

January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

The National Rural Health Association is writing regarding its concern about the implications of the Census Bureau’s finalized rule removing the terms “urbanized area” and “urbanized cluster,” and the recent publication of the 2020 Census Qualifying Urban Areas list.¹ These changes by the Census Bureau have an unintended but significant impact on rural health clinics (RHCs).

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes every component of rural America’s health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

RHCs must be located in a rural area, which is defined in the RHC regulations as “an area that is not delineated as an urbanized area by the Bureau of the Census.”² The Census Bureau’s final policy for Urban Area Criteria, published in March 2022, removed two important terms that have an unintended impact upon RHC eligibility criteria. The Census removed two types of urban areas – “urbanized area” and “urbanized cluster” – and combined the two to create a single designation termed “urban area.”³ Per the new Census criteria an urban area is that with a population of 5,000 or more and thus rural means any area that falls outside of the urban area definition and has a population of less than 5,000.⁴

This change creates a twofold problem for the RHC program. First, as referenced above, RHC regulations rely upon the definition of “urbanized area” to define where RHCs may be located. This term no longer exists under Census Bureau regulations leaving ambiguity in the program regulations. Second, the new definition of “urban area” is a population of 5,000 or more, which materially expands the reach of the urban area definition to encapsulate traditionally rural areas. The drastic difference between population thresholds in the old and new definitions will remove many areas from RHC eligibility if CMS adopts the new “urban area” term. In the meantime, on the ground the provider community is uncertain about how to move forward with establishing new RHCs and the status of existing RHCs.

NRHA members have expressed serious concerns about the state of uncertainty that exists since the December 2022 list of urban areas was released. Providers considering building or opening a new

¹ 87 FR 16706; 87 FR 80114.

² 42 C.F.R. § 491.5(c)(1).

³ 87 FR 16707.

⁴ 87 FR 16711.



RHC are now holding off because they are not clear on whether the proposed site will still be rural-eligible when they are done with construction several months from now.

NRHA urges CMS to clarify how it will proceed with the Census change regarding RHCs through informal guidance in a QCOR memorandum and eventually a proposed rulemaking. CMS must not adopt the Census definition of urban area and retain the status quo by continuing to certify RHCs based on a population of 50,000 or more. Using the “urban area” threshold would threaten the ability of many areas to open an RHC in order to meet community need. While nothing changed in terms of the population, resources, or health needs of a community, the regulatory change by the Census would be the only barrier to an RHC opening in a community that otherwise needs it and would have been eligible under prior definitions.

In its guidance, CMS should assure providers that pending congressional action or a proposed rulemaking, it will preserve the status quo when a facility is located in an area that does not have a population of more than 50,000. CMS must clarify that RHCs that are currently open and waiting for their first survey will be evaluated against the previous urbanized area definition. CMS must also include guidance for those currently undergoing stages of construction, opening, or relocating and again ensure that the clinic would essentially be grandfathered in under the previous urbanized area standard once the clinic is ready to open and be surveyed. For providers that are planning to open a new RHC, CMS should reasonably apply the previous definition until further formal guidance via statute or rulemaking is effective.

NRHA further proposes that CMS consider changing the regulatory language regarding RHCs. As noted above, RHCs must be located in “rural areas,” defined in the CFR as any area not delineated as an urbanized area. To maintain the status quo and ensure that large swaths of RHCs do not lose their status, **CMS should promulgate a rule amending the Code of Federal Regulations at 42 C.F.R §§ 491.2 and 491.5(c) to state that RHCs are qualified if they “are not in an urban area of 50,000 or more.”**

NRHA thanks CMS for its continued support of rural communities across America. We look forward to working towards our mutual goal of improving quality and access to care. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light grey circular stamp.

Alan Morgan
Chief Executive Officer
National Rural Health Association