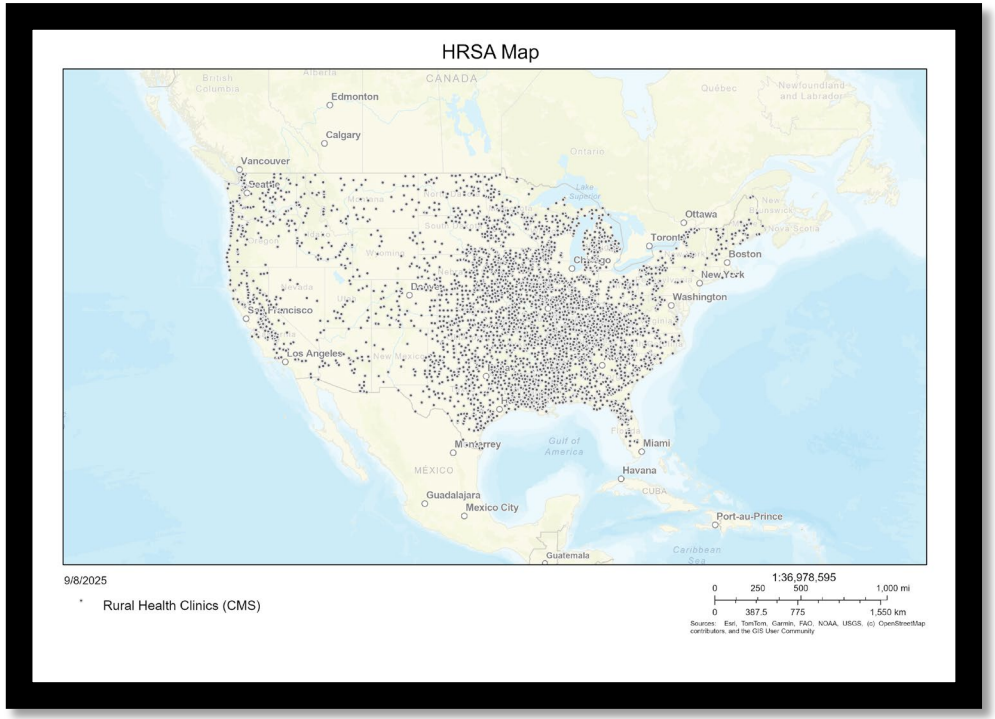
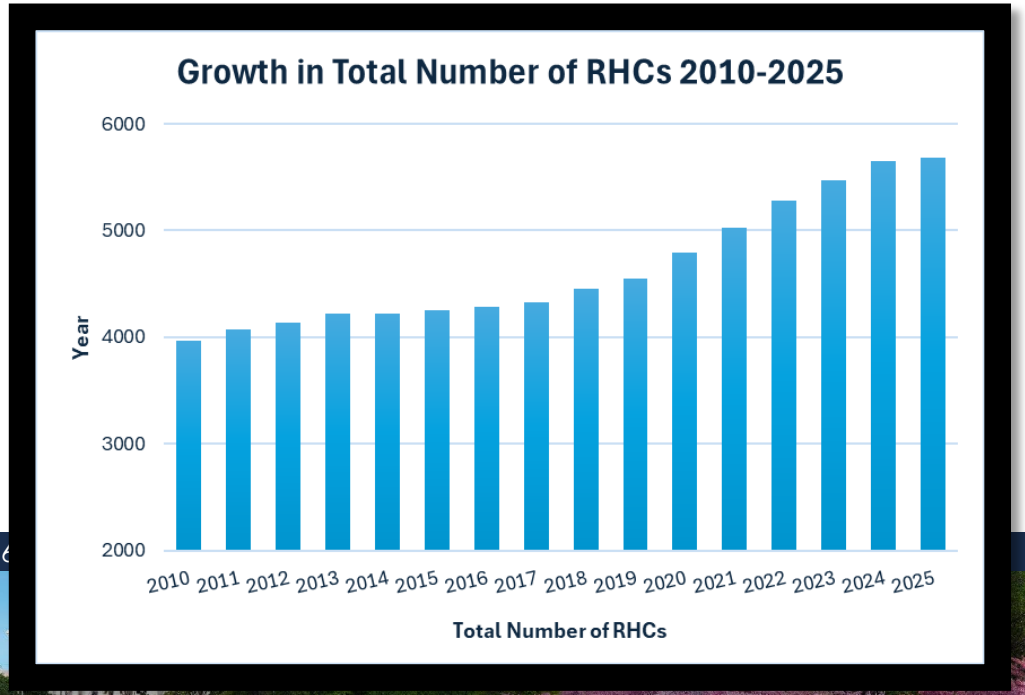
Rural Health Clinic Updates from Washington, D.C.

Sarah Hohman, MPH, CRHCP
Director of Government Affairs
National Association of Rural Health Clinics

Status of the RHC Program

- There are over 5,700 RHCs in 47 states
  - **63 in Montana!**
- RHCs provide care to over 39 million Americans annually
- Payor mix - predominantly Medicare and Medicaid
- RHCs rank Medicare Advantage reimbursement and Medicare Advantage administrative burdens as top 2 most concerning issues





NARHC Policy Survey 2026

- As policymakers continue to make decisions that directly impact RHCs, it is critical that we can point to real, nationwide data that reflect true experiences of RHCs like yours.
- To gather data ahead of time, click here
- **To complete the survey by February 23rd, click here**

Medicare Telehealth Coverage RHCs

Medical Telehealth

- RHCs can serve as telehealth distant site providers through December 31, 2026
- Paid ~$97 for all services on Medicare's allowable telehealth list (200+ codes)
- Bill as G2025, not encounters

Mental Health Telehealth

- Permanent coverage in RHCs, reimbursed at AIR, counts as an encounter
- New mental health telehealth patients must be seen in person within last 6 months (beginning February 1 unless waived by Congress)

Telehealth Advocacy

- NARHC is pushing for the next telehealth extension to include a **fix** for RHC telehealth policy (allow telehealth visits to be RHC encounters, reimburse at AIR)
- Legislation introduced this Congress achieves this priority
  - CONNECT for Health Act of 2025 (H.R.4206 & S.1261)
  - Telehealth Modernization Act
  - HEALTH Act

H-1B Visa Policy Change

- The Trump Administration created a $100,000 fee for H-1B visa applications in September 2025
- Over 500 rural employers annually utilize H-1B visas to recruit and retain practitioners
- NARHC sent a joint letter with the National Rural Health Association urging the Department of Homeland Security to create a carveout to this new policy for healthcare workers
  - DHS expects exemptions to be very rare, limiting this as an option for rural recruitment moving forward

FY2026 Government Funding

- The federal government's fiscal year began on October 1, 2025
  - At this point, Congress had not passed funding bills for FY26, which led to a 43-day government shutdown
  - In reopening the federal government, Congress funded agencies through January 30
  - **They are still working on the funding bills to avoid another partial shutdown**
  - Shutdown was a result of the lack of bipartisan deal on enhanced Affordable Care Act subsidies..

Enhanced Affordable Care Act Subsidies – What are they? How do they impact rural?

- Approximately 2.8 million rural Americans rely on plans purchased through the ACA marketplace, 80% in zero-premium plans due to enhanced subsidies

- Expiration of these subsidies are expected to increase premiums by an average of 107% for rural residents
  - These individuals are expected to forego coverage, resulting in a higher uninsured population (4 million more Americans)
  - Thus far, 1.4 million fewer have enrolled in 2026 coverage

- Critics of these subsidies cite 'phantom enrollees,' issues with further subsidizing health insurers, and other waste, fraud, and abuse concerns – permanent extension of subsidies would cost $380 billion

Will Enhanced ACA Subsidies Return?

- Maybe, but unlikely to be soon
- 17 Republicans voted with Democrats to pass a 3-year clean extension of subsidies
  - Many of these Republicans are in vulnerable districts for 2026 elections, and many of their constituents rely on these subsidies
- Senate is still in negotiations for a potential health care deal that could include a subsidy extension with reforms (income caps, $5 premiums, and others)

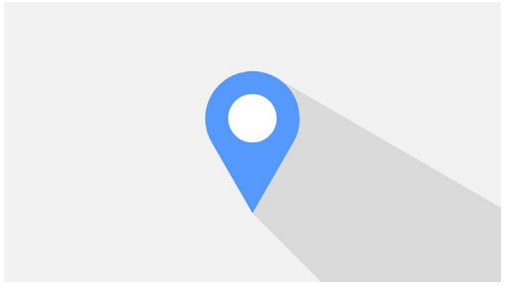
RHC Regulatory Reduction Bills

Modernizing Rural Physician Assistant (PA) and Nurse Practitioner Utilization Act (H.R.5199)

- Aligns RHC physician supervision requirements with state scope of practice laws governing NPs and PAs
- 27 states have granted full practice for NPs, and 8 for PAs, yet NPs and PAs in those states still must have an MD/DO medical director, just because they're practicing in an RHC

RHC Location Modernization Act (H.R.5198)

- Maintains status quo RHC location policy, necessary as a result of the Census Bureau no longer defining "urbanized area"

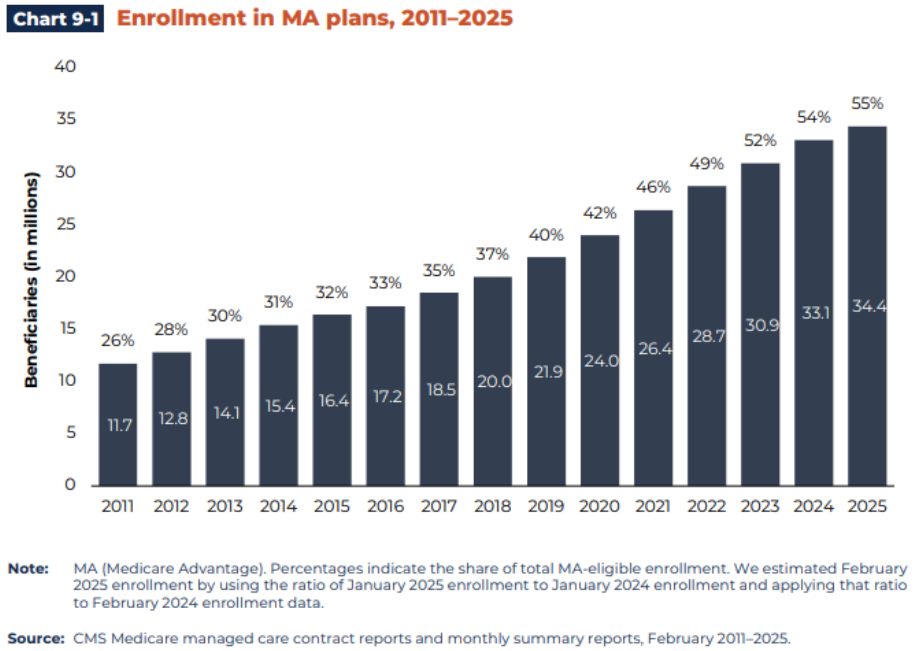


Rural Behavioral Health Improvement Act (H.R.5217)

- Removes 49% statutory barrier that limits the amount of behavioral health services an RHC can provide
- Supports further integration of behavioral health and primary care

Medicare Advantage

- Growth continues in the MA program
- Beneficiaries have an average of 42 plans to choose from
- While many patients like their plans, providers are feeling the squeeze



Medicare Advantage for RHCs

- While some RHCs are able to negotiate with MA plans for reimbursement comparable to their Medicare rates, there is no requirement that MA plans treat RHCs differently (despite your role in the health care safety net)
- FQHCs receive quarterly wrap payments to make up the difference between contracted MA rates and traditional Medicare reimbursement rates

Medicare Advantage – Legislative

- Increased negative attention on MA industry as a whole
  - $83 billion / year in overpayments versus what beneficiaries would cost if enrolled in traditional Medicare
  - Favorable selection, coding intensity
- Continues to be popular program among many patients, and Republican lawmakers
- **Prompt and Fair Pay Act (H.R.4559)**
  - Would require MA plans to pay providers at least what they'd receive from traditional Medicare + it's bipartisan!
  - NARHC is seeking an RHC specific solution to this issue as well

H.R. 1 / 'One Big Beautiful Bill' Act

- Signed into law July 4, 2025 after months of negotiations in both chambers
  - Reconciliation = partisan
  - Nearly $1 trillion in decreased health care spending

- Most significant health care reforms since the Affordable Care Act
  - Republicans' Perspective: Reducing waste, fraud, and abuse; tax cuts for working families
  - Democrats' Perspective: Tax cuts for wealthy Americans while cutting safety-net programs (Medicaid / SNAP)

H.R.1 Healthcare Provisions

- Medicaid Eligibility Checks
  - Requires **states** to increase eligibility checks on the Medicaid expansion population – currently checked annually, changing to every 6 months
  - Begins January 1, 2027
  - States must also establish processes to more regularly obtain beneficiary address information in between renewals
    - Intent to decrease number of individuals enrolled in multiple states, ensuring deceased patients and providers do not remain enrolled

- Medicaid Work / Community Engagement Requirements
  - Requires **states** to implement work requirements for those 19-64 who don't meet an exemption
    - 80 hours per month
    - Exemptions include: serving as a caretaker for disabled individuals or those under 14, pregnant women, members of a tribe, 'medically frail' individuals, those enrolled in school
    - Begins January 1, 2027 (with lookback period 1-3 months prior)

State Responsibilities / Decisions

- How are individual processes / systems designed?
  - Do they support Medicaid recipients in maintaining coverage or administratively burdensome?
- Does your state follow the 2027 implementation, submit a good faith waiver for an extension until December 2028, or submit 1115 waivers to start work / community engagement requirements early?
  - Montana submitted a proposal in September 2025 to begin these requirements early – could begin as early as summer 2026
- Does your state consider additional exemptions to work requirements such as for short-term hardship, in areas with high unemployment rates, etc.?
- Does your state use a 1, 2, or 3 consecutive month look back period for eligibility and work requirement compliance?
- How will your state engage stakeholders to reach all beneficiaries?

Coverage Impacts (Per the Congressional Budget Office)

- The Medicaid and Affordable Care Act policy changes are estimated to result in a loss of health insurance coverage for approximately 10 million Americans by 2034

- Estimated coverage losses are a result of stricter eligibility rules, paperwork requirements, and the difficult decisions states need to make to balance their budgets
  - Reduce provider payments
  - Tighten eligibility
  - Take from other programs
  - Increase taxes

Risks to Rural from H.R.1

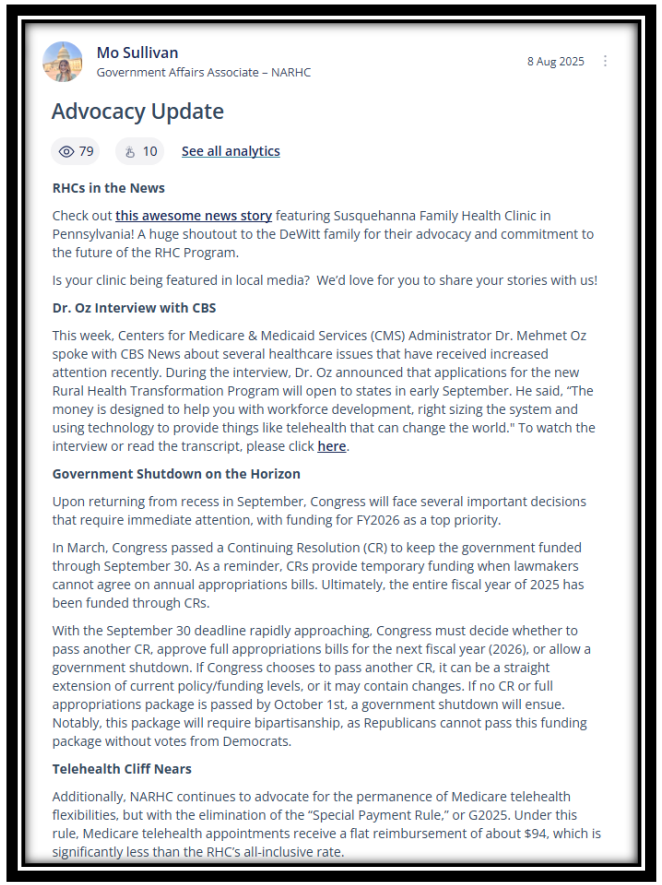
- RHCs and CAHs do not receive grant or other funding to treat an uninsured population
- Patients will still seek care even if they lose coverage
  - Likely a more complex, sicker patient population
- **Can your facilities remain financially viable with an increase in the uninsured population?**
- How can you be engaged at the state level and with your patients as they navigate these new requirements?

Rural Health Transformation Program (RHTP)

- $50 billion fund distributed at $10 billion per year (2026-2030) by CMS to states
- Awards announced in December 2025
  - Montana to receive $233 million in 2026
  - Every state will prioritize RHCs differently, please engage with your state on funding opportunities
  - Virtual stakeholder meeting this Thursday, January 22
    - https://healthinfo.montana.edu/rhtpkickoff.html

Stay “In the Know” on RHC Issues

- NARHC.org
  - Email Listserv
  - Discussion Forum
    - Weekly policy updates!
  - NARHC News
  - Biweekly Office Hours
  - Resources
    - TA Webinars
    - Policy and Advocacy
- State rural health organizations & offices of rural health
- Federal Office of Rural Health Policy (FORHP) Weekly Updates
- RHIhub
- CMS RHC Center



Thank You and Questions!

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Director of Government Affairs
National Association of Rural Health Clinics (NARHC)
202-543-0348
Sarah.Hohman@narhc.org