



April 7, 2020

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
200 Independent Avenue, SW  
Washington, DC 20201

Administrator Verma:

We are writing to you on behalf of the more than 4,400 Rural Health Clinics (RHCs) and the thousands of communities and millions of patients they care for in rural underserved areas.

It gives us no great pleasure to have to write this letter but it is important that the Centers for Medicare and Medicaid Services (CMS) leadership, the President, Congress and the American people know what CMS has been doing over the last few weeks to cause enduring harm to the healthcare delivery system in rural communities around the country.

Since the early days of the Coronavirus pandemic, CMS has shown a disappointing lack of regard for the economic and clinical challenges RHCs face in providing care in rural underserved communities. Rural underserved communities confront unique economic, demographic, geographic, topographic, and internet/cell service challenges that make it more costly on a per patient basis to deliver care than in most other settings. Despite decades of evidence to the contrary, the leadership at CMS seems to be under the mistaken belief that the way you pay for or deliver care in Indianapolis, Baltimore, or Northwest Washington, DC, is the same way you can pay for and deliver healthcare in rural underserved areas.

While public statements by CMS officials expressing concern for rural patients have been widely reported, the reality is that CMS's actions have fallen well-short of your rhetoric. Indeed, CMS has, at times issued public statements of actions it has taken that were at best misleading and at worst, false as they relate to patients living in rural underserved areas.

We have been profoundly disappointed by the way CMS has treated Rural Health Clinics and the patients they care for during the Coronavirus pandemic.

The most recent example of CMS's disregard for Medicare patients living in rural underserved areas involves the ability of RHCs and FQHCs to engage in telehealth visits with their Medicare patients.



On March 27<sup>th</sup>, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Included in this historic legislation was language temporarily authorizing Physicians, PAs, NPs, and other RHC clinicians the ability to engage in telehealth visits with their Medicare patients and most importantly, get paid for these visits.

Unfortunately, as we write this letter, CMS has yet to issue any guidance on how – or how much – RHCs and FQHCs will be paid by Medicare for telehealth visits.

This delay was utterly predictable and avoidable – this did not have to happen.

As you know, in mid-March when CMS was using the 1135 authority to waive a range of Medicare laws and regulations, NARHC requested that you use this authority to allow RHCs to be the distant site for telehealth visits. CMS rejected this request.

In a press release announcing the telehealth waivers you were approving, CMS told the media and the American people that you were waiving certain telehealth laws, noting;

“This is a critical point given the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission, since it will prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely.”

CMS’ press release failed to mention that your abundance of concern about the safety of vulnerable populations did not extend to vulnerable populations that lived in urban or rural underserved areas. Is there something you know about vulnerable elderly patients living in rural or urban underserved areas that makes it OK for them to venture out of their homes to get in-person care from Rural Health Clinics?

*“A couple came to one of our clinics, they call first, his wife is having some pain and not feeling well. They arrive, because of visitor restrictions the husband can’t come to the visit with his wife. He’s always been with her to an appointment. We set up a facetime using our own iPhone so he can “be there”. They’ve been married 52 years. He waits in the car while the provider sees his wife. Her scans have come back – she has cancer, likely terminal. This happened before CMS allowed for “tele” in RHCs. This couple should have never been out, let alone in the clinic. They needed tele med, it was the safest thing for them.”*

As CMS staff is well aware, there is nothing in the actual telehealth statute that prohibits physicians, PAs, NPs, Psychologists, and Social Workers working in RHCs from being the



distant site telehealth provider or from getting paid for these telehealth visits as a Rural Health Clinic visit. The prohibition is solely based on CMS policy – a policy that you had the authority to change – even if only for the duration of the National Public Health emergency.

But instead of using the 1135 waiver authority, you insisted that Congress had to pass legislation temporarily authorizing RHC health professionals the ability to engage with their patients via telehealth. This has delayed the ability of rural Medicare beneficiaries to obtain needed care via telehealth and deprived Rural Health Clinics of much needed revenue for seeing patients via telehealth.

Had CMS acted reasonably and in fulfillment of your stated goal to “prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely” you would have used your waiver authority to pay for telehealth visits by physicians, PAs and NPs working in rural health clinics.

Instead, CMS chose to ignore the plain meaning of the statute and told Congress that it was necessary to rewrite the telehealth law to allow RHC physicians, NPs and PAs to temporarily provide and get paid for telehealth visits.

To make matters worse, instead of asking Congress for the simple straight-forward authority to pay RHCs for telehealth visits the same as they would have been paid had the patient presented in the office in-person (which by the way is what the telehealth statute says for every other telehealth provider), CMS conditioned it’s support on Congress granting CMS the authority to develop a new way of paying RHCs for their telehealth visits with Medicare patients.

And so we wait some more. It has now been more than 10 days since the President signed the CARES Act and we have no guidance from CMS on how or how much RHCs will be paid for telehealth visits.

*I walked out with a MA last Friday. It was late and I asked if she was thankful the day was over. Her reply – “honestly I’m thankful I am able to work and earn pay. Everyone in my family is laid off right now. I bring the only pay check now.” As I reached my car I sat in tears, she was an employee I knew on Monday I had to flex off.”*

The consequence of this strategy by CMS has meant that rural beneficiaries have been waiting nearly a month to get the care they need, and hundreds of rural health clinics are on the brink of financial disaster. Patients – Medicare, Medicaid, Commercially insured, self-pay - are not coming into the clinics. Without patients coming into the clinic and no ability to replace these in-person visits with telehealth visits/revenue, many clinics are on the brink of bankruptcy.



We estimate that because of the revenue lost due to the inability of RHCs to bill Medicare for telehealth visits for the past 30 days, combined with what we expect will be Medicare telehealth payments that are less than the RHCs costs once you do create that new payment model, hundreds of RHCs will be forced to close their doors – permanently. Some of these will be small hospital owned RHCs and others will be RHCs owned by physicians, NPs, PAs and local governments.

*“I watched a nurse lock a clinic door last week – she’s worked there 15 years. She knows the community, the patients like they are her family. We will never open that clinic again post COVID.”*

And when a Rural Health Clinic closes, it will not just be Medicare patients who lose care, but commercially insured patients, Medicaid patients and uninsured patients as well. Because as you know, rural health clinics are – almost by definition - the ONLY provider in their underserved rural area.

Sadly, when the Coronavirus pandemic is in our nation’s rearview mirror and the historians are writing the clinical post-mortem, the adverse impact of the policies CMS failed to adopt in a timely fashion to ensure the availability of healthcare in rural underserved areas during the Coronavirus pandemic will not be a proud chapter in the agencies long history.

Sincerely,

*Angie Charlet*

Angie Charlet  
President  
National Association of Rural Health Clinics  
[acharlet@icahn.org](mailto:acharlet@icahn.org)  
(866) 306-1961

*Bill Finerfrock*

Bill Finerfrock  
Executive Director  
National Association of Rural Health Clinics  
[bf@narhc.org](mailto:bf@narhc.org)  
202-997-3407

Cc: HHS Secretary Alex Azar  
The Honorable Nancy Pelosi  
The Honorable Richard Neal  
The Honorable Mitch McConnell  
The Honorable Chuck Grassley  
The House Rural Healthcare Coalition

HHS Deputy Secretary Eric Hargan  
The Honorable Kevin McCarthy  
The Honorable Kevin Brady  
The Honorable Chuck Schumer  
The Honorable Ron Wyden  
The Senate Rural Health Caucus



PS FYI, here is the relevant language from the Social Security Act establishing the telehealth benefit (Section 1834 (m) of the Social Security Act):

*1834 (m)(1) - The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary.*

*1834 (m)(2) The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.*

As you can clearly see, there is nothing in the law that prohibits CMS paying for telehealth services delivered by RHC physicians, NPs or PAs. And as you can also clearly see, CMS is authorized to pay for telehealth services “an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system. In other words, Medicare is authorized to pay for a telehealth visit performed by an RHC physician, PA or NP at the amount that Medicare would have paid had these patients been seen in-person at the RHC.