October 5, 2023

The Honorable Jason Smith
Chairman
Committee on Ways and Means
United States House of Representatives

RE: Improving Access to Health Care in Rural and Underserved Areas

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 5,300 federally certified Rural Health Clinics (RHC), we are pleased to provide the following proposal in response to the Ways and Means Committee's Request for Information on *Addressing Chronic Disparities in Access to Health Care in Rural and Underserved Communities*.

First, we thank the Chairman for his leadership, and the entire Committee for their attention to these critical issues. Since 1977, RHCs have served an indispensable role in the country's health care safety net, increasing access to outpatient services in rural, medically underserved areas. NARHC conducted a survey that found that in 2022, RHCs served over 37 million patients, representing over 11% of the entire population and approximately 62% of the 60.8 million individuals living in rural America.

As the RHC program is the primary facility type offering outpatient care to rural Americans, we believe that RHCs are uniquely situated in their continued ability to be part of solutions to the disparities facing rural communities. While inpatient and rural hospital issues are certainly important, we urge the committee to consider rural outpatient issues equally. Historically, hospital issues have tended to dominate the rural health narrative, but we believe that clinic and outpatient initiatives and issues are just as important for the long-term health of rural America. Our response below is focused on the following RHC-specific challenges as well as proposed solutions for each:

1. Outdated Conditions for Certification;
2. Medicare Advantage;
3. Telehealth Policy;
4. 340B Policy;
5. Price Transparency Policy;
6. Value-Based Care / Quality Reporting for RHCs;
7. Cost Sharing for Care Management Services.

Outdated Conditions for Certification

The Rural Health Clinic program was signed into law by President Jimmy Carter in 1977. Many of the rules and regulations still governing the conditions for certification were finalized in 1978. As you might imagine, our 45-year-old ruleset is in severe need of modernization. For this reason, we strongly support the *Rural Health Clinic Burden Reduction Act* (H.R.3730), which is a compilation of noncontroversial

and cost-neutral policies that simply modernize the RHC conditions for certification. The five provisions and their importance to RHCs across the country are outlined below:

Section 2 Modernizing Physician, Physician Assistant, and Nurse Practitioner Utilization Requirements

In 1977, the RHC program broke ground by being the first facility where Nurse Practitioners and Physician Assistants could bill Medicare directly for their services. However, given this new precedent, states did not have practice acts governing advanced practice practitioners. Therefore, Congress included in the RHC statute a series of physician oversight responsibilities as a condition for RHC certification.

Since then, all 50 states have developed practice acts governing PA and NP scope of practice, rendering additional federal standards that only apply to RHCs unnecessary. For example, 27 states have granted Nurse Practitioners full practice authority, but if those NPs are working in an RHC, they would still need to hire a medical director who performs physician supervision just to meet the federal RHC rules. This may be in contradiction to those standards established by each state, only costs the RHC and Medicare money, and prevents PAs and NPs in many states from practicing to the top of their license.

The *RHC Burden Reduction Act* would rectify this by aligning the federal RHC scope of practice laws with state scope of practice laws.

Section 3 Removing Outdated Laboratory Requirements

Currently, RHCs must "directly provide" certain lab tests as prescribed by the Secretary. CMS has interpreted "directly provide" to mean maintaining the equipment and supplies *within the square footage* of the RHC. This requirement is redundant and wasteful because many RHCs are located in close proximity to their parent hospital and when an RHC orders lab work, their patients are sent to the hospital for a full-service lab with equipment, supplies, and staff readily available to perform a full lab panel. The current requirement is particularly illogical for the Hematocrit and Hemoglobin tests. While RHCs are required to have the equipment for these tests on site, these blood tests are not performed separately anymore. Instead, a comprehensive blood panel would be completed. In this very common situation, the laboratory equipment/supplies in the RHC may be entirely unused, resulting in wasted costs and square footage.

The *RHC Burden Reduction Act* would ensure that patients still have "prompt access" to these lab services, as RHCs are also required to ensure prompt access to other diagnostic services but would increase operational flexibility and reduce redundancy for clinics like those described above.

Section 4 Allowing Rural Health Clinics the Flexibility to Contract with Physician Assistants and Nurse Practitioners

RHCs must formally employ (as referenced by a W-2) at least one of their Pas or NPs. All other providers and staff may be contracted. Given the recruitment and retention challenges especially prevalent in rural areas, we strive to increase flexibilities to allow RHCs to employ **or** contract all of their providers, depending on what is most feasible and appropriate for their practice.

The *RHC Burden Reduction Act* would allow RHCs to satisfy the PA/NP/CNM utilization requirements through a contractual agreement if they choose to do so. This provision would not change the requirement that a NP/PA be on site 50% of the time the clinic is in operation.

Section 5 Fixes Outdated Language Related to RHC Location Requirements

The 1950 Census revised the urban definition and began defining "urbanized areas" as areas with a population of 50,000 or more. The RHC statute, as written in 1977, required that RHCs be located in an area that is not an urbanized area, as defined by the Census Bureau. Therefore, since 1977, an RHC's rurality requirement has been that it was located in an area of less than 50,000.

The 2020 Census criteria eliminated the definition of "urbanized area," instead now only defining urban areas as those with a population of 5,000 or more, and rural areas to be those with a population of less than 5,000.

In March 2023, CMS released interim guidance that considers both the 2010 and 2020 Census data to determine RHC location eligibility. While this is acceptable in the short term because it largely preserves status quo policy, it remains interim policy, leaving RHCs without any permanent rurality requirement. Further, the RHC statute uses a term that is no longer defined.

NARHC remains concerned that without a statutory change, the policy could be re-interpreted to mean that RHCs may only be located in rural areas (areas of less than 5,000). If it is interpreted this way, the impact on healthcare access in rural America will be staggering. *The RHC Burden Reduction Act* retains status quo policy by clarifying that RHCs may be located in areas with less than 50,000 people.

Section 6 Removes Limitation on RHC Provided Behavioral Health Services

Currently, RHCs "may not be primarily engaged in the treatment of mental diseases." This has been interpreted to mean that RHCs can only provide up to 49% behavioral health services. While most RHCs currently do not reach this threshold, given Medicare coverage of Marriage and Family Therapists and Mental Health Counselors, as well as permitting RHCs to bill for Intensive Outpatient Program services beginning January 1, 2024, there has been an increased focus on integrated behavioral and medical care. We do not want the 49% limitation to limit an RHC patient's access to this important care. One of the challenges with such an arbitrary threshold is that CMS has been unable to define how RHCs should measure their behavioral health services, leaving a wide array of interpretations from different surveyors on how to apply this policy. For example, it may be counted as type of visits, number of hours, type of providers, etc. This additional red tape may require a provider to put their efforts into coding, versus just

treating the patient needs in front of them. For instance, if a primary care provider diagnoses a patient with anxiety, should that be considered a medical encounter or a behavioral health encounter?

A recent survey of RHCs on this issue demonstrated that to approximately 1/3 of RHC respondents, this statuary barrier limited their provision of behavioral health services. Given this and other anecdotal data, we don't expect that a majority of RHCs will suddenly have the providers and other operations to drastically increase their behavioral health services, however we see this as an important component of access to care discussions. RHCs will still face immense challenges hiring new behavioral health providers, ensuring adequate space within their clinics for these services, etc., however they will not need to worry about arbitrary and poorly defined behavioral health/medical health ratios that may prevent them from offering much needed behavioral health services.

We strongly encourage the Committee to implement these commonsense provisions to increase operational flexibility and reduce outdated red tape in the RHC setting as they seek to increase access to care for rural communities. While we would appreciate a CBO score on this bill to corroborate our statement that it is cost-neutral, we recognize that a bill of our magnitude is unlikely to be officially scored. Nevertheless, we believe that these provisions, if anything, would save Medicare money, particularly through sections 2 and 3. For example, a Nurse Practitioner in a full scope of practice state may be interested in owning and operating their own RHC, however given the current federal standard, they must employ/contract with a MD/DO to fill the medical director role. Given RHC's cost based reimbursement structure, the salary of this additional provider, who may never even see RHC patients, is included on the RHC's annual cost report, which sets each RHC's Medicare reimbursement rate.

Additionally, the often unused lab equipment carries a cost that RHCs include on their Medicare cost report. The machine used for Hemoglobin and Hematocrit alone (2 of the required labs) is approximately $1,200 per device (replaced on average every 3 years) and has a ~$100 annual maintenance fee. It is difficult to ascertain how immediately this change would impact clinics (many may wait for the device to require replacement then not replace, or may immediately remove the equipment to use the square footage), but if we estimate that half of RHCs (2,650) would implement this change given that they could otherwise offer prompt access, it's an estimated $11 million over 10 years ($1,200 per device replaced 3 times in a ten year period ($3,600), and serviced annually in the non-replacement years (additional $600) for a total of $4,200 saved per RHC. While we recognize that $10 million saved within a program over 10 years is not monumental, we would project that this is a low estimate and doesn't include wasted square footage implications, etc.

We firmly believe that the policies included in the *RHC Burden Reduction Act* (H.R.3730) align with the Committee's priorities to streamline Medicare's outdated patchwork of RHC rules in a financially sustainable and viable way.

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 every quarter from Medicare which make up the difference between what traditional Medicare would pay and what the Medicare Advantage plans pay. This policy ensures that FQHCs are not disadvantaged if their patients choose to enroll in Medicare Advantage plans.

As Medicare Advantage enrollment exceeds traditional Medicare enrollment in many parts of the country, and continues to grow, RHCs are facing increasing financial strain from MA plans who are spreading rapidly in certain rural markets and refusing to pay RHCs the All-Inclusive Rate (AIR) that traditional Medicare does. NARHC 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 (less than or significantly less than).

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, oftentimes those owned by large health systems, but many RHCs have little leverage to walk away from the negotiating table in areas where Medicare Advantage plans have significantly increased enrollment. Our primary concern 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, through one of two options.

1. RHCs would be assured adequate reimbursement via a wraparound payment, similar to FQHC policy regarding Medicare Advantage reimbursement. If the RHC's MA contract paid less per encounter than traditional Medicare, RHCs would receive a quarterly payment from Medicare to essentially make their payments "whole," or
2. As the eligible population elects to enroll in MA versus traditional Medicare, Medicare Advantage could be required to take on the responsibility of supporting rural health by reimbursing RHCs at a minimum, "floor" amount as determined by Congress or the Secretary.

Either policy would allow for continued beneficiary choice between MA or traditional Medicare. Also, it would allow RHCs and Medicare Advantage plans to continue to negotiate contracts with each other while also ensuring that this shift does not jeopardize access to care in rural America. Since the inception of the RHC program, Congress has recognized the need for enhanced Medicare reimbursement to incentive and retain providers in rural communities however this benefit does not translate to MA plan reimbursement of safety-net providers.

NARHC believes that a lack of action on this increasingly concerning gap in policy will impact access to care as low reimbursement rates threaten continued operations.

Telehealth Policy

The COVID-19 pandemic made it very clear that telehealth has significant potential to improve access to care in rural areas. However, the current telehealth policy threatens RHCs, 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' emergency expansion of telehealth policy via waivers in early 2020. As a result, for a few weeks at the beginning of the COVID-19 pandemic, 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. Thanks to Congress, 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 pays 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.

NARHC is concerned with this "special payment rule" methodology for several reasons.

1. 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.
2. The current rules require RHCs and FQHCs to "carveout" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process.
3. 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 Accountable Care Organizations and other quality programs.

Complicating matters further 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 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. Telehealth is an important benefit for increasing access to care, however telehealth is not a replacement for proximity to a provider. Current policy allows for telehealth companies to siphon patient volumes from local RHCs who know and serve their communities.

While the innovative technology of telehealth remains valuable, RHCs can only be expected to compete with the sophisticated levels of telehealth technology available in urban areas, through a solution to the above reimbursement and billing disparities.

We are pleased that the *CONNECT for Health Act (H.R. 4189), The HEALTH Act of 2023 (HR.. 5611),* and other pieces of legislation introduced this Congress would eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs. **We urge Congress to rectify this issue, at the latest, as part of any telehealth extension legislation.**

340B

As Congress directs its attention to the 340B program, we encourage Members to preserve the original intent of the 340B program. For many rural, safety-net providers, 340B is a lifeline that stretches critical federal dollars and allows for doors to stay open, and for patients to continue receiving lifesaving care.

Approximately sixty-five percent of Rural Health Clinics are eligible for participation in the 340B program via their parent hospital through child site arrangements. However, the remaining over 1,800 non-hospital owned, or “independent” RHCs are not eligible. Some independent clinic analysts have projected significant revenues if the independent RHCs sold their practice to a qualifying parent hospital. This potential revenue may encourage further consolidation in health care as independent RHCs face thinner margins and seek opportunities for further revenue through a different ownership structure. Further, NARHC encourages Congress to modify the statute to allow Rural Emergency Hospitals (REH) to be eligible for the 340B program.

NARHC believes that if Congress aims to reform the 340B program, Congress should reconsider program eligibility to direct these program resources where they are most needed, including all Rural Health Clinics, regardless of ownership structure.

Price Transparency Policy

The less frequently discussed provisions of the No Surprises Act are Good Faith Estimate (GFE) requirements, which RHCs, along with all providers, are subject to. GFEs must be issued to all uninsured or self-pay patients upon request, and automatically when they schedule an appointment three or more days in advance.

While NARHC is broadly supportive of efforts to increase price transparency for patients, RHCs, as oftentimes the sole provider within a community, have long since been working with their patients to ensure that the cost of care is not a limitation to receiving care whenever possible. Prior to these requirements passed in the NSA, upon request by the patient, RHCs have generated an estimate of charges for self-pay, uninsured, and uninsured patients.

However, since the implementation of these requirements, we have heard overwhelming feedback from the RHC community that the rules are confusing and burdensome. There are two main concerns:

1. Requiring administrative staff to identify and adjudicate which patients should be offered GFEs adds additional steps and time to the scheduling of each visit. These processes rely on non-clinical administrative staff to make clinical determinations as to what care will be reasonably provided in order to generate a GFE, work far outside the scope of appropriate administrative staff responsibilities. Further, the remarkably fast timelines that GFEs must be received by patients within are not appropriate for 1) the staff time necessary to create one, nor 2) the challenges of reaching patients who may not be able to receive GFEs electronically, i.e., rural patients without broadband access.
2. Good Faith Estimates are required to be given automatically to eligible patients upon the scheduling of a visit (3 or more days in advance). Patients who receive GFEs without requesting them may become confused and avoid seeking care based on the now known costs. This can result in patients avoiding primary and preventive care and instead appearing in emergency departments for more expensive care.

We request Congress engage further with providers and other stakeholders on price transparency policies that achieve these goals without adding so much complexity and cost to the scheduling process, and that it recognizes the unique position of RHCs and the patients they serve. **We suggest first modifying GFE requirements to only require that they be provided upon eligible patient's request.**

Value-Based Care / Quality Reporting for RHCs

NARHC supports the efforts of Congress and CMS to increase health care quality, while reducing cost. Primary care is an essential component of this effort. However, the unique mechanisms of RHC reimbursement have made it difficult and/or impossible for RHCs to participate in Medicare quality programs. The majority of current quality initiatives available to providers are designed for traditional fee-for-service (FFS) settings and do not translate well into the RHC space. Therefore, the adoption of quality initiatives in the RHC setting has been thwarted.

This can be changed for the better and we are committed to discussing alternatives to this paradoxical issue. Clinicians that bill exclusively through the RHC payment methodology should have an opportunity to participate in quality programs. We believe that this would be best achieved through the design of a quality payment program designed specifically for RHCs.

To that end, we believe that for an RHC-specific quality program to be successful, it must be:

1-Simple to participate in; and
2-Designed to work with the current RHC payment mechanisms.

1-Simplicity of Participation

Any RHC quality program should be simple to explain and simple to participate in. Ideally, RHCs would focus their efforts on a small subset of easily reported outcomes-based measures. The focus should be on improving patient outcomes, not mastering (and keeping up to date with) reporting rules and strategies.

Further, these measures should be easily reported through Medicare Part A claims on a UB-04 form. While it may be infeasible to report certain outcomes measures through the UB-04 form, NARHC continues to hear from our community that claims-based reporting is superior to registry-based reporting.

2-Cohesion with the RHC payment model

RHCs are paid by Medicare through a single All-Inclusive Rate (AIR) for every RHC encounter throughout the year. This AIR payment is based on the RHC's costs per visit and is subject to certain upper-payment limits (or caps) depending on whether the RHC is grandfathered or not. In the RHC payment model, Medicare reimbursement for face-to-face encounters does not vary from code to code. As we alluded to above, RHCs bill Medicare on a UB-04 form, not a CMS 1500.

We believe that any successful RHC quality program would incentivize improved patient outcomes by augmenting this core payment mechanism, not replacing it. A simple one to two percent adjustment to an RHC's AIR based on their quality performance would provide significant motivation to the RHC community to participate in the value-based program. Populations served by RHCs experience a myriad of additional factors that present challenges to their access to care and health outcomes. A specific model that accounts for these factors and provides further opportunities to improve upon them would be especially valuable.

We look forward to continuing to engage both Congress and CMS in efforts to design an RHC specific value-based care program. 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.

Cost Sharing for Care Management Services

Outpatient health care services continue to expand to encompass much more than the traditional, in-person office visit. RHCs are part of this innovation, and both providers and patients have benefitted from Chronic Care Management and other general care management services, increasing access to health care services and individualized care coordination. These efforts have shown to improve health outcomes, improve patient satisfaction, reduce unnecessary emergency department visits and inpatient stays, and save Medicare, among other payers, money.

For many rural Medicare patients however, the cost-sharing responsibilities are too significant. Therefore, many RHCs only enroll dual eligible patients or those with a supplemental plan who will cover the cost-sharing portion of the service.

We encourage Congress to pass the *Chronic Care Management Improvement Act of 2023 (*H.R. 2829), eliminating cost-sharing for Chronic Care Management services to ensure that all Medicare beneficiaries have access to these important services.

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. We look forward to working with the Committee this Congress in determining the expanded role that RHCs can play in the provision of medical and behavioral health services in rural communities across the nation.

Please don't hesitate to contact Sarah Hohman at Sarah.Hohman@narhc.org with any questions or to discuss further.

Sincerely,

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