Statement for the Record

of the

National Association of Rural Health Clinics
1009 Duke Street
Alexandria, VA 22314

to the

United States Senate
Committee on Finance
Subcommittee on Health Care

Improving Health Care Access in Rural Communities: Obstacles and Opportunities
May 17, 2023

On behalf of the over 5,300 Rural Health Clinics (RHC) across the nation, we sincerely appreciate the opportunity to provide a statement for the record.

The RHC program, first created in 1977, provides outpatient care for over 60% of rural America and 11% of the entire country (approximately 37 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America. However, recent trends in healthcare such as the increased adoption of telehealth and the continued growth of Medicare Advantage present obstacles to the continued success of our nation's Rural Health Clinics.

While healthcare-wide trends such as increasingly complex prior authorization burdens and healthcare workforce shortages have major impacts on Rural Health Clinics, we would like to focus this statement on the following RHC-specific issues:

1-Medicare Advantage;
2-Telehealth Policy;
3-Outdated Conditions for Certification; and
4-Value-Based Care for RHCs.

Medicare Advantage

The RHC program incentivizes providers to practice in rural areas through two major benefits: enhanced Medicaid reimbursement, and enhanced Medicare reimbursement. Operating as a rural health clinic provides no benefit relative to Medicare Advantage (MA) reimbursement.

This fact stands in contrast to Federally Qualified Health Centers (FQHCs), who receive supplemental payments from Medicare which make up the difference between what traditional Medicare would pay and what the Medicare Advantage plans are offering. This policy ensures that FQHCs are not disadvantaged if their patients are increasingly enrolled in Medicare Advantage plans.

As Medicare Advantage enrollment now exceeds traditional Medicare enrollment, RHCs are facing increasing financial strain from MA plans who are spreading rapidly in certain rural markets and refuse to pay RHCs the All-Inclusive Rate (AIR) that traditional Medicare does. We conducted a survey of RHCs and found that approximately half of our RHCs reported that Medicare Advantage plans do not pay the same as traditional Medicare.

RHCs must negotiate contracts with each and every Medicare Advantage plan and are reimbursed according to the terms of that contract. Some RHCs are able to negotiate reimbursement comparable to traditional Medicare but many RHCs have little leverage to walk away from the negotiating table in areas where Medicare Advantage plans have significantly increased enrollment. Our fear is that Medicare Advantage plans will enroll a substantial portion of the local Medicare population and refuse to offer RHCs reimbursement rates that are tenable in rural settings.

NARHC advocates for the creation of a reimbursement floor policy. Such a policy would allow RHCs and Medicare Advantage plans to continue to negotiate contracts with each other while also ensuring that MA plans must offer a reasonable reimbursement level that does not jeopardize access to care. As the FQHC wrap policy provides FQHCs benefits relative to Medicare Advantage, an RHC floor payment policy would ensure that the shift from traditional Medicare to Medicare Advantage does not harm access to care in rural America.

Telehealth Policy

Telehealth represents a massive opportunity to improve access to care in rural areas. However, the current telehealth policy threatens rural health clinics, giving fee-for-service providers stronger incentives to invest in telehealth than safety-net providers. The longer this remains the case, the more likely it is that RHCs and FQHCs will fall behind in the adoption of telehealth relative to their traditional peers.

RHCs and FQHCs were not included in HHS's emergency expansion of telehealth policy. For a few weeks at the beginning of COVID, fee-for-service providers were able to offer telehealth services to their patients, while RHC and FQHC patients were forced to come in-person to receive a Medicare-covered healthcare service. The CARES Act rectified this issue and allowed RHCs and FQHCs to serve as distant site providers but that legislation did not allow RHCs and FQHCs to bill for telehealth normally. Instead, the CARES Act created a "special payment rule" that paid RHCs outside their normal All-Inclusive Rate methodology at a level that is significantly less than what RHCs receive for in-person services. This stands in stark contrast to traditional physician offices which receive payment parity between in-person and telehealth services.

We are concerned with this "special payment rule" methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to "carve-out" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, billed whenever an RHC provides one of the 200+ telehealth services reimbursable by Medicare, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth properly, which hinders their ability to properly participate in ACOs and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that telehealth should work this way for all services, not just mental health services.

Should Congress agree to reimbursing RHCs and FQHCs through their normal payment mechanisms, NARHC believes that some guardrails may need to be created to ensure that only safety-net providers serving safety-net patients may receive the enhanced reimbursement rates. We do not want to create a loophole that allows patients and clinicians in well-served suburban

or urban areas to route their telehealth billing through the RHC and take advantage of the RHC reimbursement methodology.

We are pleased that the CONNECT for Health Act would eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs and we urge Congress to rectify this issue, at the latest, as part of any telehealth extension legislation.

Outdated Conditions for Certification

The Rural Health Clinic program was created in 1977, and the regulations governing the conditions for certification were finalized in 1978. As you might imagine, the 45-year-old ruleset is in severe need of modernization. For this reason, we strongly support the Rural Health Clinic Burden Reduction Act (S. 198), which is a compilation of uncontroversial and cost-neutral policies that simply modernize the RHC conditions for certification.

When RHCs were created, the program broke ground by being the first place where Nurse Practitioners could bill Medicare directly for their services. However, as this was new territory for Nurse Practitioners, Congress included a series of physician oversight responsibilities as a condition for RHC certification.

Flash forward to 2023, and 27 states have granted Nurse Practitioners full practice authority. But state scope of practice does not matter if the NPs work in a Rural Health Clinic because the RHC conditions for certification still require physicians to see patients in the clinic and review medical charts among other oversight responsibilities. The end result is that these NP-led RHCs are forced to comply with outdated federal RHC scope of practice rules even though they would have full practice authority in other facility types in their state.

The current statute governing conditions for certification as an RHC simply does not allowing clinicians to practice to the top of their license. The RHC Burden Reduction Act would rectify this by aligning RHC scope of practice laws with state scope of practice laws.

Other outdated conditions for certification require RHCs to maintain lab equipment that is rarely used and discourage the integration of behavioral health in the RHC setting. These rules only add unnecessary burden and cost for RHCs. Congress has an opportunity to improve rural health in a cost-neutral manner by passing the RHC Burden Reduction Act to modernize the Rural Health Clinic conditions for certification.

Value-Based Care for Rural Health Clinics

NARHC supports the establishment of a quality payment program designed specifically for Rural Health Clinics. As discussed above, the RHC program offers a unique reimbursement structure for both Medicare and Medicaid patients and this payment model is the key distinguishing feature of the entire program. The enhanced payment methodology allows for clinics and clinicians to operate in rural and underserved areas, significantly bolstering access to outpatient care in these communities.

The unique mechanisms of RHC reimbursement have made it difficult and/or impossible for RHCs to properly participate in Medicare quality programs. The current slate of quality initiatives available to providers are designed for traditional fee-for-service (FFS) settings and do not translate well into the RHC space. As an example, RHCs use a different form to submit claims to Medicare than their peers, the UB-04, as opposed to the CMS-1500 that fee-for-service providers use. As a result of this fundamental fact, RHC Medicare reimbursement is not compatible with many of the Medicare quality and value-based programs.

We believe that clinicians that bill exclusively through the RHC payment methodology should have an opportunity to participate in some type of quality payment program. As HHS sets ambitious goals to have every Medicare beneficiary in a value-based care relationship by 2030, it is imperative for us to consider how the safety-net programs, specifically RHCs and FQHCs, will be able to participate in this broader vision.

RHC participation in quality programs could be greatly increased and improved if a quality payment program specifically for RHCs was created. Because the RHC payment structure is essential to the RHC program but also quite different than FFS payment, NARHC asserts that the best way to bring value into the RHC model is to design a program solely for RHCs using the All-Inclusive Rate methodology as the foundation. We believe that such a quality reporting program could be implemented in a cost neutral way that would improve efficiency and encourage improved value-based care across the entire RHC program.

Conclusion

The National Association of Rural Health Clinics thanks the Senate Finance Subcommittee on Health for organizing this hearing. We hope that the above statement helps illuminate some of the policy obstacles and opportunities facing the 5,300 Rural Health Clinics across the country. Should the Committee have any questions, the NARHC is happy to serve as a resource, you may reach us by phone at (202) 543-0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.