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Are Rural Health Clinics Part of the Rural Safety Net?

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The Rural Health Clinic (RHC) is a federally designated primary care provider type that addresses access to primary care in underserved rural areas. RHCs are an important part of the rural health care infrastructure as they provide a wide range of primary care services to the rural residents of 45 states. As defined by the Institute of Medicine (IOM), safety net providers "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations."[1] The IOM did not include RHCs, in its list of core safety net providers despite the fact that RHCs serve vulnerable populations. Patient populations served by RHCs include a high proportion of rural elderly and poor through the Medicare and Medicaid programs. Since RHCs are located in underserved rural areas and serve vulnerable populations (consistent with the IOM's definition), many consider them to be safety net providers. This study examines the role of RHCs as safety net providers. Since the IOM recognizes Community Health Centers (CHCs) as core safety net providers, we hypothesized that RHCs might be more likely to take on the safety net role in areas not served by a CHC, due to greater demand by Medicaid and uninsured patients.

Fast Facts

- 86% of independent RHCs offer free care, sliding fee scales, or both
- 97% were currently accepting new Medicaid/ SCHIP patients
- RHCs' patient mix has a higher proportion of Medicaid/SCHIP patients in counties not served by a federally funded Community Health Center

Table 1 Characteristics of Independent Rural Health Clinics
(n=392, except as noted)

	Total	Confidence Interval
Provide free or discounted care?	336 (86%)	(±3.5%)
Currently accepting free or discount patients	319 (81%)	(±3.9%)
Place limits on free or reduced cost care (n=320)	43 (13%)	(±3.1%)
In past 2 years, free and discounted care same or increased (n=336)	308 (92%)	(±3.0%)
Percent of billings – free, discounted or bad debt (mean, n=270)	13.2%	(±1.7%)
Percent of visits paid by Medicaid (mean) (n=358)	27.3%	(±1.5%)
Accepting new Medicaid/SCHIP patients	382 (97%)	(±1.6%)
Offer language interpreter service	228 (58%)	(±4.9%)
Offer help enrolling in Medicaid/SCHIP	184 (47%)	(±4.9%)
CHC site in same county	206 (53%)	(±4.9%)

To address whether and to what extent independent RHCs are serving a safety net role, or have the capacity to serve that role, we conducted a telephone survey of 392 randomly selected independent RHCs. Response rate for the survey was 93%. We investigated whether and to what extent RHCs offer free or discounted care, serve Medicaid populations, and assist Medicaid-eligible patients to enroll in the program. We also investigate whether the proximity of a federally funded Community Health Center might have an effect on the extent to which an RHC serves the safety net role.

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Table 2. Rural Community Health Center Sites* Providing Primary Care and Rural Health Clinics in Selected States

STATE	TOTAL PRIMARY CHCs	RURAL PRIMARY CHCs	RURAL HEALTH CLINICS
INDIANA	60	3	58
KANSAS	29	14	178
LOUISIANA	67	18	108
MINNESOTA	46	10	82
NORTH DAKOTA	16	12	62
NEBRASKA	16	9	125
OKLAHOMA	30	15	38
SOUTH DAKOTA	32	21	61
UTAH	36	15	18
WISCONSIN	55	18	47
WYOMING	10	5	17
TOTAL FOR USA	5837 *	1586	3782

Many Section 330 grantees operate multiple sites. Rural classification of CHC sites is determined by street address of site. Micropolitan counties are classified as rural.

Eighty-six percent of the RHCs surveyed provide free or discounted care, and an estimated 27% of their visits are from Medicaid patients, while only 47% reported that they help their patients enroll in Medicaid. In addressing the question of whether proximity of a Community Health Center was associated with safety net activities, we began by determining the number of rural CHC sites in each state, and found several rural states that have few rural CHCs. The proximity of a CHC, either in the same county or in the same zip code, was not associated with an RHC offering free or discounted care, but was associated with the percentage of total patient visits attributable to Medicaid patients. Using 30% or more of patients on Medicaid as a threshold, we found that RHCs with a CHC in the same county were significantly less likely to meet this threshold (38%) as compared with RHCs without a CHC in their county (65%).

While it is clear that RHCs were established by Congress to address geographic access to primary care, as opposed to financial access, our findings suggest that some of them are addressing both access barriers. Lacking the grant funds and federal technical assistance provided to CHCs to build service capacity, few RHCs have had the resources to expand their scope of services. The Affordable Care Act has made it clear that partnering with CHCs is an option for RHCs that find themselves serving safety net populations. More study is needed laying out the details of such arrangements, the reimbursement and governance implications, and the relative advantages and disadvantages from the perspectives of the CHC, the RHC, the physician, and, especially, the patient.

* The Bureau of Primary Health Care currently lists over 7000 CHC sites. In addition to program expansion, the difference between our count of CHC sites and that of the BPHC is due, in part, to sites that do not provide sufficient primary care services to be considered a primary care medical home. These include sites delivering dentistry only, those delivering services to the homeless, and several other service categories. The difference is also due, in part, to sites which we could not identify as urban or rural, due to an incomplete or ambiguous address.

References

1. Institute of Medicine. *America's Health Care Safety Net: Intact but Endangered.* Washington, DC: National Academy Press; 2000.

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