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Testimony Submitted for the Record to the Senate Finance Committee, Subcommittee on Health

On behalf of my roles with both Frances Mahon Deaconess Hospital (FMDH) and the National Association of Rural Health Clinics (NARHC), I thank the Subcommittee for their attention to the obstacles and opportunities facing rural health. During my testimony, I hope to take you on a journey of what it is like to access and help to provide health care while living in the heart of rural America.

The Rural Health Clinics program was created in 1977, and remains the oldest federal program aimed at improving access to outpatient care in rural, medically underserved areas. The RHC program, as a whole, serves approximately 37.7 million patients per year - more than 11% of the entire population and approximately 62% of the 60.8 million Americans that live in rural areas. Rural Health Clinics are a separate and distinct program from the Federally Qualified Health Center program, also represented on today's panel, and both serve a critical role in our country's health care safety net. RHCs receive enhanced Medicare and Medicaid reimbursement but are not grant funded.

I feel fortunate to represent one of those Rural Health Clinics, located in Glasgow, Montana. If you are picturing mountains, we are not that side of the state! Glasgow lies in the Northeast corner of Montana and is an agricultural community with big skies and wheat fields as far as the eye can see. Glasgow has been deemed the "Middle of Nowhere" by the Washington Post, as it the most geographically isolated area, taking 4.5 hours in any direction to get to a city.

As a provider based RHC attached to a Critical Access Hospital, we have no choice but to be very strategic on how we can best serve our community and the surrounding areas. Glasgow has a population of about 3,500 residents, 7,600 people live in the county and about 15,000 in the two neighboring counties. Fort Peck Indian Reservation is also located 15 miles to the East of us. With the closest larger hospital over 300 miles away, we work very hard to provide our service area with as many service lines as

possible to relieve some burdens for our patients. Our RHC provides a wide range of services including Primary Care, Behavioral Health, General Surgery, Orthopedics and OBGYN. We are especially proud that we recently achieved 24/7 coverage in General Surgery, OBGYN and Orthopedics. Our RHC serves approximately 8,600 patients annually, roughly 33% Medicare, 22% Medicaid, and 37% commercial pay.

My testimony today will focus on specific challenges and solutions in workforce, telehealth, access to care barriers, and the educational pipeline. Through my role as a Board member with the National Association of Rural Health Clinics I will also share insights into other opportunities and obstacles facing my colleagues in the over 5,300 other RHCs across the country.

Workforce

As is the case for many other rural areas, recruitment challenges are significant in the "middle of nowhere." After years of provider turnover and unfilled openings, we strategically found a staffing model which would allow us to provide specialty services locally. In 2020, we contracted with a company that provides 24/7 orthopedic coverage. The providers are a team of three, full-time employees, and the same team covers the entire month on a rotating basis. This model worked so well we explored the idea for General Surgery and OBGYN as well and are considering it for radiology, another specialty where we are facing recruitment challenges. Being able to offer these services locally provides better patients outcomes, continuity of care, a better work life balance and helps prevent provider burn out. This model has worked well for those specialties, but we struggle with accommodating the behavioral health needs of the community. We currently staff one Psychologist and one Licensed Clinical Social Worker Candidate. Our LCSWC is a local resident that was interested in furthering her career in the field and we were able to support her in this. This still does not meet the needs of our communities and access to behavioral health services remains a nationwide crisis in need of significant attention. Our staffing plan shows a shortage of 3 behavioral health providers, but a recent study shows there is a need for 60 in our region alone. To help bridge many of these gaps in access, we have pursued telehealth options for behavioral health, pain management, and maternal fetal medicine. We recently partnered with Intermountain Health to provide

immediate tele-crisis services through our emergency room to our patients that are having a behavioral health crisis. While new, this service has been working well.

The ability to serve as a distant site telehealth provider has much potential for Rural Health Clinics and other providers, as shown throughout the COVID-19 pandemic, and I thank Congress for seeing the value in telehealth. Offering telehealth services, particularly in rural communities, does present challenges of its own, however. The majority of our patient population does not have access to a computer, the internet, or a phone according to the Social Determinants of Health Index, we were provided with from Cynosure for our pilot project. The connectivity measure for the area was listed as high in many of the communities we serve at FMDH. Telehealth services may seem like a great solution to help bring care to the patient, but when they cannot access the care, it becomes more of a burden and frustration to those we're seeking to help. Many of our patients travel 50-100 miles one way to attend an appointment at our facility and do not have the ability to utilize telehealth services. Further, RHCs and FQHCs are reimbursed for telehealth services through a "Special Payment Rule" at $98.27 per visit. While traditional outpatient offices that bill fee-for-service Medicare receive reimbursement parity between in person and telehealth services, safety net providers like us are paid significantly less for telehealth visits than our in-person encounters, disincentivizing investments in telehealth technologies and obscuring the claims data as to exactly which services are offered through telehealth. I ask that as the Committee considers long-term Medicare telehealth policy, it takes into account rural provider perspectives, including the value of adequate reimbursement and audio-only flexibilities to reach patients with connectivity challenges.

Education Pipeline

FDMH seeks to inspire our youth to follow a career in healthcare based on the quality of care they receive from our organization. From my generation alone we currently have 7 providers and multiple nurses on our staff that were born and raised in Glasgow and have moved back to provide care in rural America. My 12-year-old son wants to pursue a career in medicine because of the care he has received

here. We strive to introduce our youth to the healthcare field, this year we will be hosting the first Med Camp for kids in grades 6-8, introducing them to multiple areas of the hospital and clinic. With many clinics and hospitals being at staffing crisis levels, we need to be proactive with our youth and getting them to think about the future. We are also proud participants and supporters of the WWAMI education program through the University of Washington School of Medicine, through which Washington, Wyoming, Alaska, Montana, and Idaho expose medical students to an increased variety of clinical settings throughout their training, including RHCs like ours. Many of our local students have participated. Investing in our youth now helps both our present and our future.

Transportation

The greatest barrier that our community is facing is transportation. We strive to provide our community and surrounding communities with as much access to health services as we can provide locally, whether we provide them in house, provide outreach to other facilities, bring in specialty outreach clinics, or provide telehealth services. The services we cannot provide are 300 miles away and can cause patients stress and financial burdens. Impacts of no-shows and cancelled appointments, resulting from high gas prices, lack of a reliable vehicle or a vehicle entirely, inability to take time off work or have a friend or family member transport them, include lapses in or delayed care, poor adherence to provider recommendations, lack of surgical follow-ups, and much more, all resulting in negative health outcomes and more expensive, higher level care needs. This is only exacerbated when patients need higher level care at a facility hours away. When patients are transferred to a larger facility for this care, they are at least 300 miles away from home. Many families struggle to get to their loved ones as well as how to get them back home after discharge. I can share many stories with you, but one that stands out is from this winter when a patient presented to the ER by ambulance, a non-emergent ride which was denied by Medicaid. After the patient was discharged, they were planning to walk/hitchhike 30 miles home to Frazer, in a temperature of -17 below, and -35 windchill. While staff were able to help this individual and

consistently seek partnerships and other solutions to address these significant barriers, we need more comprehensive solutions.

My clinic is just one of 5,300 RHCs across the country, providing critical services in innovative ways to serve the needs of their patients. The unique structure of the RHC program comes with significant regulatory requirements and oversight, intended to protect the integrity of the RHC benefits. However, many provisions of the RHC statute written in 1977 have never been updated. For example, RHCs are required to have lab equipment within the square footage of the clinic for specific laboratory services. At FMDH, our patients go across the hall to our full-service lab for these services, meaning that our expensive equipment is unused for all purposes except meeting survey and certification requirements. Requirements like these increase cost and administrative burden, challenging an already overwhelmed workforce and threatening the delivery of quality, outpatient care in rural communities. Finally, the drastic increase in Medicare Advantage enrollment across the country, including in rural communities, threatens the rural safety net. While RHCs receive enhanced traditional Medicare payments in comparison with their fee-for-service counterparts as Congress recognizes the increased costs of providing care in rural America and the high value of care in these communities, there is no statutory requirement around RHC Medicare Advantage reimbursement. With oftentimes lessened negotiating power as one of few providers in a rural area, many RHCs across the country are facing financial stability concerns due to low Medicare Advantage reimbursement.

In conclusion, I want to thank you for inviting me to share these unique perspectives as part of today's hearing. We often forget our "why," and this experience has reminded me of why I do what I do. I am proud to be a voice and advocate for this population. I thank the Subcommittee for their continued leadership on these critical issues, and I look forward to seeing the work that we can do together for the over 60 million individuals across rural America. Thank you.