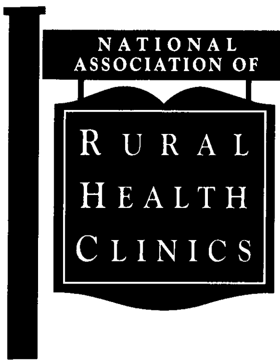

June 25, 2007

The Honorable Earl Pomeroy
Co-Chair
House Rural Health Care Coalition
United States House Of Representatives
Washington, DC 20515

The Honorable Greg Walden
Co-Chair
Rural Health Care Coalition
United States House of Representatives
Washington, DC 20515

Dear Representatives Pomeroy and Walden

On behalf of the National Association of Rural Health Clinics (NARHC), and the more than 3,000 federally certified Rural Health Clinics (RHCs) we represent, I want to commend you for the introduction of the Health Care Access and Rural Equity (H-CARE) Act of 2007 (H-CARE). NARHC strongly supports this legislation and looks forward to working with you to ensure its passage.

This bill is important to the physicians, PAs and NPs who work in RHCs throughout the United Stats, as well as their Medicare, Medicaid, and low-income patients who rely on the Rural Health Clinics program to make health care available in rural underserved communities.

It has been more than 20 years since the RHC CAP was last adjusted by Congress. Since the mid-80's, the only adjustments have been for medical inflation. This, despite the fact that we have dramatically expanded Medicare benefits over the past 20 years. RHCs are being asked to provide the 2007 package of Medicare benefits using a payment methodology that is based upon the 1987 benefit package! It just doesn't work. We commend you for including language in the HOPE legislation raising the RHC cap to $92.00 per visit.

Rural providers — physicians, hospitals, RHCs, etc. — all see a disproportionately high percentage of Medicare, Medicaid and uninsured patients relative to most providers located in urban and suburban areas. For the typical RHC, nearly 60% of their patients have their healthcare paid for by Medicare or Medicaid. This means that unlike providers located in urban or suburban communities, rural providers are overly dependent upon Medicare and Medicaid payments for their economic survival. Failure by either of these programs to pay at rates that cover the cost of delivering care means these providers cannot continue to exist.

The Health Care Access and Rural Equity (H-CARE) Act of 2007 goes a long way towards

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ensuring that all rural providers are compensated fairly and accurately for the services they provide to Medicare patients.

By encouraging collaboration between RHCs and FQHCS, the legislation will promote expansion of primary care services to low-income individuals residing underserved rural communities by using existing infrastructure without raising costs. This is a common-sense approach to improving access to care.

Finally, by mandating minimum payments by Medicare Advantage plans to RHCs and Critical Access Hospitals (CAH), the bill ensures that RHCs and CAHs will have the funds necessary to provide critically necessary services in their communities.

Again, thank you for your leadership on this issue and we look forward to working with you on this important legislation.

Sincerely,

Bill Finerfrock
Executive Director
National Association of Rural Health Clinics