



## Rural Health Clinics

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This paper summarizes the history of the development and current status of Rural Health Clinics. It includes highlight summaries of various issues of current concern and recommendations related to the issues.

### 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, minority 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.
- Nurse Practitioners (NPs) and Physician Assistants (PAs) were important new providers who could help deliver more services to patients, especially in rural areas.

The number of these RHCs has steadily increased since their inception in 1977 (currently there are approximately 4,000 RHCs). Because RHCs receive cost-based reimbursement (as defined and limited by the Medicare Program) and Prospective Payment System (PPS) or state-defined alternative payment reimbursement from Medicaid (which is based on historic costs), providers continue to turn to the RHC program to enable them to provide service to the rural poor, elderly, minority and disabled residents. As health care providers strive to serve this vulnerable population, RHCs have become an integral part of the rural health care system.

The basic requirements for RHCs are that they must be located in a non-urbanized area that is designated as a health professional shortage area (HPSA) or medically underserved area (MUA) and must employ a nurse practitioner (NP) or physician assistant (PA) at least half of the time that the clinic is providing care. They 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, which can be a hospital, skilled nursing facility or home health agency, depending on

state guidelines. 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, nurse practitioners, physician assistants, and certified nurse midwives).

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, in particular already underserved multicultural and multiracial populations that are experiencing health disparities. 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 generally within the reach of local citizens 24 hours a day, seven days a week, making the provider's quality of life in a rural community more difficult, although now that there are hospitalists at many rural hospitals, the rural providers have more recovery time.

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 physicians to include NPs, PAs and Certified Nurse Midwives (CNMs) as an integral part of the health care delivery system.
- Gives rural citizens the opportunity to learn and accept the skills of nurse practitioners, physician assistants and certified nurse midwives.
- 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 behavioral health, podiatry, optometry, dentistry, chiropractic and social services.
- Provides important access to highly vulnerable minority populations.

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 that existed in 1999 and 2000 when the PPS rates were set.

RHC allowable cost includes reasonable compensation of providers and other staff members. By statute, the Medicare cost per visit limit and the Medicaid reimbursement base rate is increased annually by the published Medicare economic index (MEI)<sup>1</sup>. 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 \$79.17 for 2013<sup>2</sup> 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. 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 an important reason for the certification of RHCs. Access to primary health care should be defined and supported in workable terms considering the needs of specific communities. Special attention should be paid to increase the number of providers from the minority populations who are being served. A serious effort to train providers that originate from rural communities and are from under-represented minorities is needed to improve access and quality of care to vulnerable rural populations.

Although it is not currently required, RHCs should serve the populations for which the designation of need for the area was granted. Although the vast majority of RHCs already offer a wide array of services to Medicare and Medicaid beneficiaries, it would be reasonable to require RHCs 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 get support to 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 funded to offer services to that population on a sliding-fee basis or a similar mechanism.

However, because Medicare reimbursement is at rates that are less than actual cost in most RHCs and the 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. If RHCs were offered Medicare and Medicaid reimbursement at rates that approximate actual cost and have access to federal grants that provide the resources needed to care for indigent and uninsured populations, a sliding-fee scale could be implemented immediately.

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 is a consideration in determining whether the RHC is provider-based or free-standing.

### **Subcontracting**

The main provision for Rural Health Clinics in the Affordable Care Act is that “nothing shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic for the delivery of primary health care services that are available at the clinic to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center.” Rather than having to create a new clinic in an area where primary care services are already being provided by an RHC, it makes sense that care can be provided to individuals who would be eligible for free or reduced cost care by the RHC subcontracting with a community health center. It would be good if the government provided more support and encouragement for this opportunity through their New Access Point grant funding as well as their instructions to FQHCs.

### **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 does require 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.<sup>3</sup>

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.

## **Future of Health Care**

Additionally, as we move towards the models of Accountable Care Organizations (ACOs), Regional Care Collaborative Organizations (RCCOs), meaningful use, Patient Centered Medical Home (PCMH), and Triple Aim (improving the patient experience of care, improving the health of population, and reducing the per capita cost of health care), the RHCs must be included as an important entity in payment reform. Rural Health Clinics rely on complex and vulnerable funding streams. Mobilizing efforts to ensure *all* safety net providers are recognized and adequately funded is essential to ensuring our ability to continue delivering care to some of the nation's most at-risk residents.

RHCs serve a large portion of the rural safety net and have been excluded from receiving Medicare Meaningful Use incentive funding, even though RHCs are implementing electronic medical records (EMR) and see a large portion of Medicare patients. Many Critical Access Hospitals (CAH) that employ physicians in their provider-based RHCs won't earn Medicare incentives for the EMR purchased for the clinic, since RHCs do not generally qualify for Medicare incentives. Additionally, unless the RHC meets the 30% "needy" patient mix, they are not eligible for the Medicaid incentives.

RHCs are actively engaged in creating synergy for programs and resources. As the environment moves towards Triple Aim, it must be recognized that many RHCs are the main source of primary care in their communities. RHCs are starting to collect quality improvement data and the implementation of EMRs will help with data generation. There is currently a national demonstration project beginning with RHCs to gather, evaluate and implement quality measures. Many State Offices of Rural Health (SORH) are engaging RHCs in programs that centered around PCMH, care coordination, quality improvement, and patient satisfaction. These programs are being implemented because the SORHs are actively seeking funding sources to accomplish this work. However, funding at the federal level needs to be available to move these programs forward to ensure the survival of rural communities and access to healthcare within the community. Attention to the recruitment and retention of providers that represent the underserved minority characteristic of the communities must be emphasized.

## **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 HPSA designations are required under existing rules.<sup>4</sup>

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

updated 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.

Nurse practitioners, physician assistants and certified nurse midwives are required by federal law to be key RHC components in the delivery of primary health care services by RHCs<sup>5</sup> 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. In order to support small rural hospitals, provider-based RHCs owned and operated by hospitals with fewer than 50 beds are exempt from the cost per visit limit.<sup>6</sup> 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, limited by law, 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 governments 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 non-physician medical provider.<sup>7</sup> Although the federal regulations allow an annual exception to these productivity standards, the determination is at the sole discretion of the Medicare Administrative Contractor (MAC). 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 non-physician medical provider, 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 MACs 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, nurse practitioners, physician assistants, certified nurse midwives and other health professionals. Emphasis on training providers that are from and represent the community will improve recruitment and retention of providers that choose and remain to work in RHCs. State and federal support to develop more rural teaching clinics would be beneficial.


## **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. NRHA recommends that federal laws and regulations should be revised to:

- Provide RHCs with federal grant funding programs, because RHCs have no support for ways to improve and increase care to indigent and uninsured populations or recruit minority providers.
- 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 or non-urbanized status 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.
- Update the current regulations so that they are not outdated, which some are now.

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.





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 MLN Matters®Number: MM8119
- 3 Medicare Claims Processing Manual, Chapter 9, §110.2
- 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: (accessed: 11/11/13).

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