



November 27, 2019

The Honorable Richard Neal
Chair
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20510

The Honorable Kevin Brady
Ranking Member
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20510

Dear Chairman Neal and Ranking Member Brady:

The National Association of Rural Health Clinics thanks the Ways and Means Committee for creating the Rural and Underserved Communities Health Task Force to take a deeper look at how to improve health care outcomes within underserved communities. We hope that the following responses are helpful in formulating policy solutions.

We would be remiss if we did not mention from the outset that we hope that Congress will address the issues that Rural Health Clinics (RHCs) have with Medicare reimbursement. The program was designed to reimburse RHC costs but is no longer working as intended. The Rural Health Clinic Modernization Act (H.R. 2788) improves the reimbursement issue modestly and makes other long-needed, commonsense updates to the RHC statute. We believe that the H.R. 2788 aligns with the Task Force's stated public goals.

Sincerely,

William John Gill, PA-C

John Gill, PA-C
President
National Association of Rural Health Clinics

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Rural Health Clinics (RHCs), the oldest federal program aimed at improving access to care in rural underserved areas, are required as a condition of certification as an RHC to be located in rural underserved areas.

In recent years, access to healthcare has often been equated to access to health insurance. However, having the ability to pay for healthcare is irrelevant if the individuals does not have a healthcare provider (hospital or clinicians) from whom they can receive care. We believe access to health care providers is a critically important factor that influences patient outcomes in rural or urban underserved areas.

RHCs are vital to the health of rural patients.

Social Determinants of Health (SDOH) are also important factors affecting the ability of individuals to obtain the care they need, when they need it. the patient's race, ethnicity, gender, and geography can all affect health outcomes. In addition, socioeconomic factors have also consistently correlated with various patient outcomes. There is overwhelming data on "Social Determinants of Health" showing that income, education, zip code, employment status, and other indicators all can impact health outcomes.

Relevant research:

[Measuring Access to Care in National Surveys: Implications for Rural Health](#) (Univ. of Minnesota)

[Risk Factors and Potentially Preventable Deaths in Rural Communities](#) (Univ. of North Carolina)

[Death by ZIP code: Investigating the root causes of health inequity](#) (AMA)

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Since 2018, RHCs have had the ability to receive Medicare payments for non-face-to-face chronic care management (CCM) services provided to Medicare patients with multiple chronic conditions. While too early to have sufficient data to evaluate the success of this initiative, anecdotally, many RHCs report they are providing this service to their eligible patients and the program has worked well.

Despite successes, challenges remain. One challenge for the Medicare CCM program is the fact that coinsurance is not waived. The Task Force should work with CMS to ascertain data on the CCM benefit and determine how it is impacting health outcomes for Medicare beneficiaries.

We have seen very successful telehealth programs in states where Medicaid pays for RHC provided telehealth visits. In Louisiana, for example, Medicaid allowed an RHC to place a nurse in various schools in their region and perform telehealth services during the school day. This program allows Medicaid covered children check-ups and care without the parents having to take time off from work to get their children to the clinic. This also saves Medicaid money because the RHC can identify/treat problems that might otherwise have gone unnoticed and resulted in an ER visit or hospitalization.

Here is a quick 4 minute video on the program in Bienville Louisiana:

<https://www.youtube.com/watch?v=on4r1XSgqeY>

Unfortunately, RHCs and FQHCs are not currently allowed to be the distant site provider for a Medicare telehealth visit. However, both the Connect for Health Act and the RHC Modernization Act would change this.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Adequacy of patient volume is a challenge in rural areas. Many rural communities cannot support a clinician who is compensated under a payment methodology (fee-for-service) that relies upon volume in order to succeed.

Many of the costs associated with a primary care medical practice are fixed costs. With sufficient volume, costs can be spread across a larger number of patient visits lowering the “per service” cost to a level that is financially manageable under a fee-for-service system. In smaller communities, those opportunities for economies of scale are non-existent.

If we have any hope of attracting and retaining healthcare providers in low-volume areas, then it is critically important that the payment methodology used in these areas is based on costs, not volume. This is why RHCs are paid on a cost-per-visit basis.

For physician/PA/NP owned RHCs as well as large hospital (>50 beds), there is a cap on their per visit rate (\$84.70 per visit in 2019). The vast majority of RHCs subject to the cap report costs per visit well above the per-visit cap.¹

The low cap has contributed to the closure of nearly 400 RHCs since 2012 and the conversion of more than 300 “capped” RHCs to “uncapped” RHC status over that same time period.²

¹ [Rural Health Clinic Costs and Medicare Reimbursement](#)

² [Economic and Spatial Analysis of Rural Health Clinic Closures](#)

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?

b. there is broader investment in primary care or public health?

c. the cause is related to a lack of flexibility in health care delivery or payment?

For the past few years, payment policies have been adopted by Medicare, Medicaid and commercial payers that seek to reduce unnecessary ER visits and avoidable hospitalizations. These policies are often characterized as efforts to better manage patient care.

Much of the existing hospital infrastructure was financed based on the fact that the majority of hospital revenue would be generated by in-patient hospitalizations and ER visits. As average daily census and ER visits dropped in response to better management of patients, hospitals have sought to replace those revenue streams with dollars now available for community-based care. This often manifests itself in hospitals purchasing physician practices or the establishment of community-based sites of care.

As noted in the previous question, we have seen a large number of physician/PA/NP owned RHCs (i.e. independent RHCs) being purchased by small hospitals and converted to “hospital-owned”. This has significant financial implications for the Medicare program. According to a new study by the University of Southern Maine Rural Health Research Centers, independent RHCs reported lower overhead costs applicable to RHC services (\$49.62 per visit) compared to the overhead costs reported by hospital-based RHCs (\$86.31).³

We must avoid an either/or approach where rural underserved communities have either hospital-based care with no physician/PA/NP owned care options or physician/PA/NP owned clinics but no inpatient referral options.

Paying providers located in rural underserved areas amounts reasonably associated with their costs to provider care should be the object of any future payment methodology.

³ [Rural Health Clinic Costs and Medicare Reimbursement](#)

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Despite some of the challenges we've already identified, we believe that the rural health clinic program, is one of the most successful models when it comes to addressing workforce shortages in rural and underserved areas.

Today, we have more federally certified RHCs (4,500) than at any time in the programs history. RHCs employ thousands of physicians, PAs, NPs and other health professionals who would not be able to remain in these communities were it not for the RHC program.

The National Health Service Corps (NHSC) program has helped RHCs recruit providers into rural, underserved areas and has been extremely valuable in combating workforce shortages. However, the rural health clinic model itself, is what allows clinicians to remain in rural, underserved areas after they complete their service obligation.

The NHSC Scholarship/Loan Repayment program in conjunction with the RHC program, have been successful because they have historically offered real and significant financial incentives for clinicians to practice in underserved areas. We believe enactment of the RHC Modernization Act will further strengthen the ability of physicians, PAs and NPs to remain in rural underserved areas.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Some states cover oral care provided in RHCs in their Medicaid programs. This is a “state option” benefit for RHCs.

Within the past year, more RHCs are making Substance Use Disorder services available in response to federal initiatives. HHS has assisted with making more Medication Assisted Treatment (MAT) Education available and the National Association of Rural Health Clinics has organized several education programs around these initiatives.

Unfortunately, there are statutory limits on the ability of RHCs to do more with regard to behavioral health. The Rural Health Clinic statute has a provision which states that the RHC may not be a “a facility which is primarily for the care and treatment of mental diseases.” In effect, RHCs cannot have more than 49% of the care they provide classified as behavioral health. This language causes RHCs to place limits on the amount of behavioral health they provide (including Substance Use Disorder treatment) despite the fact that there is increasing demand for these services in their community.

Expansion of telehealth by state Medicaid programs has also helped. In many instances, RHCs can either be the “originating” site where the patient is linked to a distant provider or the RHC is the delivery site and they are linked to a patient remote from the RHC.

Removing the statutory limit on behavioral health and allowing RHCs to be the “distant” site telehealth provider under Medicare could greatly expand the availability of behavioral health in rural underserved areas.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

We disagree with the premise of this question.

The problem is not the availability or integrity of data. There is ample reliable data available from a variety of sources (CDC, Social Security Administration, Medicaid enrollment data, Census Bureau, etc.). The issue is that CMS insists that data must be imported to or available on the claim form in order to have the data used for potential payment adjustments for Social Determinants of Health.

Data measures based upon the location of the provider (i.e. high need areas) or data collected and reported by the provider can be used to make payment adjustments or payment supplements to acknowledge SDOH. For example, the vast majority of RHCs and all FQHCs already collect patient income data in order to determine if a patient qualifies for free or reduced cost healthcare. In addition, when determining whether an area qualifies, for Health Professional Shortage Area or Medically Underserved Area or Medically Underserved Population designations, a range of socio-economic, demographic and health status data is collected and used to make those determinations.

Instead of continuing to suggest that the inability to adjust for Social Determinants of Health is due to “data availability” or “data integrity” we should use the data federal and state governments use for other programs to adjust payments to account for SDOH.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

No response.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

No response

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

No response.