2015 Rural Health Clinic (RHC) Key Issues

- *Expansion of Telehealth*
  - Many rural communities do not have access to specialty services. Using technology can completely change this gap in care.
  - Using telehealth services can help to improve the health of patients, and to "bend the cost curve" by allowing patients to access care in a timely way and assist them in avoiding costly inpatient stays. It also supports the economy of rural communities when patients do not have to leave the area and travel for hours to access needed care.
  - Congress should support policies that improve Medicare's effective use of telehealth, in order to ensure that these services can be developed in all areas of need, especially rural communities. There have been several good bills proposed in the past – H.R. 2001, Veterans E-Health & Telemedicine Support Act of 2013, H.R. 3077, TELE-MED Act of 2013, H.R. 3306, Telehealth Enhancement Act of 2013 and H.R. 6719, TeleHealth Promotion Act.

- *Subcontracting with Federally Qualified Health Centers (FQHCs)*
  - The main area where RHCs are included in Health Care Reform is being able to subcontract with FQHCs. CMS and HRSA must work together to support and provide guidance for this effort.
  - This will help to use our country's limited resources most effectively – we should not have to use taxpayer dollars to create a new clinic space and hire new providers and staff just to serve the uninsured in a community where there is already an RHC that may not be able to afford to treat all uninsured patients but does provide good patient care. Subcontracting would help the RHC serve all of the uninsured patients.

- *Payment Policy Issues*
  - We urge policymakers to pay particular attention to the impact of Medicare and Medicaid payment provisions on RHCs given the high level of Medicare and Medicaid beneficiaries served by RHCs.
  - The cost of providing care has risen faster than the Medicare visit rate cap and the scope of services RHCs are expected to provide has expanded without a commensurate adjustment to the cap. In other words, the payment cap is based upon a menu of services that were typically performed in a physician's office in 1987, not 2014. Bipartisan legislation introduced in the past (S. 1680, H.R. 3859, H.R. 5194, H.R. 5624) would have brought support to rural communities and RHCs by raising our Medicare upper payment limit. We urge Congress to move ahead with this effort, particularly now that they are raising the FQHC Medicare rate.

- *Regulatory Changes*
  - Allow diabetes education and medical nutrition therapy to be billed as an RHC encounter, as it is in an FQHC.
  - Allow RHCs (and FQHCs) to bill for group visits.
  - Adopt a broadened definition of "rural" in determining RHC-eligible locations.

- *Chronic Care Management (CCM)*
  - On January 1, 2015, CMS implemented a new payment policy to cover non-face-to-face care management services provided to patients with two or more chronic conditions. CMS will allow the code to be billed once per month per qualified patient. CMS will pay $41.92 for this code. Unfortunately, CMS has not yet determined how to pay Rural Health Clinics for this unique service. Consequently, patients residing in rural underserved areas who suffer from two or more chronic conditions are unable to have this service provided by their Rural Health Clinic.
  - CMS has stated that they believe these services should be covered when provided by a physician, PA or NP working in a Rural Health Clinic and they have indicated that they are considering various options. Until CMS announces policy for how to deal with CCM services, RHCs will be effectively precluded from providing CCM services.
  - Individual Members of Congress should contact CMS to encourage them to come up with a reasonable policy that would compensate RHCs for delivering Chronic Care Management services to qualified individuals. Helping people receive this care means that fewer with end up in the emergency room and the hospital, and Medicare will save money in the long run.