Testimony of

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Mr. Chairman and members of the Aging Committee. On behalf of the National Association of Rural Health Clinics, I want to thank you for this opportunity to talk with you about the challenges facing rural providers in meeting the healthcare needs of rural underserved communities.

The Rural Health Clinic (RHC) program is the oldest and largest federal program aimed at improving access to healthcare in rural underserved communities. There are more than 3,000 federally certified RHCs and many have been providing quality, cost-effective healthcare in rural underserved areas for 30 years.

To be certified as an RHC, a clinic must:

* be located in a non-urbanized area;
* be located in an area designated as a health professional shortage area (HPSA), medically underserved area (MUA), or governor-designated shortage area;
* be engaged primarily in providing outpatient primary medical care;
* employ at least one nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) at least 50 percent of the time that the clinic is open; and,
* receive medical direction from a physician who periodically reviews the services provided by the NPs, PAs and/or CNMs and is on-site and available to provide care at least one day every two weeks.

When the RHC program was created in 1977, it was viewed as an experiment by many at the federal level. The payment methodology – cost-based reimbursement rather than fee-for-service reimbursement for both Medicare and Medicaid - and staffing requirements (mandatory use of PAs or NPs) were and continue to be unique.

Congress, as far back as the mid-1970s, recognized that the traditional fee-for-service payment methodology was inadequate to support and sustain a traditional medical practice in rural medically vulnerable communities. For this reason, RHCs were authorized to be paid using capped, cost-based payment principles and payment would be an all-inclusive payment. This has

proven to be an attractive and successful incentive for providers to locate in rural underserved areas.

But even the special payment methods can't solve all problems.

Gilliam County, Oregon is a good example.

Gilliam County has a population of roughly 2,000 people. It is what many might describe as "frontier" and it is geographically larger than some states. The Gilliam County Medical Center, a federally certified Rural Health Clinic in Condon, Oregon, is the principle provider of primary health care for most County residents.

The medical center was established in 1980 by two physician assistants, David Jones, PA-C and Dennis Bruneau, PA-C and a physician, Dr. Bruce Carlson. Prior to the creation of this clinic, there was a revolving door of physicians through the community. The National Health Service Corps (NHSC) would place a physician in the community but as soon as the physician's NHSC obligation was fulfilled, the physician would leave. As state and county officials looked at this situation, it was clear that part of the reason the community could not retain their physicians was the burn-out factor so common in rural America.

It was determined that the community required at least two primary care providers who could share call and responsibility and as a result, the RHC program would be well-suited for this community because of the clinics planned reliance on PAs as the primary source of healthcare. But even with the higher reimbursement available through the RHC program, it was apparent that there would be insufficient revenue to sustain the clinic over time. Working with community leaders, the idea of creating the Gilliam County Healthcare tax district was brought to the voters of southern Gilliam County. The idea is similar to property taxes used to support the local school system, but instead, the healthcare tax district would levy a property tax to support primary healthcare. The voters of Gilliam County approved this unique subsidy.

I am pleased to tell you that nearly 30 years later, the Gilliam County Medical Center continues to exist and is still staffed by physician assistants David Jones and Dennis Bruneau and their supervising physician, Dr. Bruce Carlson. The clinic sees all patients regardless of their ability to pay. Last year, nearly 15% of the patients seen by the medical center were uninsured. This is considerably higher than the percentage of uninsured seen by the typical primary care medical practice in the U.S. This past year, the revenue generated by property taxes constituted 22% of the clinic's budget. Were it not for the combination of revenues generated by being a rural health clinic and the revenue from the tax district, the clinic would likely have closed many years ago.

The Gilliam County medical center story is only one of dozens of creative and innovative solutions to providing quality, affordable healthcare in rural America. Chairman Kohl, similar examples exist in Wisconsin that I will talk about shortly.

But we are in serious danger of losing many of the creative solutions that have been developed at a community level and, more importantly, federal policies are stifling the creation of the next Gilliam County medical center. Just recently, the Centers for Medicare and Medicaid services issued proposed changes in the RHC rules and regulations that if adopted as published, would, we believe, devastate the health care infrastructure of rural America. This CMS proposal comes on the heels of another, equally damaging proposal put forward by the Health Resources and Services Administration to change how we determine if areas are underserved.

I want to acknowledge the efforts of many of the Senators on this Committee – particularly those of Senator Smith – to force HRSA to address some of the unique problems with the shortage area rule. Like many others, I was pleased that HRSA announced last week that rather than moving ahead with what clearly became a very controversial proposal, they decided to go back to the drawing board. Without your help and support, this never would have happened.

But we still must deal with the RHC proposed rule. Again, I want to acknowledge the efforts of two members of this Committee, Senator Wyden and Senator Smith for taking a leadership role in helping the rural community get more information on the impact of this proposed rule, an

extension of the public comment period and, for introducing legislation to try to address the inconsistency between the HRSA review timetable for shortage area designations and the CMS standard that RHCs can only be located in shortage areas that have been updated within the past 3 years.

It has often been said that states are the incubators for the development of new ideas. I believe this is true. Unfortunately, federal policies are often killing these new ideas before they have a chance to take root and grow. Or, they support innovation in the early stages, only to penalize communities later on when they are successful.

In the typical rural underserved community, payments from Medicare and Medicaid can often represent 50 – 60 percent of a clinic's revenues. According to a survey of Rural Health Clinics conducted by the University of Southern Maine, over 30% of the patients coming into the typical RHC have their healthcare paid for by Medicare and on average 25% are covered by Medicaid. In addition, nearly 15% of the typical RHC patients have no insurance. This means that only 25 - 30% of the typical RHC patients are covered by commercial insurance. I would like to note that the typical RHC sees far more Medicare and Medicaid patients – as a percentage of patients – than ANY other provider of primary care services – including Federally Qualified Health Centers.

What this tells us is that rural providers, such as RHCs, are heavily dependent upon adequate Medicare and Medicaid payments to support the availability of healthcare in these communities. Unlike practices in Milwaukee or Portland where low Medicare or Medicaid payments can be offset by revenues from commercial insurers, rural providers don't have this luxury. And, unlike practices located in more urbanized areas, rural providers typically see all patients, regardless of their ability to pay – even when there is no federal support for them to do so. In rural America it would be considered a breach of faith for a provider to turn patients away.

Another innovation we have seen in the past 15 years, is the development of networks of Rural Health Clinics. These are networks that link several RHCs either independently or through a hospital network.

One of the early physician groups that got involved with the RHC program was the Miles Bluff Clinic. Through a network that includes two Rural Health Clinics and specialty physicians, the Miles Bluff Clinic has been serving the communities in central Juneau County since 1980.

Unfortunately, network arrangements such as the Miles Bluff Clinic are threatened by their own success. If the RHC proposed rules recently released by CMS are adopted as proposed, the Miles Bluff clinic will be forced to close some of its outreach facilities. The added cost associated with the reduced payments proposed by CMS will severely hamper the ability of the Miles Bluff clinic and other RHCs to continue to survive financially.

I want to encourage the Committee to appreciate and support the on-going innovative efforts at the state level to meet the challenge of bringing quality healthcare to rural populations.

Despite years of effort, we still have a mentality in some government agencies that there is only one way – the urban way – to deliver healthcare. I thought we had overcome these biases with the widespread acceptance of physician assistants and nurse practitioners, but I continue to see attitudes and policies that fail to recognize the lead the states are taking in creating new health professionals to meet the workforce needs of their communities. The efforts to develop the next "PA" or the next "NP" are often stifled because of what was done originally with PAs and NPs, the Medicare program says – we won't pay for healthcare provided by this state licensed health professional unless you get the Medicare law changed to recognize this new health professional. This not only affects individual providers, but innovative facilities as well. The Critical Access Hospital program is another example.

In addition to failing to adopt innovative delivery strategies developed at the state level, we fail to adequately keep pace with the need to make positive changes in the programs already on the books. Here are some other issues that need to be addressed:

1. Raise the RHC per visit Cap

2. Consider more carefully possible changes in the methodology used to determine health professional shortage areas.
3. Concerns about proposed changes in RHC rules and regulations
4. The need to foster greater opportunities for collaboration between RHCs, CAHs, small rural hospitals and Federally Qualified Health Centers.
5. Ensuring the ability of rural providers to offer new and expanded services approved by Congress but because of different payment policies, make it difficult for rural providers to make these services available. Services such as diabetes education.

The Rural Health Clinic program has a long and proud history of helping to meet the healthcare needs of individuals living in rural underserved areas. The RHC program isn't the answer for every rural community, but it is the answer for many. I must tell you that I am very worried about the future of this program. The policies we see coming out of CMS have a decidedly anti-rural tone. Whether this is intentional or simply sins of omission we cannot tell.

Rural America is not just another special interest group. Rural seniors deserve to have access to high quality, affordable healthcare. We can do this but Medicare needs to be a partner in this effort.