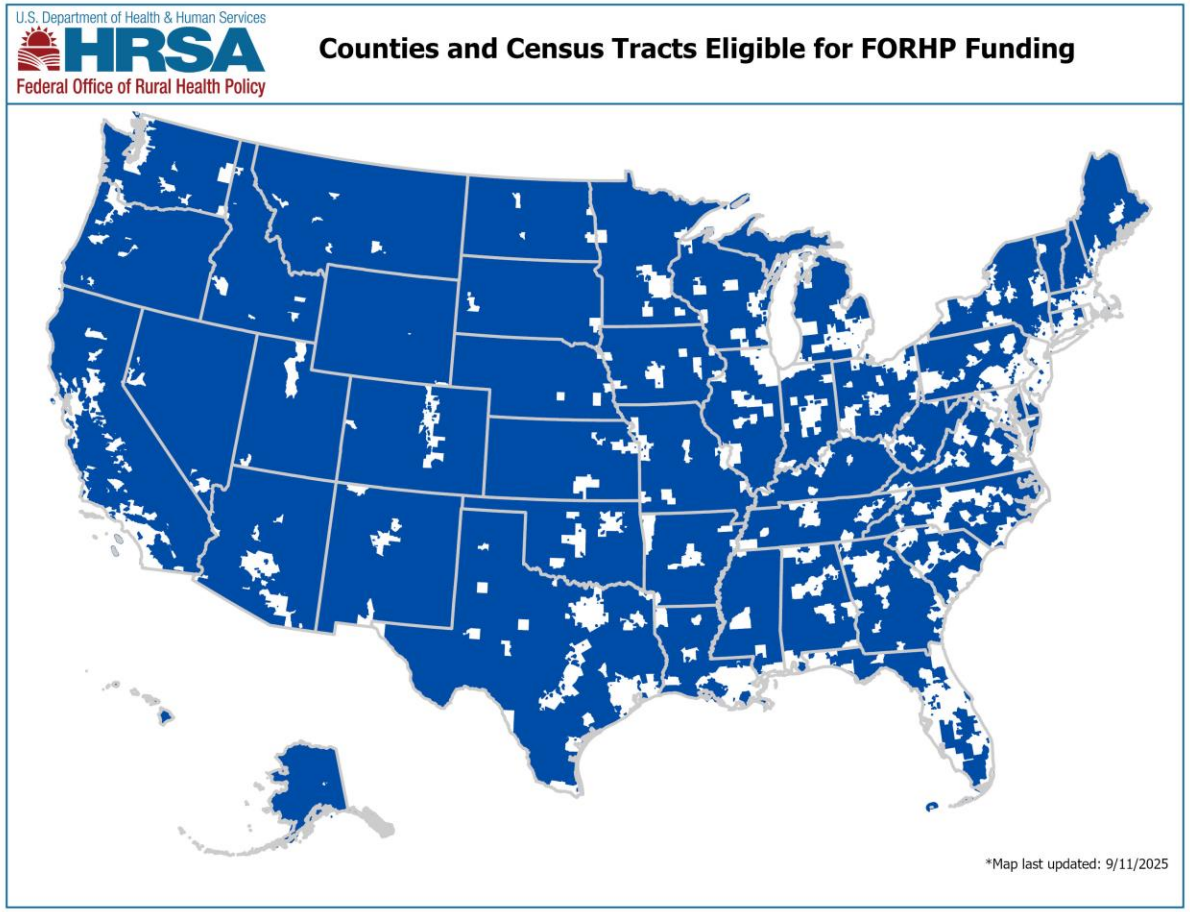
Advises the HHS Secretary on issues that affect rural America

Capacity Building

Increases access to health care for people in rural communities through grant programs and public partnerships

Cross Agency Collaboration

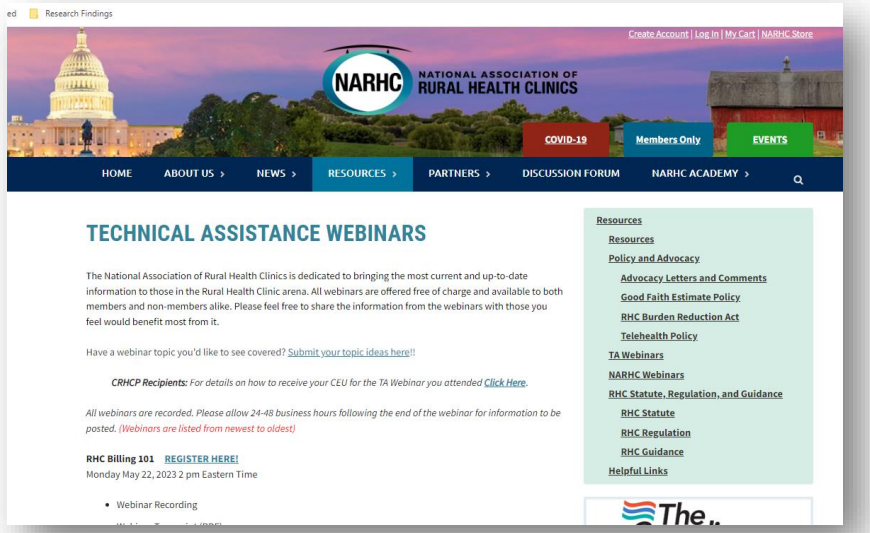
Works across HRSA, HHS, and several other federal partners to accomplish its goals

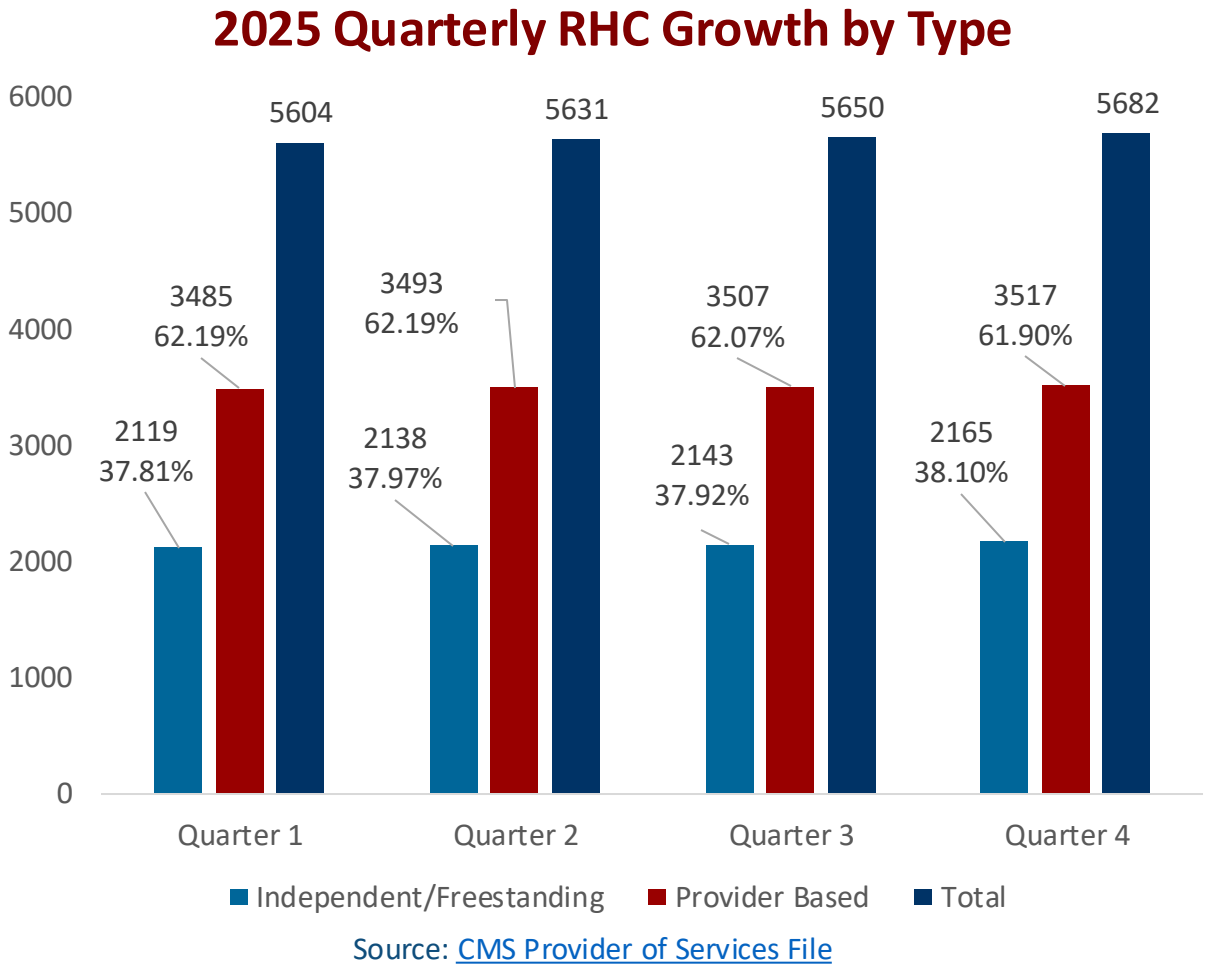


Looking Back at 2025 …

Supporting Rural Health Clinics

- **Targeted Rural Health Clinic Technical Assistance**
  - **Rural Health Clinic Technical Assistance Program (RHC TA)**
    - ✓ https://www.narhc.org/narhc/TA_Webinars1.asp





Source: CMS Provider of Services File

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Looking Back at 2025 …

Supporting Rural Hospitals and Rural Health Clinics

- **Rural Hospital Flex and Small Hospital Improvement Program**
- **Targeted Rural Hospital Technical Assistance**
  - Delta
    - ✓ https://www.ruralcenter.org/programs/drchsd
  - Rural HealthCare Provider Transitions Program
    - ✓ https://www.ruralcenter.org/
  - Appalachian Regional TA
    - ✓ https://rhrco.org/arh-tac/

U.S. Department of Health & Human Services
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Federal Office of Rural Health Policy

FORHP Rural Hospital & RHC TA Finder

RHIhub Rural Health Information Hub

Updates & Alerts | About RHIhub | Contact Us

Online Library | Topics & States | Rural Data Visualizations | Case Studies & Conversations | Tools for Success

Rural Health > Tools for Success

FORHP Rural Hospital Technical Assistance Finder

The Federal Office of Rural Health Policy (FORHP) works with six programs to provide free technical assistance (TA) to rural hospitals and Rural Health Clinics. This tool can help you identify the services available for your facility that match your TA needs.

Facility type: Critical Access Hospital (CAH)

State: Alabama **City or County** Greene County

Looking for assistance with:

- [x] **Financial consultation**
- [ ] **Financial support for new or expanded services**
- [ ] **Market assessment**
- [ ] **Peer learning**
- [ ] **Post-conversion REH assistance**
  Compliance and policy review, billing and coding reviews, survey readiness, service line assessments, and EMS engagement.
- [ ] **Quality consultation**
- [x] **REH exploration**
  Individualized guidance and support for prospective REHs, including education on the REH designation, financial modeling, strategic planning, application assistance.
- [x] **Resource leveraging**
  Help for rural communities to leverage state and federal resources, funding, and information.
- [ ] **Virtual education**

FORHP Rural Designation

The programs listed here are for locations considered rural by the Federal Office of Rural Health Policy. Is your location rural?

YES - Greene County, AL has been designated by FORHP as rural.

Am I Rural?

Find out if your area is considered rural based on several federal government definitions, including those used in determining eligibility for federal grant programs.

SHARE THIS PAGE

Matching Programs

Alabama Office of Primary Care and Rural Health
The State Office of Rural Health helps rural communities to leverage state and federal resources, funding, and information
Services: Resource leveraging

Delta Region Community Health Systems Development Program
A collaboration with the Delta Regional Authority. Provides multi-year technical assistance to healthcare facilities in rural communities in the Mississippi Delta region to support financial sustainability, quality improvement, and population health. 10 hospitals/clinics selected per year. Open year-round to apply, with new cohorts chosen each winter.
Services: Financial consultation · Financial support for new or expanded services · Market assessment · Peer learning · Quality consultation · Virtual education

Rural Emergency Hospital Technical Assistance
Provides resources and one-to-one technical assistance to ensure rural hospitals and the communities they serve have the information and resources needed to make informed decisions as to whether the Rural Emergency Hospital model of care is best for their communities.
Services: Market assessment · Post-conversion REH assistance · REH exploration

https://www.ruralhealthinfo.org/hospital-ta

HRSA Federal Office of Rural Health Policy

Health Resources for Rural Communities

Rural Health Information Hub (RHIhub)

Topic Guides

Rural Health > Topics & States > Topics

Rural Health Clinics (RHCs)

On This Page

- Overview
- FAQs

More in This Topic Guide

- Resources
- Organizations
- Funding & Opportunities
- News
- Events
- About This Guide

The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician providers such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be staffed at least 50% of the time with an NP, PA, or CNM (requirement waived during COVID-19 public health emergency). RHCs are required to provide outpatient primary care services and basic laboratory services.

The main advantage of RHC status is enhanced reimbursement rates for providing Medicare and Medicaid services. The MLN Fact Sheet, Rural Health Clinic, describes how RHCs are reimbursed "an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner." For Medicaid, a 2016 CMS letter to state health officials details how Medicaid visits are reimbursed under a Prospective Payment System (PPS) or an alternative payment methodology (APM), providing a payment that is at minimum the same amount required under a PPS. For specific Medicare regulations governing the RHC program, see Rural Health Clinics - Rules and Guidelines compiled by the National Association of Rural Health Clinics, or visit the Centers for Medicare and Medicaid Services (CMS) Medicare Rural Health Clinics Center.

Frequently Asked Questions:

- Who do I contact if I have questions regarding the development and ongoing management of RHCs?
- How do I get certified as an RHC?

Funding Opportunities

MORE ON THIS TOPIC

- Overview
- Resources
- Organizations
- **Funding & Opportunities**
- News
- Events
- About This Guide

Rural Health > Topics & States > Topics > Rural Health Clinics (RHCs)

Rural Health Clinics (RHCs) – Funding & Opportunities

For additional funding options, please see RHIhub's Online Library: Funding & Opportunities

Sort By: **Date** | Name ☐ Hide Inactive Funding

Narrow by type | Narrow by geography | Narrow by topic | Help

Integrated Substance Use Disorder Training Program (ISTP)

Grants to plan, develop, and operate a training program for nurse practitioners, physician assistants, health service psychologists, counselors, nurses, and/or social workers that trains practitioners to provide care for individuals in need of mental health and substance use disorder prevention, treatment, and recovery services.

Geographic coverage: Nationwide
Application Deadline: Mar 21, 2023
Sponsors: Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health and Human Services

Rural Economic Development Loan and Grant Program (REDL and REDG)

Loans and grants to assist in the economic development of rural areas, including funds for healthcare facilities and equipment, telecommunications networks, and job creation projects.

Geographic coverage: Nationwide
Application Deadline: Mar 31, 2023
Sponsors: U.S. Department of Agriculture, USDA Rural Development

Rural Health Care Program – Healthcare Connect Fund

Provides assistance to healthcare providers for eligible expenses related to broadband connectivity at a flat discounted rate of 65%. Participants can apply as a member of a consortium or a stand-alone entity.

Resources & Upcoming Events

MORE ON THIS TOPIC

- Overview
- **Resources**
- Organizations
- Funding & Opportunities
- News
- Events
- About This Guide

Rural Health > Topics & States > Topics > Rural Health Clinics (RHCs)

Rural Health Clinics (RHCs) – Resources

Selected recent or important resources focusing on Rural Health Clinics (RHCs).

Sort By: **Date** | Name

Narrow by type | Narrow by geography | Narrow by topic | Help

Maintaining Compliance in Your RHC Webinar

Recording of a January 26, 2023, webinar presenting an overview of a toolkit to help Rural Health Clinics (RHCs) maintain compliance and prepare for surveys. Part of the Rural Health Clinic Technical Assistance Series.
Additional links: Presentation Slides, Transcript
Date: 01/2023
Type: Video/Multimedia
Sponsoring organization: National Association of Rural Health Clinics
view details

RHC Regulatory Updates & Good Faith Estimate (GFE) Policy

Recording of a December 7, 2022, webinar providing an overview of telehealth payment rates for Rural Health Clinics (RHCs) and other regulatory updates and potential changes for 2023. Discusses price transparency in healthcare and good faith estimate requirements for RHCs. Includes links to good faith estimate resources. Part of the Rural Health Clinic Technical Assistance Series.
Additional links: Presentation Slides, Transcript
Date: 12/2022
Type: Document
Sponsoring organization: National Association of Rural Health Clinics
view details

The Impact of the COVID-19 Pandemic on Rural Health Clinics' Operations and Cancer Prevention and Control Efforts

Findings brief describing a study surveying 150 Rural Health Clinics (RHCs) to examine how COVID-19 has affected their overall operations and provision of cancer prevention and control

https://www.ruralhealthinfo.org/

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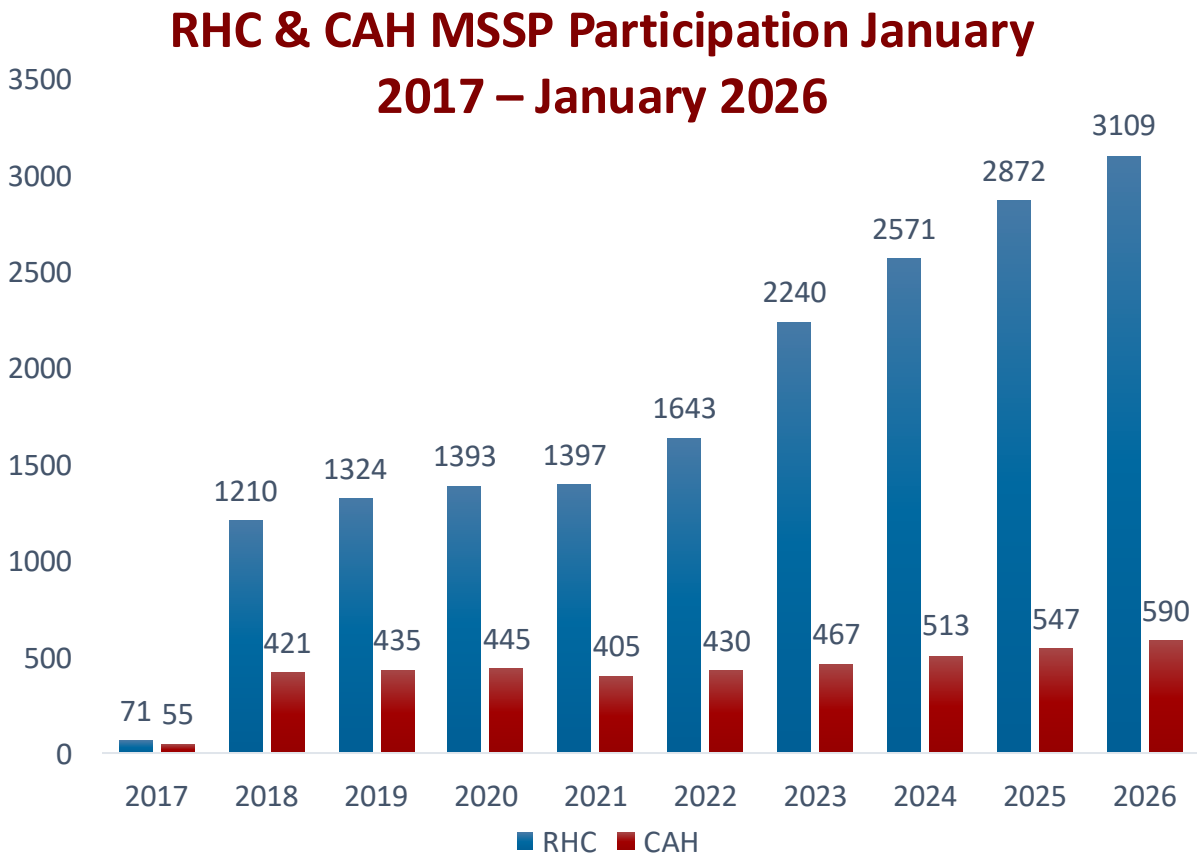
HRSA
Federal Office of Rural Health Policy

Looking Back at 2025…

Rural Health Clinics and Value Based Care



https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/data

Rural HEALTH VALUE

U.S. Department of Health & Human Services HRSA Federal Office of Rural Health Policy

Looking Back at 2025 …

Rural Health Networks 2.0 Offer a Possible Path Forward

Becker's Healthcare: Hospital ASC Spine Clinical Health IT CFO Dental Payer Podcasts Behavioral Physician MyBHC

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Hospital CFO Report

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Physicians Leadership Strategy Executive Moves Transaction & Valuation GLP-1s HR Capital Nursing Supply Health Equity

Patient Experience Pharmacy Care Coordination Legal & Regulatory Compensation Payer Rankings Workforce Specialties

Financial Management

Why 19 rural hospitals see value in interdependence

Andrew Cass - Monday, July 22nd, 2024

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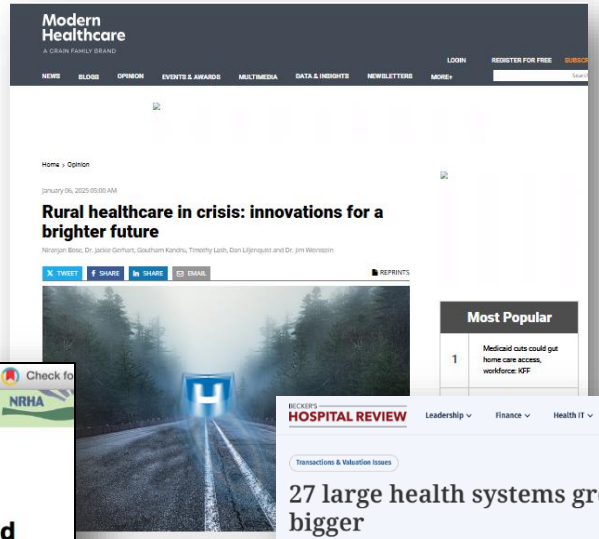
It's not about independence for the sake of independence for Ken Westman, CEO of Aitkin, Minn.-based Riverwood Health

"We really feel that we can bes staying independent without ha communities, we know our pati

Riverwood and 18 other rural h through interdependence. On J High-Value Network. At the cer featuring the 19 hospitals and r 750,000 residents. The networ



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January 06, 2025 05:00 AM

Rural healthcare in crisis: innovations for a brighter future

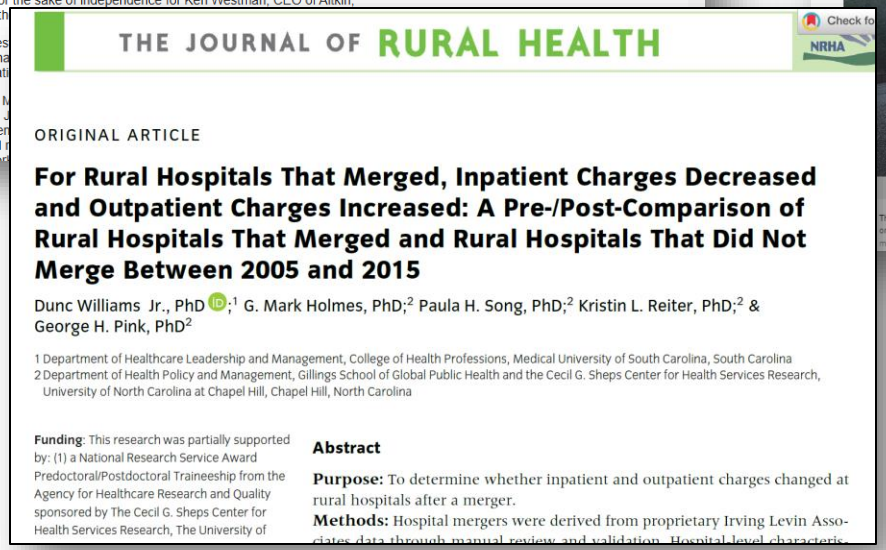
Niranjan Bose, Dr. Jackie Gerhart, Gautham Kandru, Timothy Lash, Dan Liljenquist and Dr. Jim Weinstein

TWEET SHARE SHARE EMAIL REPRINTS

Most Popular

1 Medicaid cuts could gut home care access, workforce: KFF

The U.S. healthcare system's increasing complexity is on rural America. Shrinking access, growing health dis mortality rates put the well-being of 60 million people



THE JOURNAL OF RURAL HEALTH

Check for updates NRHA

ORIGINAL ARTICLE

For Rural Hospitals That Merged, Inpatient Charges Decreased and Outpatient Charges Increased: A Pre-/Post-Comparison of Rural Hospitals That Merged and Rural Hospitals That Did Not Merge Between 2005 and 2015

Dunc Williams Jr., PhD;[1] G. Mark Holmes, PhD;[2] Paula H. Song, PhD;[2] Kristin L. Reiter, PhD;[2] & George H. Pink, PhD[2]

1 Department of Healthcare Leadership and Management, College of Health Professions, Medical University of South Carolina, South Carolina
2 Department of Health Policy and Management, Gillings School of Global Public Health and the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Funding: This research was partially supported by: (1) a National Research Service Award Predoctoral/Postdoctoral Traineeship from the Agency for Healthcare Research and Quality sponsored by The Cecil G. Sheps Center for Health Services Research, The University of

Abstract

Purpose: To determine whether inpatient and outpatient charges changed at rural hospitals after a merger.

Methods: Hospital mergers were derived from proprietary Irving Levin Asso-

BECKER'S HOSPITAL REVIEW

Leadership Finance Health IT Clinical Care Specialties Resources Events

Transactions & Valuation Issues

27 large health systems growing bigger

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By: Alan Condon 2 days ago Share

As merger and acquisition activity picks up post-pandemic, dozens of large health systems are expanding their footprints — adding hospitals, building regional dominance and solidifying national reach.

Here are 27 large health systems that have grown in quarters or are planning strategic mergers or acquisitions this year:

Editor's note: This is not an exhaustive list.

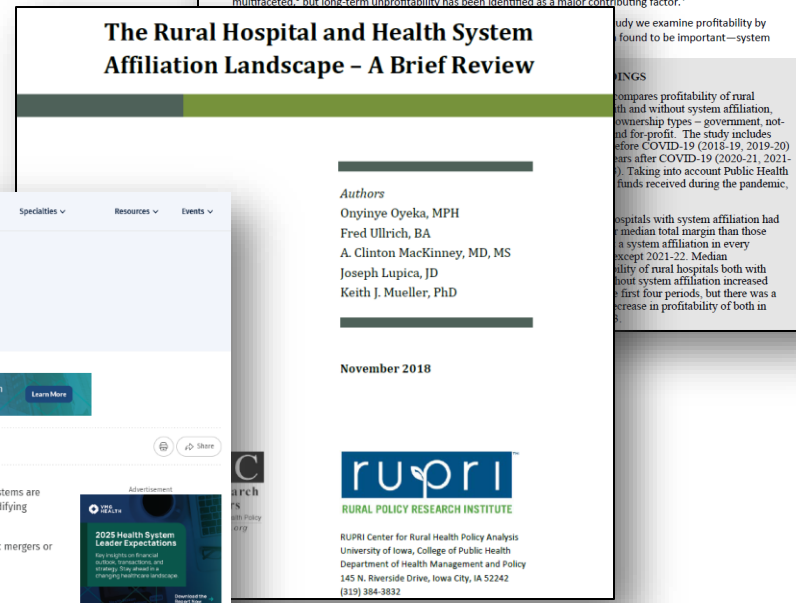
1. West Des Moines, Iowa-based **UnityPoint Health** acquired MercyOne Siouxland Medical Center in Sioux City, Iowa, effective Sept. 1. The facility, which has been rebranded UnityPoint Health-St. Luke's-Downtown, is the 37th hospital in UnityPoint's footprint, according to its website.

2. Memphis, Tenn.-based **Baptist Memorial Health Care** signed a definitive agreement in August to acquire OCH Regional Medical Center in Starkville, Miss.. The transaction would increase the number of hospitals in the health system's portfolio to 26. Baptist Memorial Health Care operates hospitals in Tennessee, Arkansas and Mississippi.

3. Atrium Health Wake Forest Baptist, part of Charlotte, N.C.-based **Advocate Health**, acquired Hugh Chatham Health in Elkin, N.C., in July. Hugh Chatham Health includes an 81-bed acute care hospital

Advertisement

2025 Health System Leader Expectations



The Rural Hospital and Health System Affiliation Landscape – A Brief Review

Authors

Onyinye Oyeka, MPH
Fred Ullrich, BA
A. Clinton MacKinney, MD, MS
Joseph Lupica, JD
Keith J. Mueller, PhD

November 2018

rupri RURAL POLICY RESEARCH INSTITUTE

RUPRI Center for Rural Health Policy Analysis
University of Iowa, College of Public Health
Department of Health Management and Policy
145 N. Riverside Drive, Iowa City, IA 52242
(319) 384-3832

NC RHRP

Findings Brief
NC Rural Health Research Program

June 2024

2018-23 Profitability of Rural Hospitals by Ownership and System Affiliation

Sruthi Malavika Srinivasan, MPS; Kristie Thompson, MA; George Pink, PhD

BACKGROUND

System Affiliation and Ownership

Rural hospitals provide vital health care services to the remote and underserved regions of rural America. However, access to care in many communities has been reduced by rural hospital closures.[1] Between January 2010 and December 2023, there were 146 rural hospital closures.[2] The causes of rural hospital closures are complex and multifaceted,[3] but long-term unprofitability has been identified as a major contributing factor.[4]

udy we examine profitability by found to be important—system

INGS

ompares profitability of rural th and without system affiliation, ownership types – government, not- nd for-profit. The study includes efore COVID-19 (2018-19, 2019-20) ars after COVID-19 (2020-21, 2021-). Taking into account Public Health funds received during the pandemic,

ospitals with system affiliation had median total margin than those a system affiliation in every except 2021-22. Median ility of rural hospitals both with hout system affiliation increased first four periods, but there was a crease in profitability of both in

U.S. Department of Health & Human Services
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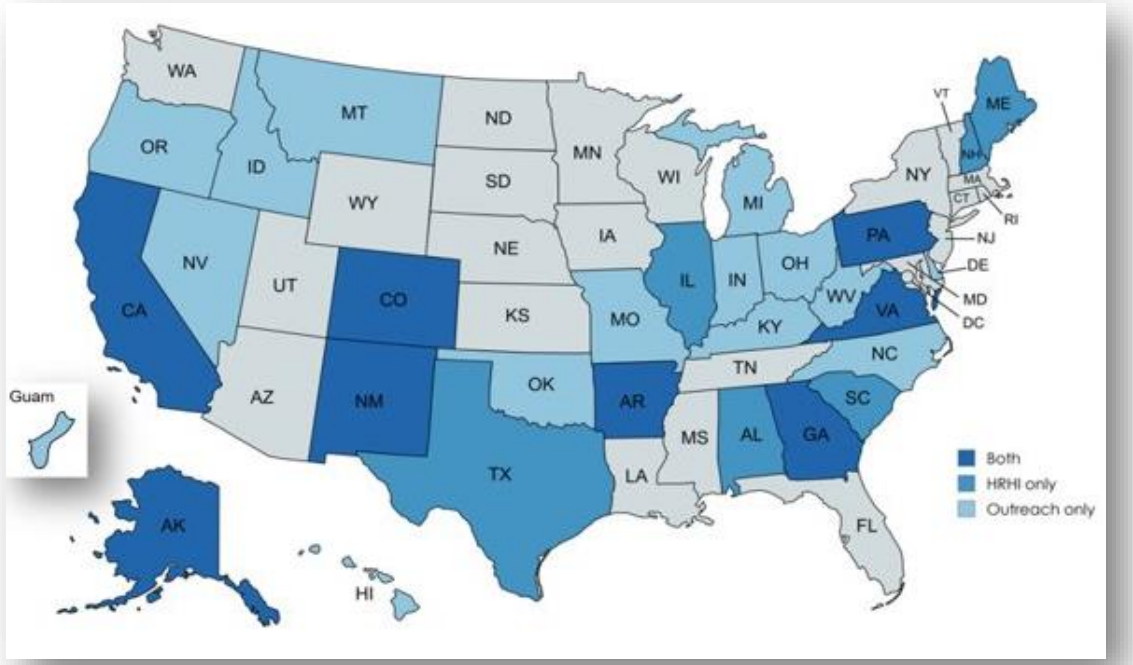
Looking Back at 2025 …

Supporting Creative Approaches in Rural Community Health

Rural Health Care Services Outreach Program

- 58 award recipients
- 29 states and territories
- $15M + invested nationwide
  - 40 Outreach awards | $9.8M +
  - 18 Healthy Rural Hometowns | $5.3M +



Outreach Program supports increasing preventive and primary care access through community-based grants that address local health needs, bring together community partners to expand services, strengthen rural health systems, and use innovative, evidence-informed approaches to improve long-term health outcomes.

https://www.hrsa.gov/rural-health/grants/rural-community/outreach-program-awards

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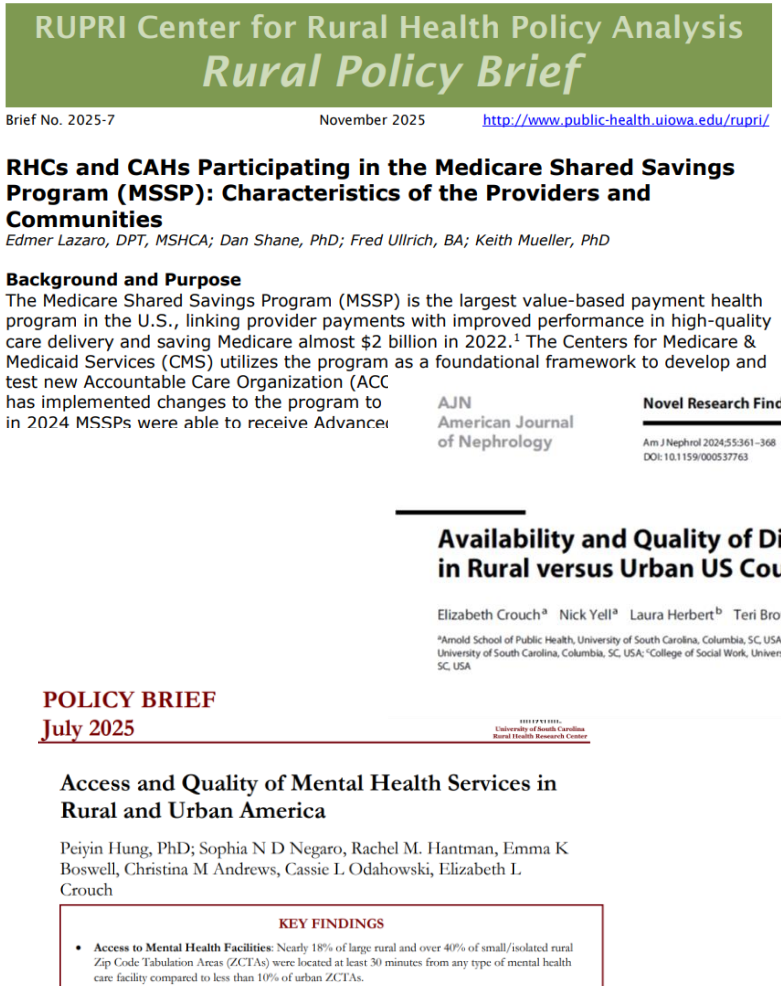
Looking Back at 2025 …

Rural Health Research Center Continues to Draw a Spotlight

Rural Research Findings Help Inform Policy at the Federal, State and Local Level

- **Rural Health Clinics -** RHCs and CAHs Participating in the Medicare Shared Savings Program (MSSP): Characteristics of the Providers and Communities
- **Mental & Behavioral Health -** Access and Quality of Mental Health Services in Rural and Urban America
- **Chronic Disease -** Examining the Burden of Chronic Disease and Low SES to Identify High-Need Rural Counties

- **Visit Rural Health Research Gateway for additional rural research.**


RUPRI Center for Rural Health Policy Analysis

Rural Policy Brief

Brief No. 2025-7 November 2025 http://www.public-health.uiowa.edu/rupri/

RHCs and CAHs Participating in the Medicare Shared Savings Program (MSSP): Characteristics of the Providers and Communities

Edmer Lazaro, DPT, MSHCA; Dan Shane, PhD; Fred Ullrich, BA; Keith Mueller, PhD

Background and Purpose

The Medicare Shared Savings Program (MSSP) is the largest value-based payment health program in the U.S., linking provider payments with improved performance in high-quality care delivery and saving Medicare almost $2 billion in 2022.[1] The Centers for Medicare & Medicaid Services (CMS) utilizes the program as a foundational framework to develop and test new Accountable Care Organization (ACC
has implemented changes to the program to
in 2024 MSSPs were able to receive Advance

AJN American Journal of Nephrology

Novel Research Findings

Am J Nephrol 2024;55:361–368
DOI: 10.1159/000537763

Received: January 10, 2024
Accepted: February 8, 2024
Published online: February 11, 2024

Availability and Quality of Dialysis Care in Rural versus Urban US Counties

Elizabeth Crouch[a] Nick Yell[a] Laura Herbert[b] Teri Browne[c] Peiyin Hung[a]

[a]Arnold School of Public Health, University of South Carolina, Columbia, SC, USA; [b]College of Nursing, University of South Carolina, Columbia, SC, USA; [c]College of Social Work, University of South Carolina, Columbia, SC, USA

POLICY BRIEF
July 2025

University of South Carolina Rural Health Research Center

Access and Quality of Mental Health Services in Rural and Urban America

Peiyin Hung, PhD; Sophia N D Negaro, Rachel M. Hantman, Emma K Boswell, Christina M Andrews, Cassie L Odahowski, Elizabeth L Crouch

KEY FINDINGS

- **Access to Mental Health Facilities**: Nearly 18% of large rural and over 40% of small/isolated rural Zip Code Tabulation Areas (ZCTAs) were located at least 30 minutes from any type of mental health care facility compared to less than 10% of urban ZCTAs.

U.S. Department of Health & Human Services
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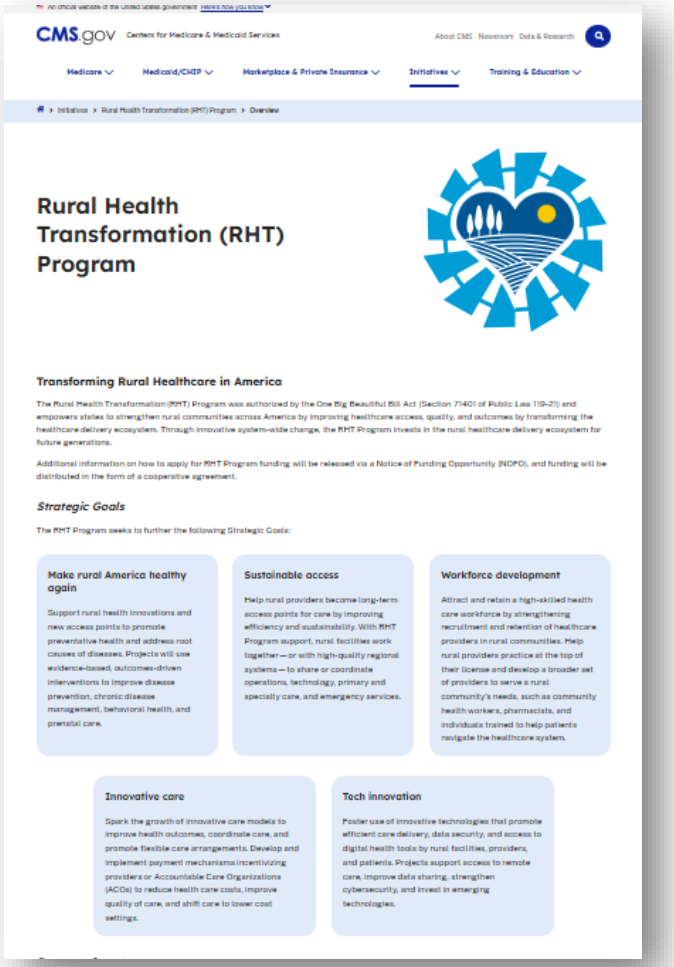
Rural Health Transformation Program

Partnerships Play a Critical Role

- HRSA supports the **CMS Rural Health Transformation Program**
- Builds on longstanding collaboration
- Leverages existing resources in support of the state plans



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Looking Ahead to 2026 …

Focusing on Administration Priorities Across Our Programs

Key Areas Fit Well with FORHP Programs and the Needs of Rural Communities

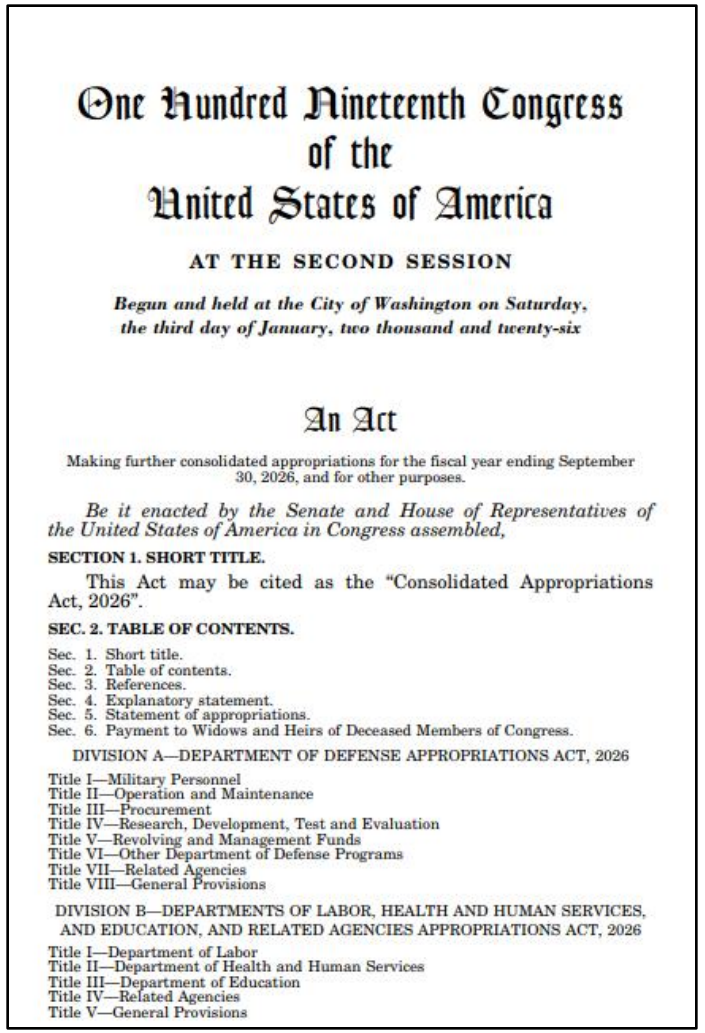
Source: Page 5, HHS 2026 Budget in Brief: https://www.hhs.gov/sites/default/files/fy-2026-budget-in-brief.pdf

Looking Ahead to 2026 …

Enacted Budget Invests in Core Programs

Targeted increases for rural health programs in Fiscal Year 2026

- Includes Some Increases
- Rural Hospital Support Program



One Hundred Nineteenth Congress
of the
United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Saturday, the third day of January, two thousand and twenty-six

An Act

Making further consolidated appropriations for the fiscal year ending September 30, 2026, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2026".

SEC. 2. TABLE OF CONTENTS.

Sec. 1. Short title.
Sec. 2. Table of contents.
Sec. 3. References.
Sec. 4. Explanatory statement.
Sec. 5. Statement of appropriations.
Sec. 6. Payment to Widows and Heirs of Deceased Members of Congress.

DIVISION A—DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2026

Title I—Military Personnel
Title II—Operation and Maintenance
Title III—Procurement
Title IV—Research, Development, Test and Evaluation
Title V—Revolving and Management Funds
Title VI—Other Department of Defense Programs
Title VII—Related Agencies
Title VIII—General Provisions

DIVISION B—DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2026

Title I—Department of Labor
Title II—Department of Health and Human Services
Title III—Department of Education
Title IV—Related Agencies
Title V—General Provisions

U.S. Department of Health & Human Services
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Federal Office of Rural Health Policy

Looking Ahead to 2026…

Direct Technical Assistance to Hospitals and Rural Health Clinics

Delta Region Community Health Systems Development Program

Looking Ahead to 2026

Partnerships Play a Critical Role

- **National Association of Rural Health Clinics (NARHC)**
  - NARHC Community Forum
  - Policy Summit
- **CDC Office of Rural Health**
  - Rural Data Cut Coordination
- **National Rural Health Association**
  - Rural Health Issues Group
  - Rural Academy Pilots
- **State Rural Health Associations**
- **National Organization of State Offices of Rural Health**
  - Rural Capital Resource Group
- **HRSA Bureau of Health Workforce**
  - National Health Service Corps (NHSC)
- **3RNET**
  - NARHC Job Board

Contact Information

Lindsey Nienstedt

Federal Office of Rural Health Policy (FORHP)
Health Resources and Services Administration (HRSA)

Email: lnienstedt@hrsa.gov

Web: HRSA.gov/ruralhealth/

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www.HRSA.gov

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Capitol Hill Meetings 101

When will the meetings take place?

- Your confirmed meeting times are noted in your packets
  - They were also sent to you via email calendar invites
- Typical meetings last <u>15-30 minutes</u>
- Arrive a few minutes early!

NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

<u>Policy Summit 2026 Hill Meeting Schedule</u>

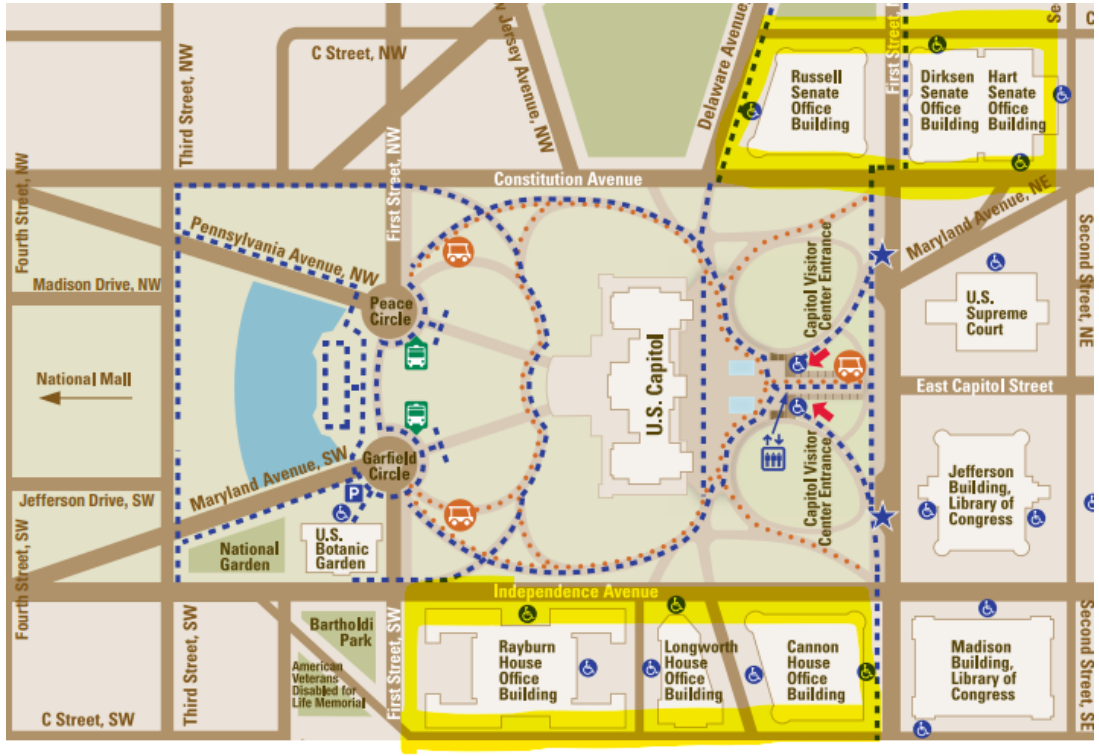
Attendee: **Aubrey Haynes**

<u>Senator/Representative</u>	<u>Time</u>	<u>Location</u>
*Senator John Boozman (R-AR) - - *Kathleen & Naomi*	10:30AM	555 Dirksen
Senator Tom Cotton (R-AR)	11:30AM	326 Russell
Representative Rick Crawford (R-AR-01) -- *John*	1:00PM	2422 Rayburn
Representative Steve Womack (R-AR-03) -- *Grace*	2:00PM	2412 Rayburn

*Indicates <u>group</u> meeting with other summit attendees present
***Indicates that meetings are immediately following one another
Indicates that Sen/Rep is <u>expected</u> to be in attendance

Where will the meetings take place?

- House Office Buildings: **Cannon, Longworth, Rayburn**
- Senate Office Buildings: **Russell, Dirksen, Hart**
- Security: You must pass through a metal detector and empty your pockets
  - Be sure to give yourself ample time!
- The Senate offices are connected, and the House offices are connected BUT…
- The Senate and House are *not* connected for the general public – be prepared for a <u>5-10 minute outdoor walk</u> between the buildings!



Navigating House Office Buildings

- House Office Buildings:
  - **Cannon** (CHOB): Rooms have 3-digit numbers. The first number tells you the floor.
    Example: Room 327 is on the 3rd floor.
  - **Longworth** (LHOB): Rooms have 4-digit numbers that start with 1. The second number tells you the floor.
    Example: Room 1365 is on the 3rd floor.
  - **Rayburn** (RHOB): Rooms have 4-digit numbers that start with 2. The second number tells you the floor.
    Example: Room 2145 is on the 1st floor.

Navigating Senate Office Buildings

- Senate Office Buildings:
  - **Russell** (RSOB): Rooms are labeled SR- followed by a 3-digit number. The first digit tells you the floor.
    Example: Room SR-216 is on the 2nd floor.
  - **Dirksen** (DSOB): Rooms are labeled SD- followed by a 3-digit number. The first digit tells you the floor.
    Example: Room SD-145 is on the 1st floor.
  - **Hart** (HSOB): Rooms are labeled SH- followed by a 3-digit number. The first digit tells you the floor.
    Example: Room SH-320 is on the 3rd floor.

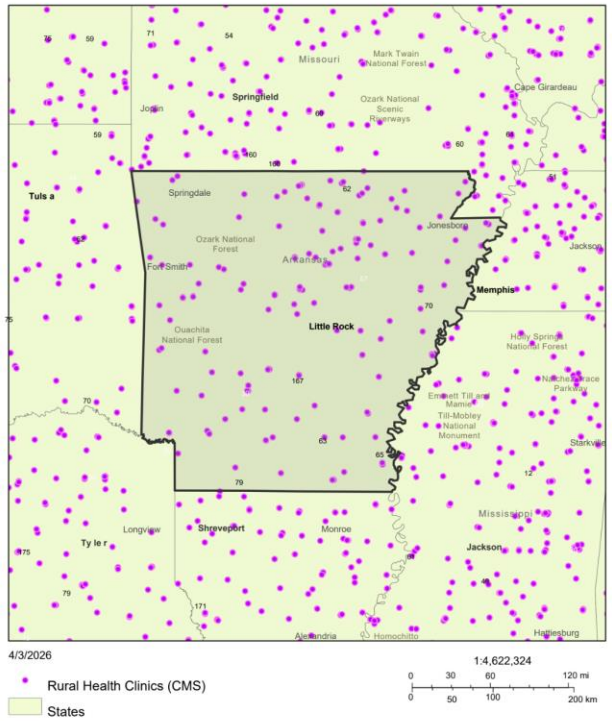
Who will you be talking to?

- Legislative Assistant/Legislative Correspondent/Legislative Directors/Deputy or Chiefs of Staff
  - These individuals are responsible for advising the member on health policy
- Your Representative and/or your Senator
  - They will be interested in hearing about your work in the district and/or the state
  - Having them understand your clinic's implications is KEY
  - Members often have busy schedules and may not be present for the whole meeting

Meeting Packets in your Folders

Please hand these materials to the Members of Congress or Staffers in your meetings!

Rural Health Clinics in Arkansas



Arkansas Rural Health Clinics

160 Rural Health Clinics

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ACCESS MEDICAL CLINIC MARKED TREE
AMC AR RHC BOONEVILLE
AMC AR RHC GARFIELD
AMC AR RHC HEBER SPRINGS
APPELLO HEALTH AND WELLNESS CLINIC
ARKADELPHIA CLINIC FOR CHILDREN & YOUNG ADULTS, PA
ASHLEY FAMILY CLINIC
ASHLEY HEALTH SERVICES
BANISTER LIEBLONG CLINIC
BAPTIST HEALTH - FAMILY CLINIC BRINKLEY
BAPTIST HEALTH - FAMILY CLINIC DEWITT
BAPTIST HEALTH - FAMILY CLINIC HAZEN
BAPTIST HEALTH - STUTTGART MEDICAL CLINIC
BAPTIST HEALTH FAMILY CLINIC - ALMA
BAPTIST HEALTH FAMILY CLINIC - GURDON
BAPTIST HEALTH FAMILY CLINIC - HEBER SPRINGS
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BAPTIST HEALTH FAMILY CLINIC - SPARKMAN
BAPTIST HEALTH FAMILY CLINIC LONOKE
BAPTIST HEALTH FAMILY CLINIC- GREERS FERRY
BAPTIST HEALTH FAMILY CLINIC-BISMARCK
BAPTIST HEALTH FAMILY CLINIC-CADDO VALLEY
BAPTIST HEALTH FAMILY CLINIC-PRESCOTT
BAPTIST HEALTH HEBER SPRINGS CAMPUS
BAPTIST HEALTH STUTTGART CAMPUS
BAPTIST HEALTH-FAMILY CLINIC CLARENDON
BAPTIST URGENT CARE-WYNNE
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BAXTER HEALTH FAMILY CLINIC AT MELBOURNE
BAXTER HEALTH FAMILY CLINIC AT MOUNTAIN VIEW
BAXTER HEALTH FULTON COUNTY FAMILY
BAXTER HEALTH MARKET STREET FAMILY CLINIC
BAXTER REGIONAL AHRENS CLINIC
BELL CLINIC, PA
BH ARKADELPHIA MEDICAL CLINIC
BRADLEY BIBB MD PLLC
BRADLEY BIBB MD PLLC
BRADLEY BIBB MD PLLC
BRADLEY COUNTY MEDICAL CENTER RURAL HEALTH CLINIC
CAVE CITY MEDICAL CLINIC
CHI ST VINCENT MEDICAL GROUP HOT SPRINGS
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CLINTON MEDICAL CLINIC
CONWAY REGIONAL MEDICAL CLINIC-VILONIA
DALLAS COUNTY MEDICAL CENTER FAMILY CLINIC
DE PAUL COMMUNITY HEALTH CENTERS - DUMAS
DELTA HEALTH SERVICES
DRASCO MEDICAL CLINIC
EARLE FAMILY MEDICAL CLINIC
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FERGUSON RURAL HEALTH CLINIC
FORE FAMILY PRACTICE LLC
GREAT RIVER FAMILY CLINIC
GREENBRIER CHILDREN'S CLINIC
GREENBRIER FAMILY MEDICINE

NARHC 2026 POLICY SUMMIT

Advocating for Rural Health Clinics

WHO WE ARE
The National Association of Rural Health Clinics (NARHC) advocates for Rural Health Clinics (RHCs) and the millions of patients they serve in rural and underserved communities.

WHAT IS AN RHC?
Rural Health Clinics (RHCs) are safety-net providers delivering primary care and other essential outpatient health services to rural America.

- 5,700+ RHCs nationwide
- 40 million+ Americans served
- Providing outpatient care in medically underserved communities

OUR 2026 POLICY PRIORITIES

PRIORITY	THE ISSUE	WHY IT MATTERS	NARHC SUPPORTS
Medicare Advantage	MA plans often reimburse RHCs below Traditional Medicare rates.	Lower reimbursement threatens RHC sustainability and patient access.	Reimbursement floor policy, Prompt & Fair Pay Act (H.R.4559), Timely Access to Care Act (H.R.3514 & S.1816)
Telehealth	RHC telehealth visits are reimbursed at a lower flat rate than in-person visits.	Lower payment discourages telehealth investment in rural areas.	CONNECT for Health Act (S.1261 and H.R.4206) & the HEALTH Act (H.R.5496)
Regulatory Reduction	Outdated provisions under the RHC program statute add unnecessary administrative burdens.	Modernizing regulations improves operational flexibility and patient care.	PA/NP Utilization Act (H.R.5199), Location Modernization Act (H.R.1598), Behavioral Health Improvement Act (H.R.5217)
FY2027 Appropriations	Proposed HHS budget cuts eliminate key rural health programs.	Cuts threaten workforce recruitment and healthcare access.	Continued funding for SORHs, workforce programs, NHSC, opioid response programs

To discuss these priorities further or ask questions about the RHC program, contact NARHC Director of Government Affairs, Sarah Hohman, at Sarah.Hohman@narhc.org

RHCs are different from another outpatient, safety-net program, Federally Qualified Health Centers (FQHCs)/Community Health Centers (CHCs). Unlike RHCs, FQHCs/CHCs receive mandatory and discretionary grant funding and are predominantly in urban areas.

CONGRESS CAN STRENGTHEN RURAL HEALTH CLINICS through targeted legislation and funding support

LEARN MORE Scan the QR code

Meeting Flow

- What to expect when you walk in
- How to start the meeting
  - Quick introductions and **an overview of your RHCs / health system / organization**
- Overview of RHC program
  - **Never assume they know what an RHC is!**
- Ask the member or staff what their **rural health** priorities are
- Review NARHC legislative priorities (pick a few per meeting!)
  - Telehealth; Medicare Advantage; Reducing Regulatory Burdens; Rural Appropriations

Providing an Overview of the RHC Program

- RHC Program, a specific CMS designation, was created in 1977 to bring health care to rural, medically underserved parts of the country

- Since then, it has been successful at doing so, with over 5,800 RHCs providing care to 40 million Americans annually

- To become an RHC, facilities must meet a variety of requirements, apply, and be surveyed
  - The value of being an RHC is cost-based style Medicare and Medicaid reimbursement

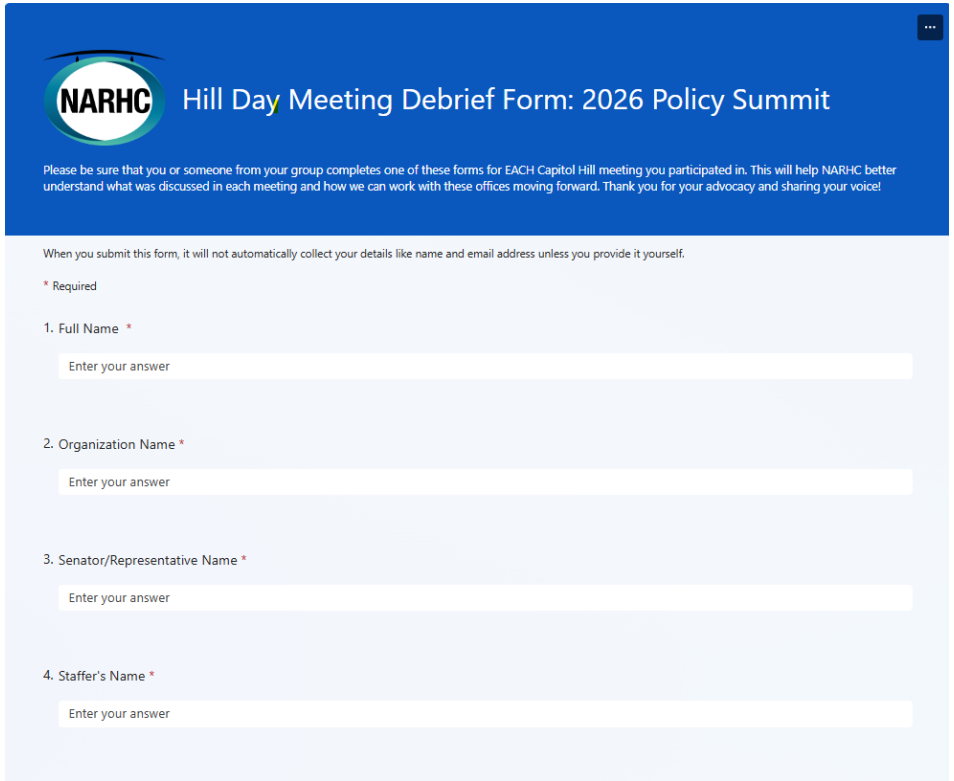
Providing an Overview of the RHC Program

- There are 2 types of RHCs
  - Independent / Free-Standing
  - Provider-Based (Integrated into a hospital / health system)

- RHCs are **NOT** Federally-Qualified Health Centers / Community Health Centers
  - Both facilities are important parts of the health care safety-net, however FQHCs **receive significant federal funding (both mandatory and discretionary funding)** and predominantly serve the underserved in rural and suburban areas

Post-Meeting Instructions

- After each meeting, at least one member of your group should complete an online **"Post-Meeting Summary"** form –linked here and in tomorrow morning's Hill Day reminder email
  - https://www.narhcpolicysummit.org/resources
    - This site also contains digital versions of all one-pagers in your packets
  - With 535 offices across the Hill, this is critical for NARHC's tracking and follow-up process



Follow Up and Thank You

- NARHC will send you an email early next week with a draft email to assist you in following up with the staffers you met
- *Follow up is critical for this entire process to be worth it*
- The more connections you make, the greater your advocacy will be!

Showcasing the Policy Summit

- Take plenty of pictures while you are on the Hill
- Post them on social media (if you are comfortable) and tag NARHC or send to **marketing@narhc.org**
  - https://www.facebook.com/narhc.org
  - https://x.com/NARHC1
  - https://www.linkedin.com/company/narhc/
- Spread the word!

NARHC Staff Support on the Hill

- House Side: **Longworth Starbucks** – Sarah Hohman, Juanita Henry, & Sofia Storlazzi
- Senate Side: **Dirksen Cafeteria** – Amanda Williams, Tasha Rynberg, & Eireann Maybach
- Meeting assistants: Nathan Baugh & NARHC Fellow Kelsey Beggs-King
- Staff support locations are flagged on your meeting schedules
- Your meeting schedule also includes a guide to help you find a bite to eat

Questions?

NARHC Priorities- 119th Congress

Fix and Extend Medicare Telehealth
Strengthen Medicare Advantage
Reduce Regulatory Burdens
Maintain Rural Appropriations & Ensure RHTP Dollars Reach RHCs
Other NARHC Supported Legislation

How many pieces of legislation have been signed into law this Congress?

- 70

- How many pieces of legislation have been introduced this year?

- Over 13,660

Thank you for being here to advocate!
We need you.

General Health Policy Updates

- "Active" committees
- Reconciliation 3.0? Only potential health package before midterms
- Post-midterms health package opportunities
  - Appropriations
  - Health workforce package?

Follow Along with Policy Priority Materials in your Folders!

These are yours to reference throughout your meetings tomorrow!

NARHC 2026 Policy Summit

POLICY PRIORITY 1: MEDICARE ADVANTAGE

POLICY ISSUES

1. RHC providers are incentivized to practice in rural areas through cost-based Medicaid and traditional Medicare reimbursement. As MA rapidly expands, **RHCs face growing financial strain because many plans refuse to pay the cost-based style that traditional Medicare provides.**
2. RHCs must negotiate reimbursement rates through unique contracts with each MA plan (rural beneficiaries have an average of 22-30 different MA plans to choose from). Many RHCs have little negotiating leverage in areas where MA plans have significantly increased enrollment. **These challenges may increase pressures on RHCs to consolidate as oftentimes larger systems have more negotiating power.**
3. Conversely, **Federally Qualified Health Centers (FQHCs) receive supplemental payments from Medicare to cover the difference** between the reimbursement rates of traditional Medicare and

SUPPORTING DATA

A recent NARHC survey revealed that **more than half of RHCs nationwide receive less reimbursement from MA plans** than from Traditional Medicare (see chart below).

RHC Medicare Advantage Reimbursement Compared to Traditional Medicare	
significantly more (20%+) than traditional Medicare reimbursement	3.40%
slightly more (5-20%) than traditional Medicare reimbursement	16.40%
roughly the same (+/-5%) as traditional Medicare reimbursement	28.80%
slightly less (5-20%) than traditional Medicare reimbursement	26.70%
significantly less (20%+) than traditional Medicare reimbursement	24.70%

NARHC 2026 Policy Summit

POLICY PRIORITY 2: TELEHEALTH

POLICY ISSUES

- RHCs are subject to a "special payment rule" that reimburses Medicare telehealth visits at a flat rate of $97.53 & bills one single code, G2025, for all 280+ billable telehealth services.
- Most other Medicare providers (those billing fee-for-service) receive payment parity for telehealth and in-person services since 2020.
- The payment rate for G2025 is lower than an RHC's all-inclusive rate, which disincentivizes investment in telehealth technologies.
- Limited data can be gathered from G2025 as it obscures and distorts claims data. As discussions about the future of telehealth continue, RHCs lack reliable data to demonstrate which telehealth services are used most frequently, while traditional providers have 6 years o usable data to contribute to these conversations.
- The special payment rule requires RHCs to separate costs associated with telehealth on their annually filed cost report, which generates significant administrative burden for RHCs. Rural safety-net providers already face greater workforce challenges compared with traditional provider types, making this policy especially burdensome.
- What was intended to be a "temporary" special payment rule has now been in effect for nearly 6 years. As a result, RHCs have been operating without adequate telehealth reimbursement for an extended period, facing ongoing financial strain. Repeated short-term extensions offer no security, only prolonging the flawed rule and creating persistent uncertainty about the future of RHC telehealth.
- **In early 2026, Congress passed another extension of the special payment rule policy for RHCs while maintaining parity for traditional provider types. These current flexibilities will remain in effect through the end of 2027.**

SUPPORTING DATA *Illustrative Example: Telehealth Billing for Level 4 E/M ~ The Most Commonly Billed Medicare Code*

Facility	Service	Billed As	Medicare Reimbursement
Traditional PFS Office	CPT Code Level 4 E/M	99214	$135.61 (+geographic adjustments)
Rural Health Clinic	CPT Code Level 4 E/M	G2025	$97.53 (no geographic adjustment)

NARHC 2026 Policy Summit

POLICY PRIORITY 3: Rural Health Clinic Regulatory Reduction Legislation

Bipartisan Bills to Reduce Outdated Administrative Burdens in RHCs

POLICY ISSUES

The delivery of healthcare has evolved significantly since the Rural Health Clinic (RHC) statute was written in 1977. Certain outdated provisions, like those addressed below, result in unnecessary added costs and administrative burden for clinics already facing the challenges that come with providing care in rural communities.

- **Modernizing Physician Assistant (PA) and Nurse Practitioner (NP) Utilization Requirements**: 27 states have granted NPs full practice authority, and 7 states have granted PAs full practice authority, yet NPs and PAs practicing in RHCs in those states still have separate, federal supervision requirements. This additional supervision requirement creates an additional and unnecessary barrier for staffing RHCs, ultimately limiting access to care.
- **Fix Outdated Language Related to RHC Location Requirements**: To be certified as an RHC, the facility needs to be in a Health Professional Shortage Area, Medically Underserved Area, or Governors Shortage Designated Area, as well as an area outside of an urbanized area, defined by the Census Bureau. Prior to 2020 this meant an area of less than 50,000. However, the 2020 Census stopped defining "urbanized/non-urbanized areas", and now uses urban (greater than 50,000) or rural (less than 5,000) – leaving the space between 5,000 and 50,000 a gray area for CMS interpretation. This new Census Bureau definition threatens the location eligibility of many critical RHC locations.
- **Remove Restriction on Amount of Behavioral Health Services Allowable in RHCs**: Currently, RHCs are limited to providing no more than 49% of their services as behavioral health care. This outdated restriction unfairly limits RHCs compared to other provider types and reduces access to critical behavioral health services in rural communities. The cap prevents clinics from fully responding to patient needs and integrating behavioral health into primary care, particularly in areas experiencing high rates of substance use disorder and mental health challenges. In addition, the policy creates unnecessary administrative burdens, requiring staff to closely monitor scheduling and service mix to remain below the arbitrary threshold.

NARHC 2026 Policy Summit

POLICY PRIORITY 4: Rural Health Transformation Program & Other Government Resources

POLICY ISSUES

The President's proposed Department of Health and Human Services (HHS) budget for Fiscal Year 2027 slashes funding for integral rural health programs, ultimately threatening rural provider stability and patient access.

The following rural health programs are proposed for elimination in the FY2027 HHS Budget: State Offices of Rural Health (SORHs), Rural Hospital Flexibility Grants, Rural Hospital Stabilization Pilot Program, Area Health Education Centers (AHECs), & various workforce programs (Primary Care Training and Enhancement, Nurse Education, Practice, and Retention, and many others). These programs provide essential resources and support to rural communities. Their elimination would be a dangerous further disinvestment in all facets of rural.

While Congress injected $50 billion into rural healthcare via the Rural Health Transformation Program (RHTP), no one is exactly sure how this money will actually be spent over the next five years.

The legislative text of H.R.1 created the program is quite open-ended and as such, almost every entity in healthcare is interested in receiving this funding to help be part of the 'transformation.' The distribution of funds is ultimately left to the discretion of the Centers for Medicare and Medicaid Services (CMS) Administrator, Dr. Oz, and each state. As a result, funding could be directed to other healthcare facilities beyond rural hospitals and RHCs, including urban providers, or used in statewide 'transformation' efforts in which no facility may see direct dollars from the fund.

SUPPORTING DATA

State Offices of Rural Health (SORHs) are critical resources for RHCs. NARHC represents RHCs across the country and relies on SORHs for state-specific knowledge and support. They provide targeted programming and resources to support the RHCs within their states. Examples include:

- **Oregon**: Established a learning cohort supporting RHCs in developing and sustaining comprehensive regulatory compliance for survey readiness.

RHC Policy Priority 1: Medicare Advantage

- RHC providers are incentivized to practice in rural areas through enhanced Medicaid and traditional Medicare reimbursement. As MA rapidly expands, RHCs face growing financial strain because many plans refuse to pay the All-Inclusive Rate (AIR) that traditional Medicare provides
- NARHC advocates for the creation of a reimbursement floor policy, financed through establishing a minimum payment that MA plans must reimburse to RHCs as safety-net providers

A recent NARHC survey revealed that more than half of RHCs nationwide receive less reimbursement from MA plans than from Traditional Medicare (see chart below).

RHC Medicare Advantage Reimbursement Compared to Traditional Medicare	
RHCs report that their Medicare Advantage contracts reimburse:	
significantly more (20%+) than our traditional Medicare reimbursement	**3.4%**
slightly more (5-20%) than our traditional Medicare reimbursement	**16.4%**
roughly the same (+/-5%) as our traditional Medicare reimbursement	**28.8%**
slightly less (5-20%) than our traditional Medicare reimbursement	**26.7%**
significantly less (20%+) than our traditional Medicare reimbursement	**24.7%**

If the **Medicare Advantage** policy priority speaks to you, we encourage you to have the following information prepared for your Hill Day meetings:

- % of patients on Traditional Medicare
- % of patients on Medicare Advantage plans
- % of Medicaid/CHIP patients
- % of commercially insured patients
- % of uninsured patients
- % of other
- Contract reimbursement rates with MA plans in comparison to your Traditional Medicare reimbursement
- Additional detail demonstrating the annual loss to your facilities because of this disparity
- Example stories regarding Medicare Advantage patients who faced delays in care due to prior authorizations, no longer being in-network with their providers, etc.

Medicare Advantage Asks

- Support legislation to reduce administrative burdens – S.1816 / H.R.3514
- Support legislation to encourage prompt and fair pay from MA plans – H.R.4559

- If an office or Member is particularly animated about MA, make sure to flag for NARHC staff!

RHC Policy Priority 2: Telehealth

- RHCs are subject to a **"special payment rule"** that reimburses Medicare telehealth visits at a flat rate of **$97.53** & bills one single code, **G2025**, for all 280+ billable telehealth services (coding piece will change October 1)
- Most other Medicare providers (those billing fee-for-service) receive payment parity for telehealth and in-person services since 2020

Illustrative Example: Telehealth Billing for Level 4 E/M Most Commonly Billed Medicare Code

Facility	Service	Billed As	Medicare Reimbursement
Traditional PFS Office	CPT Code Level 4 E/M	99214	$135.61 (+ geographic adjustment)
Rural Health Clinic	CPT Code Level 4 E/M	G2025	$97.53 (no geographic adjustment)

If the **Telehealth** policy priority speaks to you, we encourage you to have the following information prepared for your Hill Day meetings:

- % of visits done via telehealth services
- # of G2025 billing visits
- Your All-Inclusive Rate (AIR) to demonstrate the financial loss between that and G2025 reimbursement ($97.53)
- # of Annual Wellness Visits (AWV) obscured by G2025 system
- Additional detail demonstrating the annual loss to your facilities because of this disparity
- Example stories regarding Medicare telehealth reimbursement impacting patient access

Telehealth Asks

- Understand the key differences between RHC telehealth policy and other Medicare provider telehealth policy
- Support the CONNECT for Health Act of 2025 (S.1261 andH.R.4206), the Save America's Rural Hospitals Act (H.R.3684), the Telehealth ModernizationAct (S. 2709 and H.R.5081), and the HEALTH Act (H.R.5496)

- If an office or Member is particularly animated about telehealth, make sure to flag for NARHC staff!

Policy Priority 3 - RHC Regulatory Reduction Legislation

- Since the RHC statute was written in 1977, the delivery of healthcare has significantly changed
- There is a strong need for legislative change for reducing the burdens on Rural Health Clinics
  - Outdated provisions
  - Unnecessary added costs
  - Administrative burden
- NARHC supports the following common-sense, cost-neutral updates to modernize the RHC program

Bill 1 – H.R.5199

- Modernizing Physician Assistant (PA) and Nurse Practitioner (NP) Utilization Requirements
  - Leads: Representative Tracey Mann (KS-01) and Representative Jill Tokuda (HI-02)
  - Supporting Organizations: American Association of Nurse Practitioners, National Rural Health Association, & National Organization of State Offices of Rural Health
- This act modernizes RHC physician supervision requirements by aligning them to *state scope of practice laws governing NP and PA practice*.

Bill 2 – H.R.5198

- Fixes Outdated Language Related to RHC Location Requirements
  - Leads: Representative Tracey Mann (KS-01) and Representative Jill Tokuda (HI-02)
  - Supporting Organizations: National Rural Health Association & National Organization of State Offices of Rural Health
- This bill maintains status quo policy as to where an RHC can be located, ensures that RHCs can continue to be located in an area that is less than 50,000
  - Requires a statutory update due to Census Bureau no longer defining terminology (urbanized/non-urbanized) used in current eligibility definition

Bill 3: H.R.5217

- Removes Restriction on Amount of Behavioral Health Services Allowable in RHCs
  - Leads: Representative Jill Tokuda (HI-02) and Representative Tracey Mann (KS-01)
  - Supporting Organizations: National Rural Health Association, National Organization of State Offices of Rural Health, American Psychological Association Services, & National Association for Rural Mental Health
- This act removes the statutory barrier that limits the amount of behavioral health services an RHC can provide (now at 49%), allowing clinics to better treat all needs of their patients and further integrate services.

What's the ask?

1. In the House – Contact the leads listed on each bill to co-sponsor these bipartisan, burden reduction bills

2. In the Senate -- Generate awareness of the outdated administrative burdens affecting RHCs and the need to modernize the statute in these common-sense ways
   - Flag interested offices for NARHC staff

RHC Policy Priority 4: RHTP & Other Government Resources

HHS FY2027 Proposed Budget

- The following rural health programs are **proposed for elimination in the FY2027 HHS Budget**:
  - State Offices of Rural Health (SORHs)
  - Rural Hospital Flexibility Grants
  - Rural Hospital Stabilization Pilot Program
  - Area Health Education Centers (AHECs)
  - Workforce Programs (Primary Care Training and Enhancement, Nurse Education, Practice, and Retention, and many others)
- These programs provide essential resources and support to rural communities. Their elimination would be a dangerous further disinvestment in all facets of rural

Rural Health Transformation Program (RHTP)

- $50 billion fund in response to advocacy around negative impacts of H.R. 1 on rural and safety-net providers
- Funds were awarded by CMS on December 29, 2025
- All 50 states submitted applications and received funding
- 50% of appropriated funds equally distributed amongst all states with approved application, while remaining 50% distributed at CMS discretion under specific criteria
- **34 states** mentioned RHCs in their rural health transformation plan
- **Will RHCs see any of this money?**

If the **RHTP & Other Government Resources** policy priority speaks to you, we encourage you to have the following information prepared for your Hill Day meetings:

- Example stories regarding support from resources funded through HHS (SORH support, FLEX funding, etc.)
- Financial strain that could be alleviated with RHTP support

Thank You!

Go forth and advocate!

2 E. Main St, Fremont, MI 49412 | 866-306-1961 | NARHC.org

Remarks From Our Platinum and Reception Sponsor:

WINTERGREEN