NACRHHS Policy Brief on Modernizing the Rural Health Clinic Act Provisions – 3/22/18

Naomi Lelm: Good afternoon everyone. I'm Naomi Lelm, senior project coordinator for the Rural Health Information Hub. I'd like to welcome you to today's webinar on the National Advisory Committee on Rural Health and Human Services Policy Brief on Modernizing the Rural Health Clinic Act Provisions.

I'll quickly run through some housekeeping items before we begin. We hope to have time for your questions at the end of the webinar. If you do have questions for our presenters, please submit them at the end of the webinar using the Q&A section that will appear on the lower right hand corner of your screen following the presentation.

We've provided a PDF copy of the presentation on the RHIhub website, accessible through the URL on your screen, or by going to the RHIhub webinar page at www.ruralhealthinfo.org/webinars and clicking into today's presentation. If you do decide to go download the slides during the webinar, please don't close the webinar window, as you'll have to log back into the event.

For technical issues, please call WebEx support at 866-229-3239. At this time, I'll turn it over to Paul Moore to have him tell us about today's topic and speakers.

Paul Moore: Thank you Naomi for that introduction and I'd like to also take this opportunity to welcome our audience to this webinar today by the National Advisory Committee on Rural Health and Human Services. The committee consists of a 21 member citizen's panel, with members drawn from a variety of backgrounds all with expertise in rural health and human services. The charge of the committee is to serve as an independent advisory body to the Department of Health and Human Services on issues related to how the department and its program serve rural communities.

The committee was formed in the late 1980s after a large number of rural hospitals had closed and was expanded a few years later to include human services expertise. Today, we'll hear form our host member along with two speakers who addressed the committee during our meeting there in Idaho. This first speaker we'll hear from today is Wakina Scott, policy coordinator with the Federal Office of Rural Health Policy. Wakina oversees the office's analysis and responses to policy issues, especially the impact of Medicare and Medicaid regulations on rural providers and communities.

Prior to this, Wakina worked at the centers for Medicare and Medicaid services, where she served as a subject matter expert on marketplace finance and Medicaid issues. Wakina received her masters of public health from George Washington University and her PhD in family science from the University of Maryland College Park. Today, Wakina will provide an overview of the rural health clinic provisions and the need for changes to modernize them.

Then we will here from John Gale, a senior health policy and services researcher for the Maine Rural Health Research Center at the University of southern Maine. John's research focuses on rural healthcare delivery systems including rural health clinics and critical access hospitals, delivery of primary care, mental and substance use services, the integration of behavioral health and primary care, telehealth and program planning and evaluation. As you see, it's pretty broad across all things rural. His work with rural health clinics includes financial and quality performance measurement, participation in patient centered medical homes, adoption and

meaningful use of electronic health records, and the delivery of mental health services by rural health clinics.

He serves on the boards of trustees for the National Rural Health Association, and serves as the chair of its policy congress. He's also active as the chair of the New England Rural Health Roundtable's policy committee. He will share with us some of the research he and his team have been conducting regarding rural health clinics.

Finally, our host member, Mary Sheridan, who also directs the Idaho State Office of Rural Health, will share her perspective as a committee member and discuss the committee's observations and recommendations. Mary is the Bureau chief of the Bureau of Rural health and primary care division of public health in the Idaho Department of Health and Welfare, and has been in that role since 2003. I know Mary personally, she's passionate about understanding rural health issues, and seeking resources to help address unmet needs.

Mary is the past president of the National Organization of State Offices of Rural Health, and continues to serve on the board. On a personal note, she's married to her high school sweetheart, the proud mother of three sons, and she loves spending time with her three grandsons.

One of the issues the committee chose to focus on in our most recent meeting in Boise, Idaho, was the current rural health clinic provisions and how they align with the current healthcare delivery system. The committee chose to meet in Idaho due to the second topic of interest they examined, that being rural suicide, because of the elevated rate of suicide in rural areas of the state.

We'll have another webinar to discuss that issue on April 24th, and we want to invite you to join us then. As expected, our host member provided the committee also a good representation of independent and provider based rural health clinics to hear from while we were there in Idaho.

Now, the committee meets twice a year to examine the issues in depth and hear directly from rural health providers of health care and human services. Following those meetings, the committee produces policy briefs for the HHS secretary with recommendations on policy or regulatory matters under the secretary's purview. Those policy briefs are available on the national advisory committee's website. With that in mind, I'll now turn it over to Wakina Scott.

Wakina Scott: Thank you, Paul. Good afternoon everyone. I guess I would like to start off first with just providing you with a bit of a background about our office. The Federal Office of Rural Health Policy was authorized through section 711 of the Social Security Act. Mainly out of the problems which arose, where there were a lot of rural hospitals closing.

Today, our role remains where we kind of have a unique role where we're looking overall at the policy across the Department of Health and Human Services and serving as the voice for rural and also at the same time, providing and administering grant programs to address rural issues and communities. To provide a brief overview of the rural health clinic act and rural health clinics in general, I wanted to start off with explaining first how rural health clinics came about.

The rural health clinics act of 1977 came about in a way to address the inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas, and to increase utilization of non-physician practitioners such as nurse practitioners and physician assistants in rural areas. Today, there are well over 4,000 rural health clinics in over 44 states.

The next two slides, I wanted to take a few minutes to provide an overview of the certification and location requirements for rural health clinics, their overall structure and payment model as a way of kind of setting up why the committee decided to look at some of the provisions for rural health clinics.

Rural health clinics are certified based on location requirements. They have to be in a non-urbanized area as defined by the US census bureau, and also in an area currently designated in a shortage area, such as a primary care geographic, more population, HPSA, a medically underserved area or a governor designated shortage area.

There is this understanding that currently, there could be RHCs that are located in areas that may no longer meet these location requirements, but are considered grandfathered in the program. We wanted to just make that clarification too, because at the time, these rural health clinics are still serving and that function until CMS has a process where they are either deemed as an essential provider for their community, or they take the next steps in becoming de certified.

In general, rural health clinics, when they're becoming a new rural health clinic, has to meet the certification requirement in being in a HPSA or non-urbanized area. They are also subject to state survey inspection for compliance with conditions of certifications.

RHCs must also meet a number of other requirements, for example, they have to be under the medical direction of physician who is present as needed. They have to employ at least one nurse practitioner or physician assistant, and they have to have a nurse practitioner, physician assistant or certified nurse midwife working at least 50% of the rural health clinic hours. They're required to furnish routine diagnostics and lab services including six specific lab tests.

They also have to have arrangements with providers to furnish services that may not be available at the clinic. They also have to meet requirements to stock certain drugs and biologicals as necessary to treat the emergencies and maintain a comprehensive policy and procedure manual, including having an annual evaluation of all of their clinic operations, or have a quality assessment and performance improvement program.

Also for background information, rural health clinics can either be provider based, that is owned by a hospital or a nursing home, or home health agency, or they can be independent, which is a free standing facility. There are also cases where rural health clinic may be a mobile unit, but in that case, they also have to meet the conditions of certification and really have a fixed scheduled location, where their mobile unit will be at, and that location does have to meet the certification requirements for location as well, too.

In terms of how rural health clinics are currently paid, for Medicare, they received an all-inclusive rate for primary and preventive services. This rate is based on their reasonable cost based per visit. The way that payment is set up is that the rural health clinic is an independent rural health clinic, or if they are an affiliated with a hospital or provider based rural health clinic that is, with more than 50 beds, then they will be subject to what's called a payment cap for their all-inclusive rate. That payment cap is currently set at about $83.45 for 2018 per visit.

Rural Health clinics that are provider based and affiliated with hospitals that have fewer than 50 beds are not subject to this payment cap, and tend to submit claims and for their actual costs, for their care. On Medicaid, since 2001, Medicaid programs reimburse rural health clinics as well for clinic specific payments based on a special payment rate as well, too. In some states they will tend to pay or provide, or allow for more services in addition to what Medicare will allow rural health clinics to provide.

I also wanted to provide clarification about the difference, how RHCs differ from federally qualified health centers. They're often seen as one and the same. While they both provide necessary primary care, there are some key differences that we will like for participants to understand.

First and most notable is that rural health clinics are not HRSA grantees. They do not receive HRSA section 330 grants funding, similar to health centers. They also do not have a patient governance requirement, and are not covered under the Federal Tort Claims Act. They can be for profit facilities, and they are not required to provide some other types of services, which are required in the health center programs such as dental or mental health services.

While there are rural health clinics out there that do provide mental health services, again, it is not something that they are required to provide. They are also not required to have a sliding fee scale or accept uninsured, but most of them do. They also have a deductible that the Medicare beneficiaries must pay, and as I mentioned previously, they are paid at what's called an all-inclusive rate, whereas health centers, or federally qualified health centers are paid at a perspective payment system rate under Medicare, which is a different rate, and a different payment for FQHC.

Currently, that payment for FQHCs is about $161 compared to the cap that I mentioned for rural health clinics, which is about $83. Another key important difference is that rural health clinics do not have federal reporting requirements beyond the Medicare cost report, whereas federal qualified health centers will have to report data to HRSA as part of program requirements. Now I'd like to turn it over to John to provide some additional information and research regarding rural health clinics.

John Gale: Thank you Wakina. What I'm going to talk to you a little bit about, not only the research that we have done on rural health clinics, as well as some of my other colleagues in the rural health research centers, just brief acknowledgement, all of our work with RHCs has been funded by the federal office and our project team includes myself, Andy Coburn, and Zach Kroll.

The rural health clinic program is really, it's an interesting thing to study because it's really one of the oldest, continuously operating rural health support programs, as Wakina mentioned, it goes back to 1977. There are, as of December of 2017, there were 4,234 RHCs serving with the rural residents of 40 states. There's been an interesting change and shift, 40% are independent, and roughly 60% are provider based, and that's a big shift. For many, many years, the independents were the primary, were the largest grouping, and then over the last four or five years, those numbers sort of came closer together. It was 48- 52% roughly, but now we're seeing a substantial growth in the number of provider based clinics.

I think that has a lot to do with the trend towards physician ownership of practices, the desire of physicians not to be small businessmen and run their own practices, but rather be employed as, by part of a system. I think that's an interesting shift. On the independent side, as most of them are for-profit facilities and really resemble small physician practices. A small number are government owned, roughly 4% and a quarter of them are not for profit.

On the provider based side, it's not surprising, they're owned by hospitals. They're either heavily non-profit or government owned with a small number owned by for profit facilities. Thinking a little bit about the clinic program, and going back to why it was important in 1977 and why we continue to need the program now, I wanted to look at some of the issues. We had access barriers for rural Medicare and Medicaid enrollees. We had an inadequate supply of primary care physicians in rural areas. We had difficulty recruiting and retaining providers in those rural areas. Medicare, Medicaid fee schedules were problematic for these low volume practices.

Our rural populations were older, poorer and sicker. The primary care workforce production wasn't aligned with demand, and the distribution. They're heavily oriented and placed in urban communities. That doesn't sound very, too different from the situation we find ourselves in now, where we have some more recent challenges, however, with rural residents experiencing greater rates of uninsurement or under insurance, and with some of the changes in the marketplace and Medicaid coverage and Medicaid expansion issues, that problem isn't going to resolve itself in the immediate future.

Many of our rural residents have very high copays and deductibles, and a lot of the working poor who are insured are really functionally uninsured, until they meet their out of pocket cost requirements. I think this is important to understand, if they have five, seven, eight, $10,000 or more, out of pocket costs, then they're working a minimum wage level job, excuse me, they're not able to pay that copay. They may have health insurance, but they're still at risk for not getting care because they tend to put off care to avoid the out of pocket costs.

I am having a little problem here. Sorry here we go. Let's look a little bit at rural health clinic safety net activities from some of our past studies. We know that 69% are located in small town and isolated areas. They have a high volume of Medicare, Medicaid, uninsured private paying charity care patients. That accounts for roughly 70% of their volume. What's left at 30% is the commercial paying. Among independent clinics and this was a study that we had done on, specifically independent clinics, 86% provide free or discounted care and 81% were continuing to accept those patients.

Well over 90% were providing, reported that the amount of free care that they provided remained the same or had increased over the past two years prior to our study. What was really interesting, and Wakina mentioned the safety net functions of federally qualified health centers is that in areas where there were no federally qualified health centers, that the rural health centers really picked up the slack. They provided higher rates of services to Medicaid recipients.

Part of what we were looking at, Medicare was roughly 27% of volume, and free, discounted care, bad debt, averaged 13% of billings, which is pretty substantial for a small volume clinic. We know that rural health clinics outnumber rural federally qualified health centers by three to one, but they're distributed unevenly. This comes from work by our colleagues at the University of North Carolina in the health research center there.

If we look across, how they're distributed across the country, rural health clinics represent 50% of the safety net providers in rural New England, compared to 91% in the west north central census division. I think understanding that they're really filling that need, and some of that is really dependent on how the trend in FQHC implementation has taken place across the country.

RHC has seen many more Medicare beneficiaries than FQHC, part of that is the payment system, with rural health clinics really being established as a geographic solution to access issues versus federally qualified health centers, which were established to target the low income people. Among the diagnostic review groups that were most common in clinics in a study that they had done, North Carolina had done in North Carolina, Georgia, California and Texas, so they were mostly factors influencing healthcare, injuries and the like. Health care behaviors, respiratory infections, symptoms and signs of ill-defined conditions.

If we look at this, we go on with their work. The majority of Medicare claims for rural healthcare visits were for office care. The rest involved a mix of home cares, skilled nursing facility and long term care services. The most common problems that they saw among the Medicare population was hypertension, diabetes, respiratory infections and diseases of the heart.

Another, some work done by our colleagues at the University of South Carolina Rural Health Research Center shows that they'd done a study looking at the location of rural health clinics and community health centers and its impact on ambulatory care conditions. What they found is that RHCs really appeared to play an important role in improving access to primary care, and it may help to contribute to limit the number of ambulatory care sensitive hospitalizations, which are hospitalizations that could be avoided if patients were to receive routine care for some of those standard conditions. The University of Central Florida, Judy Ortiz and her colleagues found that rural health clinics served counties with increasing proportion of individuals below poverty as well as large Hispanic, Latino populations.

Are they part of the safety net? I think the answer is yes. They're not a core safety net, for the definition of the Institute of Medicine, which really focuses on having that established mission in core funding to provide services to vulnerable populations, but they clearly do. They're located in rural areas. They're located, are underserved, and their services, they provide the significant base of services to uninsured people, people who are self-pay, who are Medicaid, S-CHIP and the elderly.

One of our limitations is, it's really hard to get a handle on exactly how much free and discounted care they're providing, and that's something that we'll talk about in a bit. Again, as I mentioned, the rural health clinic program was designed to address geographic, not financial access issues.

Part of what we want to look at is the extent to which rural health clinics are participating in practice transformation activities, quality care, quality reporting and others. We've done some work in this area. It's a bit difficult to get at information that quantifies the extent to which RHCs are pursuing PCMH recognition because they're often not tracked in that way. Some of the information we have is anecdotal information at the state level.

What we are seeing is a trend among Medicaid, particularly among Medicaid managed care pay programs and commercial managed care programs that are requiring either quality reporting or PCMH recognition as a condition of patients, participation, excuse me. What we're seeing, and what we did from our study, looking at rural health clinics, we had a small sample that we interviewed and surveyed so that there are essentially must pass elements that are practice needs, to pass to obtain PCMH recognition. What we found is a lot rural health clinics in our study group would have difficulty meeting a number of those must pass elements.

They did best and did well on standards relating to collecting demographic information and managing clinical activities, but less well on improving access to care and continuity of services, and by improving access, we really need after hours care or weekend care beyond the normal work day. Supporting patients own management skills, their decision making, implementing continuous quality improvement systems and building practice teams. I think it's important to understand that while they can move in this direction, there's work that's needed to be done and support needed for them.

The other large area of practice transformation activity is the Accountable Care Organization. Which is essentially, if I can simplify this, a managed care style model where a provider takes risk and responsibility for caring for a defined population and based on some of the work that we've seen, roughly 71 Medicare shared saving program ACOs out of 480 total are registered and have RHCs as participants. There's been work done by our colleagues at the University of Central Florida on the cost of ACO participation. They had a very small sample, but at least they were able to get at this level.

The cost per visit for RHCs, not in an ACO grew less rapidly than those in an ACO, and I think part of that, that difference was roughly $17 to $25. Part of it I think is really that there's an investment in infrastructure, staffing and technology necessary to participate effectively in ACO and that may account for some of those costs.

This is part of what we were talking about is it's really necessary to, for health reform and to move to quality reporting, to participate in ... to have a full adoption of health information technology and electronic health records to be able to pull information, to be able to manage patients.

From our work, the good news is that RHCs are roughly comparable to the rest of the primary care world. At the time of our study back in 2014-15, 72% of the RHCs we surveyed had an EHR in use. 63 of those folks had them fully implemented, and more than 90% of the practice. 11%, bringing that total number up to 83 had purchased it, but not yet begun implementation, and there were roughly 18% that did not have any EHR.

I think the concern is that among those without any EHR, they may be practicing staff by older providers that are approaching retirement age and are just not willing to invest. That could be a problem when they try to sell, it will have less value. I won't spend a whole lot of time on this, and it may be harder for you to read, but these are looking at meaningful use standards for electronic health records.

It breaks down for each of the phase one, meaningful use categories, but what we saw was that, as we mentioned before, being able to complete medication orders electronically, using a CPOE, using the EHR functions to conduct drug, drug interactions, and really basic activities of managing improving quality and efficiency of care, is where the clinics did well.

They did less well on developing patient registries, using clinical decision support systems, reporting quality measures, we'll talk about that in a moment, and using their system to send appropriate reminders and clinical summaries. Again, I think clinics are doing well. There's work that's needed on implementation and I think the point that I've always seen is that they do need technical assistance and support to move forward, and these are an important group of primary care providers.

Of those without any EHR, we saw that probably 44% or so were planning to purchase within the next year, roughly 28% were a year out, and 28% were not sure what they were going to do. Excuse me, all in all, they're doing well. They're consistent with other primary care providers, but as mentioned, I think they do need support to help move them forward in using the EHRs to transform the quality of their care.

I just have a few more sides, and I'll move quickly. Quality reporting, a very big issue. There isn't anyone on the call that I suspect hasn't heard more and more about public reporting of quality data. We know that providers as a group are not all that crazy about the idea. 2015 Kaiser study found that 50% of physicians and 30% of nurse practitioners and PAs thought using quality metrics had a negative impact on quality. While there may be some resistance, it's not going away.

What we're looking at and what the emphasis is, is that as of 2017, 36 Medicaid, state Medicaid programs had required quality data reporting. 22% of managed Medicaid programs had paid for performance, and 29 had capitation with holes and penalties. We're seeing some of the same things happening in commercial payers. While rural health clinics are exempt from MIPPs, the Medicare Incentive Payment Program for quality reporting, they are not likely to be able to avoid Medicaid and commercial payers.

There are a couple of other models out there, I think, that are worth looking at. The state of Washington has a program, they're calling it the advanced payment model four. They're developing alternative value based payment for RHCs. They currently have 16 RHCs and a few EHCs in testing in July of 2017. We'll be watching that.

Quality reporting initiatives, quality health improvements in Kansas, Michigan Rural Health Network, and we had done a study pilot testing quality measures. Of the group, the challenges encouraging participation. Few clinics, there are few incentives or penalties, basically under Medicare for clinics that choose not to report. The effort to develop quality reporting initiatives really struggle with participation. Some of the barriers we are seeing are difficulty extracting that data from the EHR, Staff time and burden, reporting and administrative burdens. Those without help from HR have difficulty extracting records, and a lot of it is, I think some of it is the challenge of electronic health records. While they may have, we have certified records, some of the cost of providing the extra modules or changing the programming to extract the data can be a difficult, and a burden to the clinics.

In summary, wrapping up, we have a couple of things that I think were important. We have a need for national rural health clinic data strategy. One of the biggest challenges to the program is this lack of data that makes it difficult to garner legislative support. We know they're important but we can't prove it. I think it's important to recognize, we know the safety net role is underappreciated in being able to begin to track and reflect this, their role is important.

In the end, in summary, this is a long way of saying is the clinic program still relevant, and I believe it is. We're seeing the same changes that reflect and plague rural areas, but some of the changes we need are really distinguished between access and availability. It's one thing to be available in a clinic, in a rural area, I should say, but is it possible for patients to access the services? There's really thoughts about better targeting the program to meet areas of need, greatest need and collecting data to quantify the extent to which the clinics are serving their mission. I think there are a couple of other things, the participation requirements of rural health clinics, that has been a and ongoing battle going back to the ... over requirements in ‘97, but I think there's time to look at that so that we can ensure those clinics are serving rural areas.

I think from there, I am sorry, I probably took more time, but I'll turn it over to Joely…Mary, I'm sorry.

Mary Sheridan: All right. John, I just looked through the last couple of your slides, I hope that's okay. Was there anything you wanted to add?

John Gale: I'm good. They were just contact information.

Mary Sheridan: Yes.

John Gale: No worries.

Mary Sheridan: All right. Thank you very much. This is Mary Sheridan. I'm honored to be able to share the committee's findings and recommendations with you today, and I'd also love an opportunity to talk about Idaho. Part of the work that we do in our State Office of Rural Health is to provide technical assistance and to deliver education to Idaho RHCs. We really do believe that Idaho RHCs are an important part of the healthcare safety net.

As you can see, we currently have 45 RHCs, and they are widely dispersed across the state. This includes 28 provider based RHCs, and they are predominantly owned by critical access hospitals and 17 independents. We have a long standing partnership with Idaho rural health clinics, and I

truly believe that that did help to set the stage for engaging conversation between RHCs, committee members and staff.

The first day of our meeting was held in Boise, which is the capital of Idaho. The second day involved committee members traveling to the community of Gooding, which is 100 miles southeast of Boise. Gooding is the county seat of Gooding County and has a population of about 3500.

We selected the community of Gooding because it is home to both a provider based and an independent rural health clinic, and we really felt it was important to understand the challenges and successes of both types of RHCs. The committee was graciously hosted by North Canyon Medical Center, a critical access hospital that owns and operates North Canyon Family Physicians, a provider based RHC.

The meeting also included leadership from other RHCs, including Associates in Family Practice an independent RHC with three clinic locations in Gooding County. Shoshone Family Medical Center, an independent RHC in adjacent Lincoln county, and Power County Hospital District, a critical access hospital that operates a provider based RHC about 115 miles east of Gooding.

RHCs participating in the meeting communicated honestly, effectively and clearly, which resulted in a number of key takeaways and a strong set of recommendations by the committee. Cost and financial burdens were common issues among RHCs. Many of these concerns surrounded the cost of staffing, cost of electronic medical record systems and the time between up-front costs and receiving payment for services. That being said, the RHC program is likely the only way man RHCs can survive and continue to deliver much needed services. Without the payments associated with being a certified RHC, participants were very concerned about their ability to continue to provide services.

For North Canyon Family Physicians, being part of the critical access hospital was a significant advantage for them, and it allowed them to use the same electronic medical record system. They expressed support for that interconnectivity, and felt that it does enable better patient care. However, for other clinics, the lack of interoperability and the inability to exchange health records among different systems is certainly a disadvantage.

RHCs reported that using electronic medical records can negatively impact the time clinicians spend with patients. One physicians mentioned how over the years, the staff size has increased, yet he feels he is definitely seeing fewer patients than before. Participants commented that federal requirements are often burdensome and time consuming, and meeting those requirements often takes time away from their patients.

Everyone in the room, committee members and staff were impressed by the passion RHC staff and leadership expressed about their work and their support of their rural communities. They truly care about their communities, and they want to be able to continue to care for them.

In terms of recommendations, the first recommendation is regarding the payment cap, and that was mentioned earlier. There is a cap on payments to independent rural health clinics, and this really leaves them at a huge disadvantage, particularly as their costs increase. In 2018, the all-inclusive rate per visit is $83.45. RHCs subject to the payment cap reported adjusted costs per visit, that exceed the reimbursement cap by anywhere from $25 to $81 per visit. The committee recommends a reexamination and adjustment of that payment cap, and the development of a formula regarding the determination of an annual payment increase.

Recommendation two. Over the long term, RHCs are at risk for not being able to compete effectively in a redesigned healthcare payment and delivery system that is focused on value as a payment determinant. They may be unprepared to take on risk as required under new payment models, or potentially not seen as an attractive partner to larger groups such as accountable care organizations. To help address this concern, the committee recommends the development of a grant program to allow state offices of rural health to provide technical assistance to RHCs on quality data reporting, data collection, and performance improvement strategies to support the transition to a value based system.

Number three, rural health clinics can currently serve only as a telehealth originating site, meaning they are only eligible for telehealth services where the patient is located, and they are not allowed to serve as a distance site, meaning being the provider of professional services under Medicare.

Changing this to allow RHCs to also serve as the distance site and provide professional services via telehealth will support expansion of healthcare services to rural residents. Number four, this recommendation also echoes an earlier recommendation by the committee regarding the provision of hospice services. Currently a nurse practitioner or physician and not a physician assistant in a rural health clinic can serve as the attending provider under the hospice benefit.

Hospice care is provided in defined benefit periods. After an initial 90 day benefit period, patients must be re certified in order to keep receiving benefits for hospice care. Patients being cared for by a physician assistant in a rural health clinic should be able to continue to receive hospice care. The committee recommended that allowing RHC providers such as PAs to be attending clinicians for hospice patients will increase access to these much needed services.

I would like to add that allowing PAs to serve in this capacity is included in the bipartisan budget act of 2018. This change actually should be effective January 1st of 2019. Number 5, rural areas desperately need opportunities and strategies to increase access to behavioral health and mental health care services. Everyone is certainly aware of the opioid crisis in rural America. Masters trained behavior health providers, such as licensed professional counselors, mental health counselors, marriage and family therapists, can help increase access to mental health services for Medicare beneficiaries through rural health clinics. Including these providers under the RHC all-inclusive rate will increase access to much needed behavior health services.

Number six. Rural health clinics are required to directly furnished routine diagnostic and laboratory services and have arrangements with one or more hospitals to furnish medically necessary services not available at the RHC. These requirements can lead to inefficiencies in certain situations. For example, RHC providers will typically need to order a full panel for blood work. However, they are required to directly provide a prescriptive list of laboratory tests such as a hemoglobin and hematocrit. RHCs waste money and staff time in training to be able to provide specific lab tests in their facilities, and these often go unused.

These requirements also limit the RHC's ability and flexibility to determine the best types of lab tests for patients. This requirement is clearly in need of an update to allow flexibility of laboratory services, to reduce regulatory burden and waste. The more than 4,000 certified RHCs nationwide provide much needed services to rural populations. They are an important part of the safety net and often serve as the primary care access point in rural communities. The committee believes this set of recommendations provide key strategies for modernizing the rural health clinic program, and supports the continuation and expansion of high quality care and healthcare access in rural communities. With that, I'm going to turn it back over to Naomi.

Naomi Lelm: Thank you Mary, at this time we will open the webinar for questions. You should see a Q&A box on the lower right hand corner of your screen where you can enter your questions. As you enter those, please select the option to send the question to all panelists or your question might get missed.

As we're waiting for some questions to come in online, we did have a couple of questions that were submitted via email. I'll go ahead and ask those, and if you can just chime in with your answers. What are the next steps, now that recommendations have been made?

Wakina Scott: Hi this is Wakina. I'll go ahead and jump in for that question here. Of course the next steps with the secretary has within his right to take a look at these recommendations and further act on them, but a number of the recommendations will require congressional action. For example, changing the way RHCs are paid or having some type of program support for rural health clinics, will require for congress to pass some type of legislation to address those recommendations.

Other recommendations could be looked at across the department as well, too, and probably be addressed at the regulatory level as well. For example, in looking at the lab requirements and seeing what changes could be made there, or even looking at some of the work force requirements, you know, there may be flexibility to make changes related to behavioral health providers at the regulatory level. Again, they're out there and it is an option for congress to kind of take a look at that, or within Health and Human services, other agencies can take a look at and act on these recommendations.

I would note that too, in the recent bipartisan budget act of 2018, as it relates to hospice services that there was some additional flexibility for physician assistants in particular to be attending clinicians for hospice care. That's seen as a plus for rural health clinics as well, too. Whereas before, only a nurse practitioner or physician serving in a rural health clinic could be an attending clinician for hospital care. Now it's opening the door for physician assistants to provide that same service starting in 2019. However, the key distinction is that hospice service is still not considered a rural health clinic service. When those providers do provide hospice care, they're billing as separate from your rural health clinic payments, and its part, billed as part of Medicare part B payment. Again, now you have an additional provider that would work in a rural health clinic, physician assistant that could now also provide hospice care. That's a positive.

Naomi Lelm: Okay. Our next question is, is there anything in the bipartisan budget act that impacts RHCs? Mary, I think you mentioned a little bit about that?

Mary Sheridan: Yes, and actually Wakina, is there anything else besides the hospice benefit that you're aware of?

Wakina Scott: No. I think that was the main thing. Sorry, I kind of covered that as well too, but I think that was one of the main benefits that I saw in the recent bipartisan budget act.

Naomi Lelm: Thank you. A comment from someone and a question saying, "Your recommendations are spot on. What time frame are we looking at before we might see action or changes?"

Tom Morris: Well there is really, this is Tom Morris, there is really no time table in the sense that the committee's main goal is to deliver the brief to the secretary and to the department leadership, and then we post the brief publicly. It's a question of whether there will be an opportunity to either do some of this through rule making or whether there is interest in changing some of the laws that the committee highlighted. That's out of the jurisdiction of the committee, they can only make recommendations to the secretary, and the secretary's regulatory authority.

There's obviously stakeholders who benefit from seeing the brief, and to the extent that what the committee has recommended resonates with stakeholders and they want to highlight some of their findings, that certainly has happened in the past and would be appropriate.

Naomi Lelm: All right, thank you. Another comment from a participant. I understand that we do not have a sliding scale fee or free services. Yes or no?

Mary Sheridan: This is Mary. RHCs are not required to have a sliding fee scale. Obviously, the exception would be if an RHC was certified as a national health services corps site, or maybe a state loan repayment program. If there's another program that requires them to have a sliding fee scale, but the program itself does not create that requirement. Many of them do, however.

John Gale: Mary, that's right. If they're provider based and the parent hospital has a sliding fee scale they have to operate under the same supervision and requirements as the hospital. I'd say almost without exception, the provider based clinics all use, have implemented sliding fee scales, and on the independent side, our statistics show it's very, very high. Probably 90% have implemented their own sliding fee scales though they vary, there isn't a standard requirement, but most recognize that they are serving people in need with payment issues. They've set up systems to qualify them.

Naomi Lelm: Okay. We have a follow up to that as well. What do we do with those patients that have a sliding scale fee and yet refuse to pay anything?

John Gale: That's really an individual clinic management issue. They ... I appreciate this is more easily said than done. They can decide to discharge the patient, probably should do so following reasonable communication and discussion back and forth with the patient, but it's really ... it's really a clinic management issue.

Naomi Lelm: Okay, thank you.

Wakina Scott: I can just add too, from what I've heard, anecdotally from rural health clinics, most continue to provide care, but provide a policy, if they find that they have a lot of beneficiaries that are not paying their copays or according to their sliding fee schedule will have a policy in place to try to address those that are consistently out of line with what their sliding fee schedules or their policies. Again, I think that most of them will still try to provide some level of care to the beneficiary.

Naomi Lelm: All right. Thank you. Another question we have coming through. One more situation that limits providing services to our community is the restriction of providing clinical services such as labs, imaging, and injection when a provider is not on site. Maybe more of a comment than a question there, too.

Mary Sheridan: This is Mary, and actually, I would agree that that did come up during the discussions in Gooding, yes.

Naomi Lelm: All right, a question from Michelle. Did the committee discuss changing the rules around comingling to allow a true integration of services as they move towards value based care?

Tom Morris: Mary, I don't know if you want to take this, this is Tom. It was definitely a point of discussion on one of the challenges in sort of teasing out the whole issue of comingling is the variation we see from survey group to survey group. It made it hard to really, during the brief time they have at the rural health clinics to definitively say what was going on and to get agreement on what

specifically the committee wanted to change around comingling. It's certainly an issue that I think was a point of discussion.

Naomi Lelm: If the state's Medicaid program has deemed that the RHC can serve as a distance site for telemedicine. Is there any violation of RHC compliance if an RHC allows a practitioner to provide telemedicine to Medicaid patients in that state?

John Gale: I can take a shot at this, if it's all right, if anyone else doesn't want to. The requirement that a clinic or the prohibition against the clinic serving as a distance site provider really is a Medicare reimbursement policy, not a clinical standard. If Medicaid or commercial payer would allow that in a given state, then the clinic has established its own process and protocols to make that happen in a safe and quality fashion, then I don't think there's any limitation that I'm aware of that would preclude them from doing it. They just can't service the distance site and bill for the reimbursed by Medicare. It's not a clinical standard, it's a reimbursement issue.

Naomi Lelm: All right, thank you. Another telemedicine question coming through, what are the chances of telemedicine being a paid service and an RHC as a receiving site? There is a concern that telemedicine vendors will provide convenience but steer patients away from coming in for face to face care in an RHC.

Tom Morris: Mary and John may have something to offer on this, this is Tom Morris. This came up in this course of discussion, that it's a real concern, as the technology expands and more folks are using it, some of the statutory limitations don't have a necessarily, kept up with modern practice and you know, there I a need to do this. The committee just didn't really have a firm way of addressing it specifically. More broadly than that, there's a lot of discussions going on within Washington and just about any rural health or telehealth meeting you go to where folks talk about the challenges and having different rules for different payers and having to change your configuration to meet those payers, and how it gets in the way of actually utilizing the technology.

Wakina Scott: I would add, too, just from a telehealth perspective, there are certain services, really one that comes to mind, which is chronic care management services. Fairly new service that rural health clinics are able to provide as a beneficiary that has a telehealth component as well to it. With that particular service, beneficiaries can receive a call from the rural health clinic, or the rural health clinic can do various things that are similar to telehealth and still bill Medicare for that chronic care management service for that particular month. That is one instance where there is some type of provision of telehealth but again, for allowing rural health clinics in general to be able to bill telehealth services as Tom already mentioned that will require statutory change.

Naomi Lelm: All right, thank you. Mary, a question targeted to you. During the Idaho meeting, did anyone ask about reducing or eliminating the patient portal requirements? Currently, meeting the percentage required is difficult since many patients are not interested.

Mary Sheridan: This is Mary. I would say that has surfaced as an issue certainly, but I suppose we didn't land anywhere with any type of recommendation, but yes it did come up.

Naomi Lelm: All right, thank you. We'll take one last question as we're running a little short on time. Are there any plans to make Coumadin management and RHC covered service? How about care management codes other than the basic 20 minute G05-11?

Wakina Scott: In terms of other care management codes, yes. Through the physician fee schedule for 2018, CMS did make a number of changes for care management code for rural health clinics. Now they're able to provide for more advanced type care and receive a higher, I guess, average rate

or payment for providing care management, or chronic care management. They're also able to incorporate and provide for more of the behavioral health integration type of services that other physician offices are able to provide for.

They're also able to provide for psychiatric care as well. Yes, RHCs do have a number of additional services that they can provide as implicated in the 2018 physician fee schedule.

Mary Sheridan: This is Mary, and that Coumadin specific clinic issue actually didn't come up. I'm not aware of any changes in that direction.

Naomi Lelm: All right, thank you all. As we're coming to the end of our time or a little over, I'd like to thank all of our speakers for the great information and the insight that you shared with us today and also thank you to our participants for joining us as well. As you closeout of your webinar window today, a survey will automatically open. We encourage you to complete that survey to provide us with feedback that we can use as we host additional webinars in the future. The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of today's webinar will be made available on the RHIhub website and sent to you by email in the near future so you can listen again, or you can share the presentation with your colleagues. On behalf of the staff here at RHIhub, I'd like to thank everyone again and have a great day.