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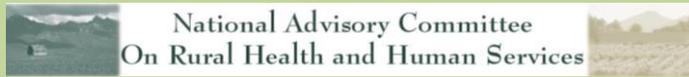
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**INFORMATION**



## NACRHHS Policy Brief on Modernizing the Rural Health Clinic Act Provisions

# Housekeeping

- Q & A to follow – Submit questions using Q&A area
- Slides are available at <https://www.ruralhealthinfo.org/webinars/modernizing-rhc-act-provisions>
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## **The National Advisory Committee on Rural Health and Human Services (NACRHHS)**

Modernizing Rural Health Clinic Provisions  
March 22, 2018

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### **What is the NACRHHS?**

- An independent advisory board to the Department of Health and Human Services (HHS) on issues related to how the Department and its programs serve rural communities

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National Advisory Committee  
On Rural Health and Human Services

## Today's Speakers



**Paul Moore, DPh**

Executive Secretary, National Advisory Committee on Rural Health and Human Services



**Wakina Scott, MPH, PhD**

Policy Coordinator, Federal Office of Rural Health Policy



**John A. Gale, MS**

Senior Healthy Policy and Services Researcher  
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**Mary T. Sheridan, RN, MBA**

Bureau Chief, Bureau of Rural Health & Primary Care  
Idaho Department of Health and Welfare

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National Advisory Committee  
On Rural Health and Human Services

## Why This Topic?

- At the 2017 spring meeting of the Committee, members voted to focus on modernizing Rural Health Clinic (RHCs) provisions
- The statutory authorization for the program is 30 years old
- Members expressed concerns that the current regulatory and statutory foundation of RHCs is not aligned with emerging trends in health care

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National Advisory Committee  
On Rural Health and Human Services

- Modernizing Rural Health Clinic Provisions,  
Policy Brief and Recommendations



- Link: <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-Rural-Health-Clinic-Provisions.pdf>

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National Advisory Committee on Rural Health and Human Services

Policy Brief:

Modernizing the Rural Health Clinic Act Provisions

March 22, 2018

**Wakina Scott, MPH, PhD**  
Policy Coordinator  
Federal Office of Rural Health Policy  
Health Resources and Services Administration



## The Federal Office of Rural Health Policy

- Authorized in Section 711 of the Social Security Act
- Created in 1987 to address the problems for rural hospitals that arose from the implementation of the Prospective Payment System (PPS)
- Serves as the voice for rural within the Department of Health and Human Services
- Administers grant programs, makes policy recommendations, and facilitates research on rural health



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## Rural Health Clinics Act of 1977

Public Law 95-210

### Purpose

- Address inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas
- Increase the utilization of non-physician practitioners such as nurse practitioners and physician assistants in rural areas



Today there are approx. 4,100 RHCs in 44 states



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## Rural Health Clinic Requirements

- Certification and Location
- Overall Structure
- Payment Model



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## Certification

To be certified as a new RHC, a clinic must be located in:

- A non-urbanized area, as defined by the U.S. Census Bureau; and
- An area currently designated as one of the following shortage areas:
  - Primary Care Geographic or Population-Group HPSA
  - Medically Underserved Area
  - Governor-designated, Secretary-certified shortage area under Sec. 6213(c) of the Omnibus Budget Reconciliation Act of 1989.



CMS currently has no process to address existing RHCs that no longer meet the location requirements

RHCs are subject to state survey (inspection) for compliance with Conditions for Certification. Subsequent surveys confirm ongoing compliance.



## RHC Requirements

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### An RHC must:

- Be under the medical direction of a physician, *who is present as needed*
- Employ at least one NP or PA
- Have a NP, PA, or CNM working at least 50 percent of RHC hours
- Directly furnish routine diagnostic and lab services (including six specific lab tests)
- Have arrangements with providers to furnish services not available at the clinic
- Meet applicable state and federal requirements (safety, scope of practice, etc.)
- Stock drugs and biologicals necessary to treat emergencies
- Have a comprehensive policies and procedures manual
- Annually evaluate all clinic operations (or have a Quality Assessment and Performance Improvement-QAPI)



## RHC Facilities

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### RHCs can be either:

- Provider-based (unit of hospital, nursing home, or home health agency) or
- Independent (freestanding facility)

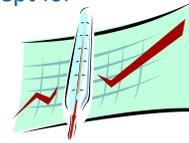
**\*\*A RHC can be a mobile unit, but must meet all Conditions for Certification and have fixed scheduled locations, each of which meet the rural and shortage area requirements**



## Reimbursement

### Medicare:

- Medicare pays an all-inclusive rate (AIR) for primary health and preventive services from RHC practitioner
  - Clinic-specific, reasonable cost-based, per-visit payment limit
  - Coinsurance for Medicare patients is 20% total charges, except for most preventive services that Medicare covers



### Medicaid:

- Since 2001, Medicaid programs reimburse RHCs a clinic-specific payment based on the first two operating years of actual costs, adjusted annually for medical inflation, or an alternate payment method designed by the state and accepted by each RHC
- Some states pay for services in addition to Medicare RHC core services for Medicaid enrollees



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## How RHCs Differ from FQHCs

- Do not receive HRSA Section 330 grant funding
- Have no patient governance requirement
- Have no Federal Tort Claims Act coverage
- Can be for-profit
- Are not required to coordinate dental or mental health services
- Are not required to have a sliding fee scale or accept uninsured
- Have a deductible that Medicare beneficiaries must pay
- Are paid an all-inclusive rate and not the FQHC PPS under Medicare
- Do not have Federal reporting requirements beyond the Medicare cost report



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## Contact Information

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**Facebook:** [facebook.com/HHS.HRSA](https://facebook.com/HHS.HRSA)

- **FORHP Policy Email:** If you have any questions related to policy updates, please contact us at [RuralPolicy@hrsa.gov](mailto:RuralPolicy@hrsa.gov).



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Muskie School of Public Service

Maine Rural Health Research Center

## Acknowledgements

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Project Team: John Gale, Andy Coburn, Zachary Croll

## RHC Program Description

- One of the oldest continuously operating rural health support programs (since December 1977)
- 4,234 RHCs serve rural residents in 44 states (12/2017)
- Independent Ownership – 40% (1,699)
  - 71% For-Profit (1,205)
  - 4% Government-Owned (64)
  - 25% Non-Profit (430)
- Provider-Based Ownership – 60% (2,535)
  - 12% For-Profit (491)
  - 27% Government-Owned (694)
  - 61% Non-Profit (1,550)

## Sound Familiar?

- Rural primary care access issues in 1977:
  - Access barriers for rural Medicare and Medicaid enrollees
  - Inadequate supply of primary care physicians in rural areas
  - Difficulty recruiting and retaining providers in rural areas
  - Medicare/Medicaid fees schedules problematic for low-volume practices
  - Rural populations older, poorer, sicker
  - Primary care workforce production not aligned with demand
- More recent rural challenges:
  - Rural residents have higher rates of un/under insurance
  - Coverage typical involves higher co-pays and deductibles
  - Many insured working poor are functionally “uninsured” until out-of-pocket cost requirements are met

## RHC Safety Net Activity

- 69% located in small towns or isolated areas
- Medicare, Medicaid, uninsured, private pay, charity care accounts for approximately 70% of volume
- Independent RHCs:
  - 86% provide free and discounted care
  - 81% accepting free/discounted care patients
  - 92% reported that free/discounted care levels remained the same or increased in past two years
  - RHCs in areas without an FQHC provide higher rates of services to Medicaid recipients
  - Free care, discounted care, bad debt average 13% of billings
  - Medicare represents 27% of visits

Hartley, Gale, Leighton, & Bratesman 2010; Gale & Coburn 2003

## Serving Vulnerable Populations

- RHCs outnumber rural FQHCs by 3 to 1 but are unevenly distributed (Radford, et al, 2014, May)
  - RHCs comprise 50 % of safety net providers in New England compared to 91% in the West North Central Census Division
  - RHCs see more Medicare beneficiaries
- Top diagnostic groups in RHC Medicaid claims in North Carolina, Georgia, California, and Texas (Domino, et al, 2016, May)
  - Factors influencing health care; respiratory infections; symptoms, signs, and ill-defined conditions

## Serving Vulnerable Populations

- Serving Medicare patients (Radford, et al, 2012, Dec):
  - Majority of Medicare claims are for clinic visits (89%), the rest are for home care, SNF, or LTC visits
  - Most common medical conditions: hypertension, diabetes, respiratory infections, and diseases of the heart
- RHC/CHC presence and hospitalizations for ambulatory care sensitive conditions (Probst, et al, 2009, July 31)
  - Appear to play a role in improving access to primary care
  - Their presence may help to limit the rate of ACS hospitalizations, particularly among older people
- Serving vulnerable populations (Ortiz, et al, 2013, Oct)
  - RHCs served counties with increasing proportions of individuals below poverty as well as Hispanics/Latinos

## Are RHCs Part of the Safety Net?

- **YES** - given their location in rural, underserved areas and their service to uninsured, self-pay, Medicaid, SCHIP, and elderly patients
- Most are not core safety net providers (per IOM definition)
- Limitation – hard evidence on the amount of free/discounted care provided and magnitude of services to vulnerable populations is not available
- Note: RHC Program was designed to address geographic, not financial access

## Participation in Patient Center-Medical Homes

- Little information exists to quantify the extent to which RHCs are pursuing PCMH recognition
- Anecdotal information of activity at the state level
- Some Medicaid and managed care programs required PCMH recognition as a condition of participation
- RHC readiness for PCMH recognition (n=225):
  - Based on performance on “must pass” elements and related factors, RHCs may have difficulty obtaining NCQA recognition
  - RHCs perform best on standards related to demographic information and managing clinical activities
  - RHCs perform less well on improving access to and continuity of services, supporting patient self-mg’t skills, shared decision making, implementing CQI systems, building practice teams

Gale, Croll, Hartley, & Coburn, January 2015

## Participation in Accountable Care Organizations

- 71 Medicare Shared Savings Program ACOS out of 480 total ACOs contained RHCs (Scott, 2017, Oct 31)
- Preliminary work by Hofler and Ortiz, 2016 of the cost of ACO participation in ACOs in the Southeast
- Results of RHCs in an ACO in 2012 (7) and 2013 (14):
  - Mean cost per visit for RHCs not in an ACO rose 4.4% from 2011-2012 compared to 13.5% those in an ACO
  - The range for the difference in mean CPV was \$17.19-\$25.19
  - Influenza vaccination rates not impacted by ACO participation while pneumonia vaccination rates were positively impacted
  - RHCs in ACOs tend to be larger than those that are not and have been in business longer

## Importance of HIT Under Health Reform

- Future of health care is linked to better HIT systems, regardless of what happens with health reform
- Necessary for patient-centered medical homes, ACOs, pay for performance, other transformation initiatives
- Full adoption of HIT leads to:
  - Improve access and serve vulnerable populations
  - Improved interaction with patients and caregivers
  - Transparency and the ability to document quality and performance
  - Improved treatment of chronic diseases
  - Improved operations
  - Improved collaboration among internal and external providers

## Electronic Health Record Implementation (n = 871)

- EHR in use 72%
- In use in more than 90% of practice 63%
- EHR purchased/implementation begun 11%
- RHC does not have an EHR 18%
- Independent RHC have greater EHR implementation rates than provider-based RHCs
- Most commonly EHR Vendors (in order of popularity):
  - Allscripts, Epic, NextGen, EclinicalWorks, McKesson, Computer Programs and Systems, Inc. (CPSI), Healthland, e-MDs, GE/Centricity, Cerner

Gale, Croll, Hartley, September 2015

## EHR Meaningful Use by RHCs

Goal(s)	Objective	Measure Specifications	All RHCs	Independent RHCs	Provider-Based RHCs
Category 1: Improving quality, safety, efficiency, and reducing health disparities	CPOE (n=468)	Completes medication orders and/or prescriptions (for patients with at least one medication in their medication list) using EHR's CPOE functions	95.9%	97.6%	94.1%
	CPOE (n=469)	Uses CPOE function in EHR to order laboratory and/or radiology tests	88.5%	86.4%	90.9%
	Drug-drug and drug-allergy interactions (n=612)***	Implemented EHR functions to conduct drug-drug interactions and drug-allergy checks	84.0%	86.4%	81.1%
	Up to date problem list (n=616)	Maintains up-to-date problem list of current/active diagnoses recorded as structured data	94.0%	95.3%	92.5%
	ePrescribing (n=620)*	Transmits prescriptions electronically using e-prescribing functions in EHR	93.6%	94.7%	92.1%
	Drug formulary checks (n=614)*	Conducts drug formulary checks with access to at least one internal or external drug formulary	61.1%	65.4%	55.9%
	Lab tests (n=621)	Transmits orders for laboratory tests electronically using EHR	66.0%	62.1%	70.8%
	Lab test results (n=611)	Incorporates clinical lab test results (whose results are in a positive/negative or numerical format) ordered by clinic providers into EHR as structured data	81.7%	84.2%	78.6%
	Active medication list (n=621)**	Maintains active medication list for patients seen with at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	95.8%	96.2%	95.4%
	Active medication allergy list (n=622)*	Maintains an active medication allergy list for patients seen with at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	96.5%	97.7%	95.0%
	Demographic information (n=621)	Captures patient demographic information (preferred language, gender, race, ethnicity, date of birth, etc.) as structured data	98.2%	98.2%	98.2%
	Vital signs (n=619)*	Records and charts vital signs (i.e. height, weight, blood pressure, calculate and display body mass index, plot and display growth charts for children 2-20 years, including BMI, etc.) for patients age 2 and older as structured data	97.4%	98.5%	96.1%
	Smoking status (n=621)	Records smoking status for patients age 13 and older as structured data	95.5%	96.2%	94.6%

## EHR Meaningful Use by RHCs

Goal(s)	Objective	Measure Specifications	All RHCs	Independent RHCs	Provider-Based RHCs
	Quality measures (n=619)	Reports ambulatory clinical quality measure to CMS, state, or other quality measurement and reporting system	57.7%	60.6%	54.1%
	Clinical decision support (n=615)**	Implemented at least one clinical decision support rule along with the ability to track compliance with that rule (Drug-drug and drug-allergy interaction alerts cannot be used to meet this meaningful use objective)	61.0%	65.4%	55.7%
	Patient lists/registries (n=612)	Generate condition-specific lists of patients to use for quality improvement, reduction of disparities, and/or outreach (or at least generate one report listing patients with a specific condition)	69.0%	70.3%	67.3%
Category 2: Engaging patients and families in their health care	Patient reminders (n=613)	Send appropriate reminders to patients (age 65 or older and/or age 5 or younger) for preventive and/or follow-up care	46.3%	47.9%	44.4%
	Clinical summaries (n=614)***	Provides clinical summaries for patients for each office visit	81.9%	88.3%	74.3%
Category 3: Improving care coordination	Summary care record (n=609)	Provide summary care record (either electronically or in paper format) for patients transitioned or referred to another setting or provider of care	81.9%	85.0%	78.2%
	Information exchange (n=613)	Exchanges key clinical information (e.g., problem list, medication list, medication allergies, and diagnostic test results) among providers of care and external patient-authorized entities (or has at least performed one test of its ability to do so)	64.0%	68.3%	58.8%

Independent, provider-based, and total differences significant at \*p ≤ .05, \*\*p ≤ .01, and \*\*\*p ≤ .001

## Implementation Plans for RHCs Without EHRs

- Plan to purchase and implement within 6 months 17%
- 7 to 12 months 27%
- More than 12 months 28%
- No plans to implement/Not sure of plans 28%

Gale, Croll, Hartley, September 2015

## Status of RHC EHR Implementation

- RHCs are implementing EHRs at rates consistent with other primary care providers
- Mixed performance compared to meaningful use standards
  - RHCs perform better on patient tracking functions
  - RHCs do less well with providing access to data, sending reminders, QI functions and reporting, QI at transitions, using patient registries, information sharing and exchange
- A substantial number of RHCs will need support in implementing an EHR to achieve meaningful use

Gale, Croll, Hartley, September 2015

## Public Reporting of Quality Data

- Resistance to public reporting by providers
  - 8/15 Kaiser study: 50% of physicians and 38% of NPs/PAs feel use of quality metrics has a negative impact on quality
  - Resistance is at odds with trends in the policy environment
    - RHCs should prepare for public reporting
- RHCs exempt from MIPS but choose to participate
- Kaiser 10/17: 36 state Medicaid programs have required quality data reporting, 22 managed Medicaid programs have P4P plans, and 29 had capitation withholds/penalties based on performance
- Commercial payers are also implementing quality reporting and value-based payment models – Maine Quality Counts and Michigan BCBS

## Public Reporting of Quality Data (cont'd)

- Washington State Health Care Authority
  - Rural Multi-Payer Model (under development in 2018): Focused on value-based payment reform, sustainable solutions for improving access, delivery system transformation, and patient engagement
  - APM4 – alternative value-based payment model for RHCs and FQHCs for Medicaid managed care enrollees - 16 clinics began testing APM4 in July 2017
- RHC quality reporting and improvement initiatives
  - Quality Health Improvement (QHi)
  - Michigan Rural Health Clinic Network
  - Maine Rural Health Research Center Pilot Test of RHC quality measures

## RHC Participation in Quality Measurement

- Challenge: Encouraging RHC participation
  - Few incentives/penalties for RHCs that do not report
  - Efforts to develop RHC quality reporting initiatives have struggled with participation
  - Little data on RHC participation in state reporting programs
- Reported barriers to RHC quality reporting
 

– Difficulty extracting data from their EHR	77%
– Availability of staff time to collect/report measures	55%
– Reporting burden	46%
– Difficulty of manual data extraction	18%
– The measures are not useful to clinicians	9%
– Measures not relevant to clinic quality mg't needs	9%

Gale, Hanson, Hartley, Coburn February 2016

## Need for a National RHC Data Strategy

- Lack of data is a big challenge to the RHC Program
  - Difficult to create a national advocacy and support strategy
  - Hard to garner support for legislative change
- May be left out of health reform/transformation
- Safety net role of RHCs is under appreciated in the absence of evidence documenting their contribution
- Current contact database of RHC owners does not exist
- Need for a consistent advocacy voice
- Encourage greater RHC participation in research

## Is the RHC Program Still Relevant?

- **YES:** Same challenges still plague rural areas
- Changes are need:
  - Distinguish between access and availability
  - Better target program benefits to areas of greatest need
  - Collect data to quantify the extent to which RHCs are improving/access and serving vulnerable populations
  - Review participation of RHCs located in areas no longer designated as shortage areas or non-urbanized areas
    - Protect clinics that are using program benefits to expand access for vulnerable populations
    - De-certify clinics that may not be using program benefits to expand access for vulnerable populations



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## Contact Information

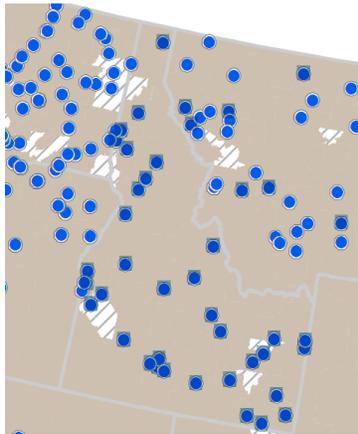
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National Advisory Committee  
 On Rural Health and Human Services

## Idaho Rural Health Clinics



45 RHCs in Idaho

National Advisory Committee  
On Rural Health and Human Services

## Idaho Site Visit



Gooding, Idaho

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## Idaho Site Visit



- Gooding, Idaho

- North Canyon Medical Center/North Canyon Family Physicians
- Associates in Family Practice
- Shoshone Family Medical Center
- Power County Hospital District

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## Takeaways from Gooding

- Both Provider-Based RHCs and Independent RHCs are facing challenges
- Costs and financial burdens were common issues for the RHCs.
- Concerns involved the cost of staffing, cost of electronic medical record (EMR) systems, and the time between up-front costs and receiving payment

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## Takeaways from Gooding

- The use of EMRs is cutting into the ability to spend time with patients
- Rural health care providers care passionately about their communities and want to continue to serve them

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## Recommendations

1. The Secretary should work with Congress to obtain authority to reexamine and pursue a change in the statute to adjust the payment cap for RHCs. In doing so, the Committee urges the creation of a formula for payments that ties payment cap increases to the current average cost per visit for RHCs currently under the cap.

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## Recommendations

2. The Committee recommends the Secretary work with Congress to provide grants to State Offices of Rural Health to support a state program that would provide technical assistance on quality reporting and other services to support the transition of RHCs to value-based care.

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## Recommendations

3. The Committee recommends the Secretary work with Congress to obtain authority to allow RHCs to be distant site providers for telehealth services under Medicare.

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## Recommendations

4. The Committee recommends the Secretary work with Congress to obtain authority to allow all RHC (non-physician) providers to order hospice and home health services and also allow RHC providers to be attending clinicians for hospice services in hospice shortage service areas.

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## Recommendations

5. The Committee recommends the Secretary work with Congress to obtain authority to allow masters trained behavioral health providers (e.g., licensed professional counselors, mental health counselors, or marital and family therapists) to be RHC practitioners for purposes of Medicare reimbursement if they are licensed to provide those services in their state.

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## Recommendations

6. The Committee recommends the Secretary publish a Request for Information to RHC providers on current RHC laboratory needs. Based on this information, the Committee recommends the Secretary use the authority granted in Public Law 95-210 to review and modernize lab requirements to reduce regulatory burden and allow flexibility in requirements to reflect patient population services.

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## Conclusions

- The RHC program is vital to providing care in rural communities
- The Committee is concerned with how RHC providers can adapt to better participate in a value-based delivery system and how RHC policies and regulations can change to better accommodate rural patients and communities

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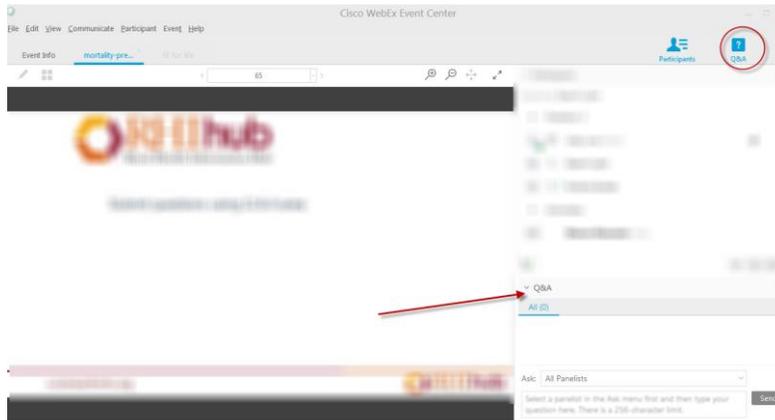
## For More Information...

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# Questions?



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## Thank you!

- Contact us at [ruralhealthinfo.org](http://ruralhealthinfo.org) with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website

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