

National Rural Health Association

Issue Paper

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Rural Health Clinics*

Background

In 1977, the U.S. Congress passed Public Law 95-210 that established criteria for the establishment of Medicare certified Rural Health Clinics (RHCs). The law created a program that was designed to support and encourage access to primary health care services for rural residents. Congress acted because it believed that:

- The rural population was becoming poorer and more elderly.
- Providers were becoming older and not being replaced by younger physicians as older physicians retired.
- The provision of health care to the rural poor and elderly was more costly than to those populations in urban areas.
- Rural health care was more costly because a limited, constricted patient mix restricted the percentage of revenue from private third-party payers.

The number of these RHCs has steadily increased since their inception in 1977 (currently there are approximately 3,300 RHCs) due to decreasing reimbursements from the standard fee-for-service system. Because RHCs receive cost-based reimbursement (as defined and limited by the Medicare and Medicaid Programs), providers continue to turn to the RHC program

to enable them to provide service to the rural poor and elderly. As health care providers strive to maintain service to this vulnerable population, RHCs have become an integral part of the rural health care system.

RHCs can be either free-standing or provider-based. Provider-based RHCs are those owned by and operated as an integral part of another Medicare certified facility, typically a hospital.

As RHCs have proliferated, so has scrutiny of the amount of money being spent for the RHCs by federal and state governments on the program. RHCs have helped maintain primary health care in areas that otherwise have not historically been able to recruit or maintain providers (physicians or mid-level practitioners). Mid-level practitioners in the context of RHCs are nurse practitioners and physician assistants.

When examining the cost of an RHC, it must be balanced against the cost of having no access or limited access for the patients the RHC serves. Preventive health care and early intervention in acute illnesses would decrease and the ultimate health care cost would increase if there was not access such as that provided by the RHC. Cost should also be evaluated on another less quantifiable continuum - the quality of life that either encourages or discourages providers locating in rural areas. Rural providers are typically within the reach of local citizens 24 hours a day, seven

* An Issue Paper of the National Rural Health Association originally issued in February 1997 and updated in 2006. This paper summarizes the history of the development and current status of Rural Health Clinics. It includes high - light summaries of various issues of current concern and recommendations related to the issues.

days a week, making the provider's quality of life in a rural community more difficult.

The provision of primary health care to rural populations through RHC certification:

- Allows access in areas that otherwise would not have sustainable health care.
- Encourages mid-level providers to be an integral part of the health care delivery system.
- Gives rural citizens the opportunity to learn and accept the skills of mid-level providers.
- Allows the potential for other services to be brought to the rural area that otherwise would not be available in a private practitioner's office, such as podiatry, optometry, dentistry, chiropractic and social services.

RHCs receive cost-based reimbursement from Medicare as defined and limited by the program. Medicaid reimbursement varies from state to state but is generally based on costs, as defined by Medicare that existed in 1999 and 2000.

Unlike most other cost-based reimbursement systems, RHC allowable cost includes reasonable compensation of providers. By statute, the Medicare cost per visit limit and the Medicaid reimbursement base rate is increased annually by the published Medicare economic index (MEI)¹. Such increases have consistently outpaced adjustments to the standard Medicare and Medicaid fee for service reimbursement methods. However, the Medicare cost per visit limit of \$72.76 for 2006² is expected to be less than actual cost for the vast majority of RHCs. The excess of actual cost over the Medicare cost per visit limit has existed since the limit was first established and the gap has continued to grow each year. Even with the Medicare and Medicaid reimbursement shortfall, this concept of cost-based reimbursement has facilitated the recruitment of providers into rural areas and has helped sustain primary health care services in those areas.

The RHC program is designed like many other health care delivery programs at the federal and state levels. A program is legislated, qualification requirements are established, certification processes are put in place and ongoing monitoring mechanisms are developed. There is a sys-

tem of checks and balances for the program to ensure both initial and ongoing compliance with established goals and requirements. In the case of the RHC program, this system does not appear to have worked as effectively as it was designed, mainly because certain segments of the system have not been regularly instituted, applied or addressed. Among others, the payment system has not been regularly reviewed and updated.

The National Rural Health Association (NRHA) has supported the RHC program as one major component of a rural health care delivery system.

Access to Care

Access to primary care has been a defining argument for the certification of RHCs. Access to primary health care should be defined in workable terms considering the needs of specific communities. RHCs should be required to serve the populations for which the designation of need for the area was granted and thus provide the eligibility criteria for certification of the clinic. Although the vast majority of RHCs offer a wide array of services to Medicare and Medicaid beneficiaries, RHCs should be required to serve all Medicare and Medicaid beneficiaries seeking primary care services available at the clinic.

RHCs originally obtaining certification under a population-based underserved or shortage area designation should serve members of the population for which the area was certified as needing health care providers. For instance, if an RHC certification is based on a HPSA-based area with a population below 200 percent of poverty level, that RHC should be required to offer services to that population on a sliding-fee basis or a similar mechanism. However, because Medicare and Medicaid reimbursement is at rates that are less than actual cost and RHCs do not have access to federal grant programs such as the Department of Health and Human Services — Public Health Service grants that provide funds for care to indigent and uninsured populations, it is impractical to impose such requirements at this time. RHCs should be reimbursed by Medicare and Medicaid at rates that approximate actual cost and have access to

federal grants that provide the resources needed to care for indigent and uninsured populations.

The limiting circumstances involved in the establishment and retention of access to care in frontier and other extremely rural areas should be taken into special consideration in any revision of the eligibility and reimbursement provisions for RHCs.

Provider-based facilities constitute a significant number of RHCs. The size and physical location of the provider entity should be a consideration in the certification criteria.

Managed Care

With the advancement of Medicare Advantage (Medicare managed care) RHCs face a new challenge — RHCs are required to negotiate rates that may be significantly less than the established Medicare rates. RHCs should be recognized as essential community providers and should be afforded protected status in Medicare Advantage and eligible to receive established Medicare payment rates.

Unlike Medicaid managed care programs, Medicare is not required to determine the difference between Medicare managed care reimbursement and established Medicare RHC rates and pay that difference to the RHC. Medicare Advantage requires Medicare managed care contractors to determine and pay Federally Qualified Health Clinics (FQHC) the difference between Medicare managed care reimbursement and established Medicare FQHC rates.³ The regulations governing the Medicare Advantage program allow Medicare contractors to circumvent the established Medicare payment methodology and effectively eliminate the RHC program for those Medicare beneficiaries that are covered under such programs.

The Medicare Advantage law and regulations should be revised to require Medicare to determine the difference between Medicare managed care reimbursement and established Medicare RHC rates and pay that difference to the RHC. As an alternative, the Medicare Advantage law and regulations should require Medicare Advantage contractors to pay the standard Medicare RHC rates and contract with all RHCs in their service area.

Eligibility For Certification

RHC program eligibility requires only the designation of a medically underserved area (MUA) or a health professional shortage area (HPSA). Regular assessments of MUA and HPSA designations are required under existing rules.⁴ Identification of new MUAs or HPSAs can enable the certification of new RHCs. Congress should provide legislative guidance for the future of existing RHCs that are located in areas that lose their MUA or HPSA designation because of population or provider changes.

Increasing and retaining access to care should be considered in the certification criteria. Both are critical considerations for most rural communities as they face the need for provider services today and in years to come. Definition of community needs should also include consideration of the retention and recruitment of primary care providers. The federal government should establish standards to measure the primary care need, and the states should apply them consistently in making recommendations for certification of RHCs. Such standards should include, but not necessarily be limited to, the number of primary care providers available to the population or geographic area. The criteria should also include community input. Criteria for evaluating need at the community level should include consideration of actual and potential patient utilization assessed by patient type and patient need, consideration of such factors as age, demographics, income and poverty levels, prevalent diagnostic patterns, community economic needs and planning. Geographic distance, provider type, patient transportation requirements and limitations, and other proven access considerations should be included in evaluating access to health care in the certification criteria.

Mid-level providers are required by federal law to be key RHC components in the delivery of primary health care services by RHCs⁵ and, therefore, should be included in some objective manner in the assessment of need for RHCs at the federal, state, and community levels.

Survey Process and Audits

Periodic and annual surveys of RHCs are included in the legislative requirements providing a

method of checks and balances when applied objectively and consistently. However, timely surveys have not been conducted consistently across the country. The RHC statutes should be revised to require more practical survey guidelines such as follow-up surveys once every three to five years. Timely surveys should be conducted to assure compliance with certification criteria.

RHCs of both types (free-standing and provider based) submit required cost-reporting documents. Those reports should be reviewed and/or audited by Medicare and Medicaid Intermediaries in a timely manner.

Free Standing VS. Provider-based Rural Health Clinics

The primary difference between free-standing and provider-based RHCs is the Medicare per visit limit. Provider-based RHCs owned and operated by hospitals with fewer than 50 acute care beds are exempt from the cost per visit limit.⁶ As a result, these provider-based clinics are eligible to be paid for the actual cost of care, including allocated hospital overhead. In contrast, free-standing RHCs and provider-based RHCs owned and operated by hospitals with 50 or more beds are generally paid at a rate that is substantially less than their actual cost. Medicare regulations should be revised to either eliminate the cost per visit limit or increase the cost per visit limit for free-standing and provider-based RHCs owned and operated by hospitals with 50 or greater beds to an amount that approximates actual cost.

Data Collection

Data collection, or the lack thereof, is a serious problem in evaluation of the RHC program and its participating facilities, particularly as the evaluation would relate to access to primary care. The cost report is the single means through which data is collected beyond individual patient bills submitted to Medicare and Medicaid.

Unlike other federal primary care programs, such as FQHC, that receive grants and higher Medicare and Medicaid reimbursement rates, collection of RHC data is not required by federal regulation. Efforts by the federal and state gov-

ernments and RHCs should be focused on the development of a single, comprehensive and objective national data collection system that will meet the needs of the regulators, payers, community health planners and RHCs. This effort should occur in conjunction with a revision of the Medicare regulations to either eliminate the cost per visit limit or increase the cost per visit limit to an amount that approximates actual cost. Additional reimbursement is essential since data collection will require RHCs to incur additional costs.

Productivity Standard Exceptions

Current federal regulations require RHCs to meet specific productivity standards or cause their reimbursable cost per visit to be artificially reduced below actual cost. The current standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent mid-level practitioner.⁷ Although the federal regulations allow an annual exception to these productivity standards, the determination is at the sole discretion of the Medicare Intermediary. Very little regulatory guidance is published to define the exception criteria. Consequently, very few productivity standard exceptions are granted.

In many instances, the RHC is unable to meet the productivity standard due to the size of its primary service area population. An example is a community that produces a total of 5,250 clinic visits annually. If the clinic is staffed with a three-quarter time physician and a full-time mid-level practitioner, the productivity standard is met. However, the community may not be able to recruit a three-quarter time physician. With a full-time equivalent physician, the RHC is unable to meet the productivity standard by approximately 1,000 visits and the actual cost per visit is artificially reduced approximately 16 percent to equal the Medicare reimbursable cost per visit after adjustment for productivity.

Federal regulations should be revised to provide Medicare intermediaries with additional guidance concerning the criteria of RHC productivity standard exceptions and allow Medicare intermediaries to consider factors such as the population and the geographic area of the community served. Another option is to waive or remove

the productivity standard if the RHC certification criterion includes a thorough analysis and determination based on community need.

Primary Care Training

RHCs are fertile ground for training primary health care providers and increasing the health care awareness of their resident communities. The use of RHCs for provider training should be encouraged and expanded, offering another avenue to increase access. Additional Medicare and Medicaid reimbursement should be paid to RHCs that participate in approved medical education programs for physicians, mid-level practitioners and other health professionals.

Conclusions

RHCs provide vital access to primary health care services, recruitment and retention of primary care providers and ongoing contributions to the long-term economic and health factors of their local communities.

Federal laws and regulations should be revised to:

- Require RHCs to provide care to indigent and uninsured populations to the extent that federal grant funding programs for that purpose are made available.
- Eliminate or increase the Medicare and Medicaid cost per visit limit to approximate actual cost.
- Require RHCs to serve all Medicare and Medicaid beneficiaries seeking primary care services available at the clinic.

- Provide additional guidance concerning productivity standard exceptions.
- Provide minimum Medicare Advantage reimbursement at Medicare RHC rates or provide federal wrap-around payments.
- Provide sufficient funding that will allow timely initial and follow-up certification surveys to assure compliance with regulations.
- Increase the data collection and reporting requirements of RHCs if payment rates are increased to cover the additional costs that will be incurred.
- Provide guidance for the future of existing RHCs that are located in areas that lose their MUA or HPSA designation because of population or provider changes.
- Establish standards to measure the primary care need, and the states should apply them consistently in making recommendations for certification of RHCs.

The NRHA strongly supports the concept of RHCs as a major component in improving access to primary health care services in rural communities and believes that the program deserves careful, rational and objective fine tuning. The NRHA will join in any discussions and efforts to improve this program and will advocate for changes consistent with the proposals in this paper.

References:

- ¹ Social Security Act §1833(f)
- ² Medicare Claims Processing Manual, Pub. 100-04, Transmittal No. 796, Dec. 30, 2005
- ³ Medicare Claims Processing Manual, Pub. 100-04, Transmittal No. 773, Dec. 2, 2005
- ⁴ Social Security Act §1861(aa)
- ⁵ Social Security Act §1861(aa)(2)(J)
- ⁶ Balanced Budget Act of 1997 (Public Law Number 103-55)
- ⁷ CMS Publication 27, "The Medicare Rural Health Clinic and Federally Qualified Health Center Manual," Section 503. Available: http://www.cms.hhs.gov/manuals/downloads/pub_27.zip (accessed: 26 Jan. 2007).

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