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

Rural Health Care: Supporting Lives and Improving Communities

May 16, 2024

On behalf of the over 5,500 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 38.7 million patients). Overall, the Rural Health Clinic program has been tremendously successful at bolstering access to healthcare across rural America. However, we hope this statement will serve as a resource for the Committee on healthcare trends presenting both challenges and opportunities unique to RHCs.

While much of the conversation around rural health surrounds rural hospitals and other inpatient facilities, we implore the Committee to prioritize legislation that supports the sustainability of the entire healthcare delivery system in rural communities – inpatient **and** outpatient.

This statement is centered around the following RHC-specific issues:

1-Telehealth Policy;
2-Outdated Conditions of Certification for RHCs; and
3-Medicare Advantage;

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. Furthermore, despite receiving reimbursement parity for mental health services delivered via telehealth, data has not shown widespread improper utilization of this benefit, i.e. non-safety net providers taking advantage of the enhanced reimbursement methodology.

We are pleased to see legislation introduced this Congress that would rectify this payment issue, including the CONNECT for Health Act of 2023 (S.2016) and the Telehealth Modernization Act (S.3967). These would both eliminate the special payment rule in favor of normal payment rules for RHCs and FQHCs.

We are pleased to see the recent work of the House committees of jurisdiction on telehealth post-2024. The Energy and Commerce Subcommittee on Health marked up and unanimously advanced a package of telehealth flexibilities based on the Telehealth Modernization Act, through December 31, 2026. Notably, this legislation includes a fix to the current RHC/FQHC telehealth reimbursement disparity.

While the Ways and Means Committee also advanced a two-year extension, they simply extended current, flawed RHC/FQHC policy, i.e. a continuation of the special payment rule and payment disparity.

We look forward to seeing the Senate Finance Committee's continued work on this issue prior to current flexibilities expiring on December 31, 2024, and urge the Committee to rectify the RHC/FQHC telehealth reimbursement disparity in the next extension, demonstrating its ongoing support of our nation's outpatient safety-net providers and the patients they serve.

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 2024, and 27 states have granted Nurse Practitioners full practice authority. But these practitioners are still not allowed to practice to the top of their license if they 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 allowclinicians 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.

Medicare Advantage

The RHC program incentivizes providers to practice in rural areas through two major benefits: enhanced Medicaid reimbursement and enhanced traditional Medicare reimbursement.

Operating as an RHC 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 contract with them for. This policy ensures that FQHCs are not disadvantaged if their patients are increasingly choosing to enroll 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. In a recent NARHC survey, 48% of RHC respondents indicated that MA reimbursed them slightly (18.4%) or significantly (29.5%) less than traditional Medicare.

Additionally, 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. These negotiation challenges also may increase pressures on RHCs to consolidate as oftentimes larger systems have more negotiating power.

These data points are of significant concern to RHCs. Without adequate reimbursement, RHCs will no longer be able to provide essential outpatient services in rural, medically underserved communities across the country.

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.

Additionally, like nearly all providers across the country who contract with Medicare Advantage plans, Rural Health Clinics feel immense administrative burden associated with the stringent prior authorization utilized by MA plans. NARHC is appreciative of the efforts by CMS to lessen these impacts and reduce the waiting time as well as increase transparency on the cause for denials, however particularly for rural patients with transportation challenges, any prior authorization timeline longer than real-time decisions significantly delays and interrupts access to care.

RHCs consistently report the need, but not the financial resources, to hire additional administrative staff to process prior authorizations, as well as track down reasons for denials, including for previously approved care. We encourage the Committee to consider further opportunities to address these access barriers this Congress, as well as to hold plans accountable for negative impacts to the health of the patient resulting from their delays and denials.

Conclusion

The National Association of Rural Health Clinics thanks the Senate Finance for organizing this hearing. We hope that the above statement helps illuminate some of the policy obstacles and opportunities facing the 5,500 Rural Health Clinics across the country. Should the Committee have any questions, the NARHC is happy to serve as a resource. Please contact us by phone at (202) 543-0348, and email us at Sarah.Hohman@narhc.org, or Nathan.Baugh@narhc.org.