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## INTRODUCTION

The Rural Health Clinic (RHC) Program is one of the nation's oldest rural primary care programs. Created in December 1977 by Public Law 95-210 - The Rural Health Clinic Services Act,[1] the RHC Program was designed to address geographic access barriers experienced by Medicare and Medicaid populations living in rural underserved areas.[1] A key feature of the RHC Program has been Medicare and Medicaid volume-appropriate, cost-based reimbursement designed to sustain these vulnerable rural primary care providers. Medicare currently pays RHCs for the lesser of reasonable costs (expressed as an adjusted cost per visit or ACPV)* for a defined package of RHC services or a per-visit reimbursement cap, from which provider-based RHCs owned by hospitals with fewer than 50 beds are exempt.[2] Although the per-visit cap is updated periodically, RHC administrators, policymakers, and stakeholders question whether the updates have allowed RHCs to keep pace with increases in staffing and other costs.[3] This brief explores this issue by examining the costs of RHCs relative to Medicare payment limits for different types and sizes of RHC providers.

## BACKGROUND

***What is an RHC?*** RHCs are an important source of primary care in rural communities with over 4,200 RHCs delivering primary care services and promoting health, wellness, and disease prevention for rural residents in 44 states.[4,†] To improve access to primary health care for rural Medicare and Medicaid beneficiaries, the RHC Program requires RHCs be staffed at least 50 percent of the time by an advanced practice clinician (i.e. nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM)). The program also provides cost-based reimbursement to ensure financial stability, especially for smaller, low volume clinics.[1] RHCs may operate as either independent or provider-based facilities. An independent RHC is a freestanding clinic or office-based practice that may be a for-profit, not-for profit, or publicly-owned (e.g., municipal or county) facility. A provider-based RHC operates as an integral and subordinate part of a hospital, skilled nursing facility, or home health agency participating in the Medicare program.[2] For provider-based RHCs, hospital ownership is the norm and so most provider-based RHCs reflect the ownership structure of their parent hospitals as either not-for-profit or publicly owned facilities. Most RHCs provide general family practice and primary care services; some focus on pediatrics or obstetrics and gynecologic services and, hence, are more heavily reliant on Medicaid rather than Medicare reimbursement.[1]

### Key Findings

In 2014, Medicare's reimbursement cap covered 42 to 77 percent of the total Medicare adjusted cost per visit (ACPV) for Rural Health Clinic (RHC) services, depending on provider type, visit volume, ownership, and applicability of the cap.

Independent RHCs reported lower mean ACPVs than did provider-based RHCs which reflect the lower direct and overhead costs of independent clinics.

Small and extra-large RHCs, regardless of provider type, reported higher mean ACPVs than did medium and large clinics.

Compared with larger clinics, small independent and provider-based RHCs rely more on physician assistants and nurse practitioners to provide services than physicians.

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*The ACPV represents a clinic's total allowable Medicare cost for RHC services divided by its total adjusted visits.

†As of December 2017, Alaska, Connecticut, Delaware, Maryland, New Jersey, and Rhode Island had no RHCs.

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***How are RHCs paid by Medicare?*** RHCs are reimbursed by Medicare for the reasonable costs of a defined package of "RHC core services".‡ This package of outpatient primary care services includes: (1) professional services provided by a physician, NP, PA, CNM, and/or nurse; (2) other services and supplies provided during a clinic visit; (3) visiting nurse services to the homebound; (4) clinical psychologist and social worker services; and (5) services and supplies incident§ to the provision of care.[2] The Rural Health Clinic Act established Medicare and Medicaid cost-based reimbursement using a bundled all-inclusive rate (AIR), expressed as a calculated average adjusted cost per visit up to a defined reimbursement cap.[2] Originally, this cap applied only to independent RHCs. However, significant growth in the number of RHCs during the early to mid-1990s triggered concerns about the rising costs of the program. In response, the Balanced Budget Act of 1997 extended the reimbursement cap to provider-based RHCs attached to rural hospitals with 50 or more beds (but not to provider-based clinics attached to hospitals with fewer than 50 beds).[1,3,5]

CMS uses productivity standards to determine the average cost per visit for Medicare reimbursement in RHCs (4,200 visits for full-time equivalent (FTE) physicians and 2,100 visits for FTE NPs, PAs, and CNMs). Other RHC providers (i.e., clinical psychologists, clinical social workers, visiting nurses, and clinicians providing services under agreement) are not subject to these productivity standards.[2] At the end of each cost reporting year, the Medicare Administrative Contractor (MAC) reconciles the total amount paid to an RHC during the year (based on the clinic's estimated AIR) to its actual allowable costs and provider productivity (the greater of the actual patient visits or the minimum productivity standard) as reported on its cost report.

Despite the provision of Medicare and Medicaid cost-based reimbursement and expanded coverage for NPs and PAs, participation in the RHC Program lagged behind congressional expectations during its early years (1977 through 1990).[1,3,6] Numerous reasons offered for this early slow growth include: the cap on per-visit reimbursement (which many providers thought to be too low); conflicting state laws limiting the use of NPs and PAs; concerns regarding the complexity of the cost reporting and certification processes; a limited awareness of the program; and concerns by states about the potential Medicaid cost impacts.[1,5,7,8,9]

In response to these concerns, Congress twice increased the RHC Program reimbursement cap prior to 1987,[3,5] and the Omnibus Budget Reconciliation Act of 1987 tied annual increases to the Medicare Economic Index.[3,5,10] Congress passed amendments to modify productivity standards used to calculate the ACPV (1989 and 1990); add the services of doctoral psychologists (1987), CNMs (1989), and clinical social workers (1989) to the package of RHC core services; exclude diagnostic tests (except selected laboratory services) from the all-inclusive reimbursement rate (1992); ease the administrative burden; promote technical assistance; and, increase awareness of the program.[1,5] States also addressed scope of practice barriers to expand the use of NPs, PAs, and CNMs.[9] These changes, along with the changing economics of primary care practice (e.g., implementation of the Medicare resource-based relative scale payment system, growing provider and overhead costs, stagnant Medicaid payment rates, and implementation of fee schedules by private payers) drove a 650 percent growth in the number of clinics between 1990 and 1995. By September 1999, the number of RHCs in operation had grown to 3,477.[1,3,5] Since then, participation in the RHC Program has grown at a more moderate pace to more than 4,200 RHCs in operation as of December 2017.[4]

## APPROACH

This study was undertaken to address the following research questions:

- How does CMS' reimbursement cap compare to the actual ACPV reported by RHCs?
- Are there variations in ACPV across RHC provider types, sizes, and organizational types?
- What cost components are associated with observed variations in ACPV across different types of RHCs?

***Data sources***: This study used Medicare cost reports for independent (Form CMS 222-92) and provider-based (Form CMS 2552-10, Worksheet

‡Services rendered by RHC providers not part of the defined package of RHC services (e.g., inpatient hospital visits or telehealth originating site fees) are reimbursed separately under the Medicare Part B Physician Fee Schedule.

§ "Incident to" services are services performed or supplies provided under the direction of an appropriate provider's treatment plan during the course of a professional service (e.g., chemotherapy administration, the professional component of radiology services, minor surgery, or setting casts).

M) RHCs for the fiscal year 2014 (with fiscal year dates between October 1, 2013 through September 30, 2014). The fiscal year RHC cost report data files are updated quarterly as individual cost reports are cleared and settled. The fiscal year 2014 data files were downloaded March 24, 2017, including all RHC Medicare cost report worksheets required for provider identification and calculation of the mean ACPV and the mean costs per visit for each of the cost centers.

Our initial download of RHC cost reports for the period ending December 31, 2014 contained records for 3,786 clinics. Of these, 472 clinics reported zero patient visits during the cost reporting period and were excluded from our analyses. We also excluded 160 cost report records with duplicate CMS Certification Numbers (formerly known as the Medicare Provider Number) representing 77 clinics, and 15 records with data quality issues. This resulted in a final analytic file representing 3,139 RHCs (1,235 independent and 1,904 hospital-based clinics). We linked these data to the December 2015 CMS Provider of Services File to obtain information on ownership type (i.e., private/for-profit, non-profit/publicly owned) and certified bed counts for provider-based clinics' parent hospitals.

***Variables:*** The primary variables for this analysis include the summary cost categories and visit data used to calculate the ACPV on the Medicare cost reports. (See the Appendix for a detailed definition of these variables.) These variables allowed us to identify the contribution of each cost category to the mean ACPV for all RHCs. They also allowed us to examine the cost factors contributing to variations in mean ACPV across different types of RHCs. These variables include:

- Total adjusted visits;
- Health care staffing costs for the different categories of employed RHC clinical staff;
- Contracted provider costs;
- Other health care costs (e.g., medical supplies, professional liability);
- Facility overhead costs (e.g., rent, interest on mortgages, housekeeping, utilities);
- Administrative overhead (e.g., office salaries, legal and accounting expenses); and
- Overhead of the parent provider attributed to provider-based RHCs.

***Analyses***: We separately analyzed the ACPV and related cost centers across RHC provider types (independent vs. provider-based clinics). This analysis reflected differences in organizational operations, oversight, and overhead allocation between independent and provider-based clinics. We also analyzed the ACPV across different sized clinics (i.e., small, medium, large, and extra-large) based on their visit volume.[**] Finally, we examined the ACPV by ownership type (private/for-profit vs. non-profit/publicly owned) for independent RHCs[††] and whether or not they are subject to the reimbursement cap for provider-based RHCs.

***Limitations***: The total number of RHCs in this study is smaller than the universe of operating clinics for several reasons. In addition to the clinic exclusions discussed in the methods section, the smaller sample reflects the fact that some RHC multi-clinic systems (both independent and provider-based) file consolidated cost reports that do not provide financial data for each clinic separately. These systems report statistical data (e.g., staffing, location, etc.) separately for each clinic, but a single set of combined financial data for all clinics. A single ACPV is calculated that applies to services provided by all system clinics. As a result, we treated the financial information for each system filing a consolidated cost report as a single record.[§§] Additionally, some RHCs may file for an extension on their cost reports, further limiting our sample size.

Another potential limitation results from possible accounting errors in the self-reported raw data that may affect our results. While we conducted data check analyses to identify outliers and ensure

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[**]To divide clinics into size categories and identify outliers, we used Tukey's method of leveraging the Interquartile Range.[11] We established fences at the values located at Q1-1.5(Q3-Q1) and Q3+1.5(Q3-Q1) to categorize clinics as small, medium, and large. We identified 213 outlier clinics with exceptionally large numbers of visits. To avoid skewing the results, we created a separate extra-large size category for our analysis. The following is our grouping of clinics by number of visits: small (1 – 4,782 visits); medium (4,783 – 9,833 visits); large (9,834 – 28,466 visits); and extra-large (28,467 or more visits).

[††]We did not analyze provider-based RHCs by ownership type as 91 percent operate under non-profit or publicly owned hospitals.

[§§]Among the 1,904 provider-based RHCs in our study, 116 filed consolidated reports representing 364 clinics (ranging from two to fourteen clinics per consolidated file). Eighty-two percent of this group reported a range of two to six clinics per system. Among the 1,235 independent RHCs, 141 filed consolidated reports representing 430 clinics (ranging from two to thirteen clinics). Eighty-one percent reported a range of two to six clinics per system.

## Table 1. Rural Health Clinic Mean Medicare Adjusted Cost per Visit, 2014

| | | N | Total Adjusted Visits | Adjusted Cost per Visit (ACPV) | Difference Between ACPVs and 2014 RHC Cap of $79.80 | % of ACPV Covered by the 2014 RHC Cap |
|---|---|---|---|---|---|---|
| Independent RHCs | | 1,235 | 12,547 | $112.12 | $32.32 | 71% |
| *Size* | Small | 340 | 2,994 | $124.80 | $45.00 | 64% |
| | Medium | 400 | 7,003 | $106.72 | $26.92 | 75% |
| | Large | 391 | 15,946 | $106.37 | $26.57 | 75% |
| | Extra-large | 104 | 52,330 | $113.06 | $33.26 | 71% |
| *Owner-ship* | Private/for profit | 886 | 12,595 | $104.00 | $24.20 | 77% |
| | Non-profit/publicly owned | 348 | 12,430 | $132.81 | $53.01 | 60% |
| Provider Based RHCs | | 1,904 | 10,616 | $176.73 | $96.93 | 45% |
| *Size* | Small | 632 | 2,555 | $189.52 | $109.72 | 42% |
| | Medium | 577 | 7,033 | $168.16 | $88.36 | 47% |
| | Large | 580 | 16,124 | $169.53 | $89.73 | 47% |
| | Extra-large | 115 | 45,118 | $185.70 | $105.90 | 43% |
| *Cap Status* | ≥ 50 beds (subject to cap) | 449 | 11,994 | $162.51 | $82.71 | 49% |
| | < 50 beds (exempt from cap) | 1,453 | 10,198 | $181.09 | NA | NA |

Source: Medicare Cost Report Data, 2014

that the data calculated correctly, we are unable to determine the appropriateness of all of the data entered in any given field.

## FINDINGS

### *Comparison of the Adjusted Cost per Visit (ACPV) to the Reimbursement Cap*

Across our different categories of analysis, RHCs subject to the reimbursement cap consistently reported mean ACPVs that exceeded the 2014 reimbursement cap of $79.80 per visit (Table 1). As a result, these clinics are being reimbursed by Medicare at a rate that is less than their calculated costs of serving Medicare beneficiaries. Among RHCs subject to the reimbursement cap (independent clinics and provider-based clinics owned by 50 or more bed hospitals):

- Independent RHCs reported lower mean ACPVs ($112.12) than did their provider-based counterparts ($176.73).
- Among independent RHCs, the 2014 reimbursement cap accounted for 64 percent of the mean ACPV reported by small clinics, 71 percent for extra-large clinics, and 75 percent for medium and large clinics.
- Private/for-profit independent clinics reported lower mean ACPVs ($104.00) than did non-profit/publicly owned clinics ($132.81).
- Among provider-based RHCs, clinics subject to the reimbursement cap reported lower mean ACPVs ($162.51) than did those exempt from the cap ($181.09).
- When analyzed by the volume of visits, small independent and provider-based RHCs, regardless of whether or not they are subject to the reimbursement cap, had higher ACPVs than other sized clinics which is likely a reflection of the diminished economies of scale associated with offering a low-volume service.
- Extra-large clinics had higher ACPVs than medium and large clinics.

We examine the factors associated with these variations in the next section.

### *RHC Cost Center Analysis*

Table 2 presents an analysis of the variations in mean ACPVs across different types and sizes of RHCs by calculating the cost per visit for the cost centers that make up the total ACPV. The differences in the mean ACPVs for independent and provider-based RHCs are a function of lower Total Costs of RHCs Services Excluding Overhead (which are the direct costs of providing these services including health care staffing, contracted staff, and related operating costs such as medical supplies, depreciation of medical equipment, and/or professional liability coverage) and the Total

Overhead Costs Applicable to RHC Services (i.e., the facility and administrative costs) reported by each type of clinic:

- Independent clinics reported lower direct costs of providing RHC services ($65.18 per visit) than provider-based clinics ($93.72) as well as lower overhead costs applicableto RHC services ($49.62 per visit) than provider-based clinics ($86.31).
- Within the overhead category, provider-based clinics' overhead includes a portion of the Parent Provider Overhead Attributed to the Facility, which adds an additional mean per-visit overhead cost of $65.62.‡‡
- Among independent clinics, extra-large RHCs reported the highest per-visit direct costs of providing RHC services compared to small, medium, and large RHCs, while small clinics reported the highest overhead costs compared to their medium, large, and extra-large peers.
- A similar pattern held true for provider-based RHCs with extra-large clinics reporting the highest per-visit direct costs of providing RHC services and small reporting the highest overhead costs compared to other size clinics.
- Non-profit/publicly owned independent clinics reported higher direct costs of providing RHC services and overhead than did their private/for-profit counterparts.
- Provider-based clinics exempt from the cap reported higher direct costs of providing RHC services than did clinics subject to the cap and slightly higher overhead costs.

### *Variations in RHC Healthcare Staffing Costs*

Table 3 provides an analysis of the variations in per-visit Health Care Staff Costs across the different types and sizes of RHCs in our analysis.

- Independent RHCs reported lower staff costs for physicians, NPs and PAs, visiting and other nurses, laboratory technicians, and other health care staff than did provider-based clinics.
- Physician costs per visit were higher than NP and PA costs across all sizes of clinics, regardless of provider type, with the exception of small independent and provider-based clinics.
- Small independent and provider-based clinics reported higher NP and PA costs per-visit ($27.80 and $32.33 respectively) than physician costs per-visit ($12.39 and $21.42 respectively), suggesting that these small clinics depend more heavily on NPs and PAs to provide services than physicians.
- In general, physician costs per visit increase and NP and PA costs per-visit decline as clinic size increases.
- Non-profit/publicly owned independent RHCs reported higher staffing costs than their private/for-profit counterparts, with the exception of costs per-visit for psychologists and social workers which were similar.
- Provider-based clinics exempt from the cap reported higher physician, NP and PA, visiting nurse, and other health staffing costs and lower costs for psychologists and social workers as well as lab techs than those subject to the cap.

## DISCUSSION AND POLICY IMPLICATIONS

In 2017, the National Advisory Committee on Rural Health and Human Services (NACRHHS) raised concerns about the viability of RHCs subject to the reimbursement cap, noting that RHC staff and stakeholders were concerned that these clinics were being paid less than their actual costs.[3] The NACRHHS concluded that the cost-based methodology used to determine the costs of RHC services under Medicare is outdated and suggested that the 2014 Medicare prospective payment system (PPS) methodology now used to reimburse Federally Qualified Health Centers (FQHCs) appears to better align services and costs than the previous cost-based payment methodology used for both RHCs and FQHCs.[3] Accordingly, the NACRHHS recommended that the Secretary:

*"Work with Congress to obtain authority to reexamine and pursue a change in the statute to adjust the payment cap for RHCs. In doing so, the Committee urges the creation of a formula for payments that ties payment cap increases to the current average cost per visit for RHCs under the cap."*[3, p.2]

This study indicates that the reimbursement cap consistently fell short of covering the actual cost of providing RHCs services (as measured by the

‡‡Parent hospitals report the costs for their provider-based RHCs using Worksheet M of Form CMS-2552-10 – Hospital and Hospital Health Care Complex Cost Report. A portion of the parent's overhead may be allocated to the RHC through a step-down allocation process used to allocate its overhead to other patient care service departments. These overhead costs may include administrative and general support, housekeeping, plant operations, health information management, capital, and depreciation costs.

ACPV) across the different categories of clinics used in our analysis. The cap covered between 42 percent and 77 percent of the reported mean ACPVs depending on clinic type, size, organizational structure, and application of the reimbursement cap. This analysis also highlights the cost factors contributing to variations in the ACPV across different types and sizes of clinics. Of particular note are higher costs among small and very large clinics, suggesting the importance of economies of scale in the design and operation of RHCs. In the case of small clinics, higher costs are mitigated, in part, by different staffing patterns compared with larger clinics, with small clinics relying more heavily on NP and PA versus physician staffing. Among the extra-large clinics, differences in service mix and/or diseconomies of scale may contribute to their substantially higher costs.

RHCs remain an important part of the rural healthcare infrastructure with more than 4,200 clinics providing services to rural residents in 44 states at the end of 2017. While our data indicate that most RHCs subject to the reimbursement cap have costs that exceed the cap, this analysis raises two questions that cannot be addressed without further study. First, how are RHCs that are being paid less than their Medicare costs able to provide services to Medicare beneficiaries and remain viable? Second, what conclusions can be drawn about the appropriateness of the variation in costs across RHCs in terms of setting RHC payment policy?

Unfortunately, we cannot address either of these two questions without further detailed study requiring data that are not easily available. We cannot draw definitive conclusions regarding all of the factors that may be affecting the costs of these RHCs or the appropriateness of those costs as reported by different types and sizes of RHCs. For example, we know very little about the operating and cost efficiencies of different types of RHCs and RHCs with different patient volumes. Likewise, we know little about how RHC costs are affected by differences in the acuity and complexity of patients treated, the range of services provided, the degree of access to care provided for vulnerable populations, and the cost of providing services in remote and frontier areas. Studies to address these questions would require use of all payer claims data as well as clinic-level operating, financial, provider, payer mix, staffing, quality, and patient data. The lack of available data on RHCs, particularly this latter category of information on clinic-level operations, complicate the ability to undertake studies to answer these questions.

Policymakers, providers, and rural stakeholders would benefit from a better understanding of how the current costs reported by RHCs are affected by these factors. In addition, we need to know more about how workforce recruitment and retention challenges and community-level factors (e.g., high rates of poverty and uninsurance) may be affecting RHC costs. At the same time, it would be useful to examine the shift to Medicaid PPS reimbursement (from the previous cost-based methodology) for RHCs effective January 1, 2001, and the lessons learned from the implementation of Medicare PPS reimbursement for FQHCs on October 1, 2014. Little information is available on the impact of the change in RHC Medicaid reimbursement rates. Research into this issue and the impact of Medicare's PPS reimbursement methodology for FQHCs would inform the development of payment methods to better align RHC services and costs and support RHCs in meeting the primary care needs of vulnerable rural communities.

This preliminary study of the costs of serving Medicare beneficiaries using cost-report data supports the NACRHHS's conclusion that the cost-based methodology used to determine the costs of RHC services under Medicare is outdated as well as concerns that RHCs subject to the reimbursement cap are being paid at less than their actual costs. However, additional studies, as discussed above, are needed to support RHC payment reform and to support the RHC Program's goal of improving access to primary care services for vulnerable Medicare and Medicaid beneficiaries in rural underserved areas.

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## Table 2. Rural Health Clinic Mean Costs per Visit by RHC Cost Centers, Medicare, 2014

| | | Total Adjusted Visits | Adjusted Cost (ACPV) | Health Care Staff Costs | Provider Costs Under Agreement | Other Health Care Costs | Total Costs of RHC Services Excluding Overhead | Facility Overhead Costs | Facility Administrative Overhead Costs | Parent Provider Overhead Attributed to the Facility | Total Overhead Costs Applicable to RHC Services * | Less: Per-Visit Vaccine Costs + |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Independent RHCs | | 12,547 | $112.12 | $54.90 | $2.27 | $8.01 | $65.18 | $11.13 | $43.72 | NA | $49.62 | ($2.19) |
| *Size* | Small | 2,994 | $124.80 | $55.44 | $3.60 | $8.26 | $67.29 | $14.68 | $53.02 | NA | $60.23 | ($2.22) |
| | Medium | 7,003 | $106.72 | $52.12 | $1.94 | $7.24 | $61.31 | $10.57 | $40.45 | NA | $47.77 | ($1.86) |
| | Large | 15,946 | $106.37 | $54.99 | $1.87 | $8.26 | $65.12 | $8.95 | $38.25 | NA | $44.02 | ($2.28) |
| | Extra-large | 52,330 | $113.06 | $63.50 | $0.65 | $9.26 | $73.40 | $9.90 | $46.45 | NA | $43.09 | ($2.97) |
| *Ownership* | Private/for profit | 12,595 | $104.00 | $50.63 | $2.10 | $7.64 | $60.37 | $10.01 | $38.79 | NA | $45.97 | ($1.85) |
| | Non-profit/ publicly owned | 12,430 | $132.81 | $65.79 | $2.70 | $8.97 | $77.46 | $13.99 | $56.26 | NA | $58.90 | ($3.05) |
| Provider Based RHCs | | 10,616 | $176.73 | $76.30 | $8.11 | $9.31 | $93.72 | $4.94 | $16.27 | $65.62 | $86.31 | ($2.80) |
| *Size* | Small | 2,555 | $189.52 | $79.38 | $6.10 | $10.93 | $96.41 | $7.89 | $18.62 | $70.27 | $96.29 | ($2.67) |
| | Medium | 7,033 | $168.16 | $74.47 | $7.59 | $7.99 | $90.05 | $4.04 | $15.42 | $62.61 | $81.53 | ($2.93) |
| | Large | 16,124 | $169.53 | $73.68 | $10.50 | $8.70 | $92.88 | $2.99 | $14.60 | $62.83 | $79.96 | ($2.81) |
| | Extra-large | 45,118 | $185.70 | $81.75 | $9.79 | $10.09 | $101.63 | $3.13 | $16.08 | $69.33 | $87.40 | ($2.84) |
| *Cap Status* | ≥ 50 beds (subject to cap) | 11,994 | $162.51 | $63.24 | $8.54 | $8.49 | $80.26 | $6.07 | $17.92 | $62.59 | $85.77 | ($3.00) |
| | < 50 beds (exempt from cap) | 10,198 | $181.09 | $80.35 | $7.99 | $9.57 | $97.91 | $4.58 | $15.76 | $66.53 | $86.42 | ($2.74) |

Source: Medicare Cost Report Data, 2014

* The sum of Facility Overhead Costs and Facility Administrative Overhead Costs (which combined represent the total overhead costs) do not equal the Total Overhead Costs Applicable to RHC Services. This is due to a step-down process used to allocate the portion of the total overhead costs that are applicable only to RHC services for purposes of calculating the Medicare ACPV.

+ ACPV is the sum of the Total Costs of RHC Services Excluding Overhead and Total Overhead Costs Applicable to RHC Services less Per-Visit Vaccine Costs.

## Table 3. Rural Health Clinic Mean Medicare Healthcare Staff Costs Per Visit by Staffing Cost Category, 2014

| | | Total Adjusted Visits | Health Care Staff Costs | Physician Net Expenses | NP and PA Net Expenses | Psychologist and Social Worker Net Expenses | Visiting Nurse and Other Nurse Net Expenses | Lab Tech Net Expenses | Other Healthcare Staff Net Expenses |
|---|---|---|---|---|---|---|---|---|---|
| Independent RHCs | | 12,547 | $54.90 | $21.91 | $18.76 | $0.25 | $10.06 | $0.19 | $3.69 |
| *Size* | Small | 2,994 | $55.44 | $12.39 | $27.80 | $0.08 | $10.87 | $0.16 | $4.08 |
| | Medium | 7,003 | $52.12 | $21.18 | $17.40 | $0.24 | $9.36 | $0.25 | $3.62 |
| | Large | 15,946 | $54.99 | $27.12 | $14.13 | $0.38 | $9.70 | $0.20 | $3.44 |
| | Extra-large | 52,330 | $63.50 | $36.23 | $11.85 | $0.31 | $11.42 | $0.03 | $3.60 |
| *Ownership* | Private/for profit | 12,595 | $50.63 | $20.59 | $17.43 | $0.26 | $8.91 | $0.15 | $3.25 |
| | Non-profit/publicly owned | 12,430 | $65.79 | $25.28 | $22.17 | $0.22 | $13.00 | $0.30 | $4.77 |
| Provider Based RHCs | | 10,616 | $76.30 | $30.12 | $21.97 | $0.26 | $12.25 | $0.29 | $11.40 |
| *Size* | Small | 2,555 | $79.38 | $21.42 | $32.33 | $0.16 | $13.47 | $0.36 | $11.63 |
| | Medium | 7,033 | $74.47 | $30.56 | $19.76 | $0.26 | $11.74 | $0.35 | $11.81 |
| | Large | 16,124 | $73.68 | $36.48 | $14.53 | $0.30 | $11.54 | $0.18 | $10.65 |
| | Extra-large | 45,118 | $81.75 | $43.73 | $13.67 | $0.62 | $11.71 | $0.11 | $11.91 |
| *Cap Status* | ≥ 50 beds (subject to cap) | 11,994 | $63.24 | $22.93 | $19.54 | $0.38 | $9.45 | $0.55 | $10.38 |
| | < 50 beds (exempt from cap) | 10,198 | $80.35 | $32.34 | $22.73 | $0.22 | $13.12 | $0.21 | $11.74 |

Source: Medicare Cost Report Data, 2014

## Appendix. Variables Used in Our Analysis

We identified two categories of variables for use in this analysis. The first includes the summary cost categories and productivity variables used to calculate the ACPV on the Medicare Cost Report form. The second includes RHC characteristics likely to influence variations in the ACPV.

Summary Cost and Visit Variables Used to Calculate ACPV (from the Medicare Cost Report)

**Total Adjusted Visits**: The greater of actual patient visits recorded by the RHC's applicable providers (i.e. physicians, NPs, PAs, and/or CNMs) or the minimum productivity standard defined by CMS. This number is used as the denominator for the calculation of the ACPV.

**Adjusted Cost Per Visit (ACPV)**: The total allowable Medicare cost for RHC services provided by a clinic divided by its total adjusted visits.

**2014 RHC Cap**: The cap on reimbursements established annually by CMS which was $79.80 per visit for 2014.

**Health Care Staff Costs**: The total cost for all clinical staff providing services at an RHC Physician, NP and PA, Psychologist and Social Worker, Visiting Nurse and Other Nurse, Lab Tech, and Other Health Care Staff Net Expenses – the costs for each of these categories of clinical staff employed by RHCs which, when added together, represent the Total Health Care Staff Costs for each clinic.

**Provider Costs Under Agreement**: The cost for providers under contract to provide clinic services or supervision as opposed to employees of the clinic.

**Other Health Care Costs**: Costs related to the delivery of services including medical supplies, transportation for staff, depreciation for medical equipment, professional liability, and other costs.

**Total Cost of RHC Services Excluding Overhead**: The sum of health care staff costs, provider costs under agreement and other health care costs.

**Facility Overhead Costs**: Costs of operating the RHC including rent, insurance, interest on mortgages or loans, utilities, depreciation on building, fixtures, and equipment, housekeeping, maintenance, property taxes, and other costs.

**Facility Administrative Overhead Costs**: Office salaries, depreciation on equipment, supplies, legal and accounting expenses, insurance, telephones, fringe benefits, payroll taxes, and other costs.

**Parent Provider Overhead Attributed to the Facility**: Overhead costs for the parent provider attributed to the RHC including administrative/general support, housekeeping, plant operations, health information management, capital, and depreciation.

**Total Overhead Costs Applicable to RHC Services**: The portion of overhead costs directly attributable to the delivery of RHC services.

**Per-Visit Vaccine Costs**: The per-visit cost of providing pneumococcal and influenza vaccines which are not reimbursable to RHCs under their all-inclusive rate.

RHC Characteristics Related to Variations in ACPV

**Provider Type**: Either independent or provider-based as classified by CMS. Independent RHCs may be for-profit, not-for-profit, or publicly owned entities. Provider-based RHCs are owned and operated under the licensure, governance, and professional supervision of a hospital, nursing home, or home health agency. The vast majority are hospital-owned.

**Clinic Size**: Clinics are assigned to one of four size groups (small, medium, large, or extra-large) based on the volume of visits.

**Ownership Type**: The organizational ownership structure of the clinic as reported in the CMS Provider of Services file (private/for-profit or non-profit/publicly owned).

**Applicability of Reimbursement Cap**: Indicates whether or not the clinic is subject to the CMS reimbursement cap on the per-visit costs of providing services. Independent and provider-based clinics owned by hospitals with 50 or more beds are subject to the reimbursement cap. Provider-based clinics owned by hospitals with 49 or fewer beds are exempt from the cap.