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The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook

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The Characteristics and Roles of Rural Health Clinics in the United States:

A Chartbook

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The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook

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Executive Summary

Overview

Public Law 95-210, the Rural Health Clinic Services Act, was passed by Congress in December 1977 in an effort to increase the availability and accessibility of primary care services for residents of rural communities. The Act provided for cost-based Medicare and Medicaid reimbursement to qualified Rural Health Clinics for a defined set of core services and expanded Medicare and Medicaid coverage for services provided by nurse practitioners (NPs) and physician assistants (PAs), even when delivered at a clinic in the absence of a physician. Subsequent amendments to the act added certified nurse midwives (CNMs), clinical psychologists, and clinical social workers to the list of core providers whose services are eligible for cost-based reimbursement.

To be eligible for participation in the Rural Health Clinics program, a facility has to apply for and become certified as a Rural Health Clinic (RHC). To qualify for certification, a facility must be located in an area defined by the U.S. Census Bureau as nonurbanized (e.g., an area with a population of less than 50,000) and designated by the U.S. Department of Health and Human Services as having a shortage of personal health care services or primary care medical services. In addition, facilities must meet relevant requirements involving physical plant, personnel credentials and staffing, licensure, governing policies, medical services, and referral arrangements before it can be certified for participation in the program. Under the original terms of the Rural Health Clinic Services Act, a clinic that was successfully certified as an RHC maintained its certification as an RHC regardless of changes to the rural status or shortage area designation of the area in which it is located. This "grandfathering" provision was designed to protect the status of clinics whose presence in an area could jeopardize its shortage area designation. Although the Balanced Budget Act of 1997 contained provisions to refine the shortage area requirements that apply to RHCs, thereby effectively eliminating this grandfathering provision, the final regulations implementing those provisions have not been promulgated as of the date of this publication.

Although Congress had anticipated widespread participation in the program when it passed the Rural Health Clinic Services Act in 1977, participation lagged

behind those initial expectations during the first 13 to 15 years of the program. Over time, Congress passed a number of amendments to address some of the perceived problems inherent in the original legislation and to boost participation. The changes to the program, in combination with changes in the rural practice environment during the late 1980s and early 1990s, served to make the it a more attractive option for rural providers. As a result, participation in the program grew rapidly during the mid-1990s. According to data released by the U.S. Office of the Inspector General in 1996, participation in the program grew by over 650 percent from the end of 1990 (when there were 314 clinics) through October 1995 (when there were 2,350 RHCs). At the beginning of our study in September 1999, we identified 3,477 operational RHCs.

Along with this growth in the number of clinics came a corresponding growth in the level of Medicare and Medicaid expenditures. This growth drew the attention of Medicare and Medicaid officials as well as the U.S. Office of the Inspector General (OIG) and the U.S. General Accounting Office (GAO). The OIG and GAO released reports in 1996 that questioned the extent to which the RHC program actually improved access for underserved populations in rural communities. A 1997 study conducted by Mathematica Policy Research refuted a number of the findings in these reports. The OIG and GAO studies have been criticized as they were based on relatively small numbers of RHCs and used an interpretation of the program's goals that was more rigorous than the original legislation. In an effort to obtain up-to-date information on the characteristics and operations of RHCs nationally, the federal Office of Rural Health Policy commissioned the survey upon which this chartbook is based.

Methods

Using data from the Center for Medicare and Medicaid Services Online, Survey, Certification, and Reporting (OSCAR) database, we selected a random sample of Rural Health Clinics evenly stratified between independent and provider-based clinics. These clinics were surveyed using a mailed survey instrument. Data obtained from the survey and the OSCAR database were supplemented with data on the characteristics of the counties in which RHCs are located, as drawn from the 2000 Area Resource File. Further analysis on the rurality of the communities in which RHCs are located was conducted using the Rural Urban Commuting Area Codes developed by the WWAMI Rural Health Research Center at the University of Washington.

Findings

- Most RHCs continue to serve rural, underserved communities. Close to 99 percent are located in rural areas as defined by the Rural Health Clinic Services Act.[1] Over 97 percent are located in areas that are currently designated as having a shortage of primary care services.[2]

- Over 81 percent of the zip codes in which RHCs are located have only one RHC located with them.

- RHCs are serving a valuable safety net role with services rendered to Medicaid, uninsured, self-pay, and free/reduced-cost care patients accounting for 45 percent of their overall volume.

- RHCs are also an important source of free- and reduced- cost care in their communities — as 36 percent of independent clinics and 29 percent of provider-based clinics reported that they wrote off between 5 and 14 percent of their total charges as free- and reduced- cost care. Another 51 percent of independent clinics and 55 percent of provider-based clinics reported that they wrote off up to 4 percent of total charges as free- and reduced- cost care.

- Recruitment and retention is a problem for many RHCs, as 18 percent of survey respondents reported a physician vacancy during the past year and 20 percent reported a NP, PA, or CNM vacancy during the same period. Of those RHCs with physician vacancies, 77 percent indicated that they had difficulty filling the position. Forty-nine percent with NP, PA, or CNM vacancies reported difficulty in finding a clinician to fill their positions.

- Some RHCs continue to face financial challenges despite cost-based reimbursement. Independent RHCs reported that, on average, total expenses exceeded total revenues by $40,505. Provider-based RHCs reported that their total expenses exceeded total revenues by $38,441 during their most recently completed fiscal year. The adjusted cost-per-visit, reported by both independent ($66.31) and provider-based ($81.01) RHCs, exceeded the cap on per-visit reimbursement that applied to independent clinics and provider-based clinics owned by hospitals of 50 or more beds in both 1999 ($60.40) and 2000 ($61.85).

- Among the survey respondents, 0.12 percent employ a clinical psychologist and 0.07 percent employ a clinical social worker. This represents a missed opportunity to add an important service needed in most rural communities.

- Under the proposed rules implementing the shortage area refinements mandated by the Balanced Budget Act of 1977, 1.5 percent of RHCs may potentially lose their certification due to the loss of their rural status.[1] Slightly less than 3 percent are at risk due to the loss of the shortage area designation for the area in which they are located, unless they can qualify for an exception as an essential provider.[2] Further study is needed to understand the full impact of the proposed regulations on the RHC program and on access to services in the communities in which at-risk clinics are located.

- Similarly, the impact of the Medicaid prospective payment system mandated by the Benefits Improvement and Protection Act of 2000 and implemented effective January 1, 2001, requires further study to estimate the impact on the financial status of RHCs.

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[1] The Rural Urban Commuting Area Codes (RUCA) used to describe the rurality of the communities in which RHCs are located is based on 1990 Census data. As the process of updating the RUCA taxonomy to the 2000 Census had not been completed as of the publication of this chartbook, we were not able to estimate the impact of the 2000 Census changes. Indications are that the actual number may be higher when the impact of the 2000 Census rural and urban classifications are available, although we are unable to estimate the magnitude of the change at this time.

[2] Based on data obtained from the 2000 Area Resource File. Unfortunately, the data from the 2000 Resource File do not allow us to identify clinics that are located in shortage areas whose designations or most recent updates are greater than three years old. Clinics located in these areas are also at risk under the proposed regulations.

Introduction

Rural Health Clinics (RHCs) have become an important part of the rural health care infrastructure. As of September 30, 1999, 3,477 RHCs were providing a wide range of primary care services to the rural residents of 45 states.[3] The patient populations served by these RHCs include a high proportion of rural elderly and poor through the Medicare and Medicaid programs. In addition, RHCs are increasingly looked upon as safety net providers *(Gaston, 1997),* based on the requirement that they be located in rural areas designated as underserved. Despite their relatively wide acceptance, RHCs and the RHC Program have come under scrutiny because of the growth in program costs and concerns about the extent to which RHCs are improving access. These issues have arisen as a result of the dramatic growth in the number of RHCs during the mid-1990s *(McBride and Mueller, 2002)* and the distribution of those clinics in areas with established health care systems *(U.S. General Accounting Office, 1996)*.

Despite these concerns, current data are not available on the characteristics and operations of RHCs nationwide. The last national survey of RHCs was conducted in 1994 *(Thometz, 1994)*.

This project was undertaken to provide an updated, comprehensive picture of the RHC program and the operations of RHCs, addressing the following questions:

- What are the characteristics of RHCs in terms of staffing levels and patterns, populations served, payer mix, hours of operation, and financial performance? How do independent and provider-based RHCs compare in terms of these characteristics?
- Where are RHCs located relative to underservice problems and access needs of rural areas?
- Where are RHCs located in relation to one another?
- To what extent have RHCs converted from some other type of practice? What are the changes in staffing patterns of clinics that have converted to RHC status?
- What safety net functions are performed by RHCs?

- What are the staffing and recruitment issues faced by RHCs?
- To what extent are RHCs participating in the training of health care professionals?
- To what extent are RHCs participating in networking activities to expand access and build service capacity?
- How have RHCs been affected by both commercial- and public- managed care plans?

[3] At the time of our study, Connecticut, Delaware, Maryland, Massachusetts, and New Jersey had no RHCs in operation.

History and Background

The Rural Health Clinic Services Act, PL 95-210, established the Rural Health Clinic program in December 1977. The goal of the Act was to improve access to healthcare services for rural residents living in designated shortage areas through the establishment of federally-certified Rural Health Clinics (RHCs), and to expand the use of nurse practitioners and physician assistants in rural communities.

To be certified as an RHC, a clinic must:

- Be located in a nonurbanized area as defined by the U.S. Bureau of the Census;[4]
- Be located in an area designated as a Health Professional Shortage Area ("HPSA"), Medically Underserved Area ("MUA"), or Governor-Designated Shortage Area;
- Be engaged primarily in providing outpatient primary medical care;
- Employ at least one nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) at least 50 percent of the time that the clinic is open;
- Comply with all applicable federal, state, and local requirements;
- Meet health and safety requirements prescribed by Medicare and Medicaid regulations; and
- Receive medical direction from a physician who periodically reviews the services provided by the NPs, PAs, and/or CNMs, provides general medical supervision, and is present on-site at least once every two weeks.

The Rural Health Clinic Services Act authorized Medicare and Medicaid cost-based reimbursement to certified RHCs for a defined set of core rural health clinic services; and established reimbursement for the services of NPs, PAs, and CNMs in RHCs, even if delivered in the absence of a physician. The core services defined by the Act include: primary health services; six basic laboratory tests (e.g., chemical examination of urine by stick or tablet, hemoglobin or hematocrit, blood sugar, examination of stool specimens for occult blood, pregnancy tests, and primary cultures for transmittal to a certified lab) with arrangements for other tests; emergency care services as a first response to common life

threatening injuries and acute illnesses; x-ray services (which can be provided through arrangements with other facilities); and hospital specialty care through demonstrated arrangements with specialty providers. Subsequent amendments to the Act added the services of clinical psychologists and clinical social workers to the list of core services, and added certified nurse midwives to the definition of midlevel providers.

Most recently, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) repealed the reasonable cost-based reimbursement for Medicaid patients served by Federally Qualified Health Centers (FQHCs) and RHCs *(Center for Medicare & Medicaid Services State Medicaid Directors' Letter, SMDL # 01-014)*. Effective January 1, 2001, state Medicaid programs must reimburse FQHCs/RHCs at a rate consistent with the new prospective payment system described in section 1902(aa) of the act. During the first phase of the Medicaid Prospective Payment System (January 1, 2001, through September 30, 2001), states are required to pay FQHCs/RHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services during Fiscal Years 1999 and 2000; adjusted to take into account any increase (or decrease) in the scope of services furnished during Fiscal Year 2001 by the FQHC or RHC. The payment amount is to be calculated on a per-visit basis. Beginning in FY 2002 and for each fiscal year thereafter, each FQHC and RHC will be paid the per-visit amount to which the facility was entitled in the previous fiscal year; increased by the percentage increase in the Medicare economic index for primary care services and adjusted to take into account any increase (or decrease) in the scope of services furnished by the facility during that fiscal year.

States are allowed to develop alternative Medicaid payment methodologies for FQHCs and RHCs as long as the following three statutory requirements are met:

1) the state and each individual FQHC/RHC to which the state wishes to apply the methodology must agree to the alternative methodology;

2) the alternative methodology must result in a payment to each facility that is at least equal to the amount that would have been paid under the Medicaid Prospective Payment System; and

3) the alternative methodology must be described in the approved state plan. These changes to the payment of RHCs took place subsequent to our survey and, as such, the impact of these changes are not reflected in the data we collected.

RHCs can either be independent or provider-based. An independent RHC is a freestanding clinic or office-based practice. In comparison, a provider-based RHC must

be an integral and subordinate part of a hospital, skilled nursing facility, or home health agency participating in the Medicare program; and be operated with other departments of that provider under common licensure, governance, and professional supervision.

RHCs are reimbursed on a reasonable cost basis for core services including the professional services of physicians, NPs, PAs, and CNMs. Independent RHCs are paid a cost-based, all-inclusive per-visit rate subject to established caps. Originally, all provider-based RHCs were reimbursed for covered services at the lower of costs or charges calculated from the cost report of the host provider *(Travers, Ellis, and Dartt, 1995)*. As of January 1, 1998, provider-based RHCs owned by hospitals of 50 or more beds are subject to the same per-visit upper payment limit as independent RHCs (*Balanced Budget Act of 1997* [P.L. 105-33, subtitle C § 4205]). Provider-based RHCs owned by rural hospitals with fewer than 50 beds, however, are exempt from those payment limits. This change came on the heels of the significant increase in the number of RHCs (and related payment levels) during the mid-1990s, as well as concerns that some providers have used RHC status to increase Medicare and Medicaid reimbursement for outpatient services without necessarily improving access to care *(U.S. Office of the Inspector General, 1996 and U.S. General Accounting Office, 1996)*.

Despite the incentives provided by the Act, participation during the early years of the program lagged behind Congress's initial expectations *(Washington and Kushner 1991)*. Although only 581 RHCs were operating as of October 1990 *(Travers, Ellis, and Dartt 1995)*, the program took off quickly after that. There were over 800 RHCs operating in 1992. From the end of October 1990 through October 1995, the number of RHCs grew by 650 percent *(U.S. Office of the Inspector General, 1996)*. As of September 30, 1999, 3,477 RHCs were in operation, of which 53 percent were classified as independent and 47 percent were classified as provider-based. As a result of this growth, RHCs are among the largest outpatient primary care programs serving underserved rural communities *(Thometz 1994)*.

The reasons for the initial slow growth during the early years of the program (prior to 1992) included the perception that early federal reimbursement rates, which were capped at a maximum cost-per-visit, were too low; a lack of knowledge about the program; conflicting state laws that limited the utilization of NPs, PAs, and CNMs; and concerns that the cost reporting and certification processes were too complex *(Travers, Ellis, and Dartt, 1995, Finerfrock and Petersen, 1994,* and *Tessen, Dugi, and Reese, 1998)*. In an effort to improve participation, Congress passed amendments to increase reimbursement rates, ease the administrative burden, and promote technical assistance and awareness of the program *(American Academy of Physician Assistants, 1997)*. Similarly, states addressed barriers related to the scope of practice of NPs, PAs, and CNMs *(American Academy of Physician Assistances, 1997, Tessen, Dugi, and Reese, 1998,* and *Michigan Center for Rural Health, 1996)*. Declining reimbursement from the standard Medicare fee-for-service system further

served to make the RHC program an attractive option for many rural providers *(National Rural Health Association, 1997)*.

The growth in the number of RHCs has been accompanied by a rapid increase in the cost of the program. Medicare spending for RHCs increased from $44 million in 1991 to $220 million in 1997 *(McBride and Mueller, 2002)*. Similarly, Medicaid expenditures for RHC services increased from $34 million in 1990 to $308 million in 1997 *(Finerfrock, 1999)*.

This growth in total payment to RHCs can be largely attributed to increased access for residents of rural communities. For example, the increase in Medicaid expenditures can be attributed to an increase in the number of Medicaid patients served by RHCs. From 1995 to 1997, the number of Medicaid recipients served by RHCs increased by 16.4 percent, compared to an 11.0 percent decline in Medicaid patients receiving physician services; an 18.4 percent decline in those receiving hospital outpatient services, and an 11.4 percent decline in those receiving care in clinics *(Finerfrock, 1999)*. In the absence of these RHCs, many patients would seek care from other health care providers. For example, the presence of an RHC in a community has been found to reduce emergency room use *(Cheh and Thompson, 1997)*.

As mentioned earlier, this recent and dramatic growth in the number of RHCs and the associated costs has resulted in greater scrutiny of the RHC program. Evaluations of the RHC program by the General Accounting Office *(U.S. General Accounting Office, 1996)* and the Office of the Inspector General *(U.S. Office of the Inspector General, 1996)* have questioned the degree to which the objectives of the program were being met. Yet these studies have themselves been controversial because of the small number of clinics studied. The GAO study *(1996)* was based on case studies of 27 RHCs located in Illinois, Mississippi, and Texas. The OIG study *(1996)* examined claims data and provider registration data from a total of 119 RHCs in Alabama, Kansas, New Hampshire, and Washington; and conducted telephone surveys with 76 of those clinics. In a more recent evaluation of the RHC program, Cheh and Thompson *(1997)* based their findings on a pre-post examination of 18 recently-established clinics in California, Kansas, Maine, Michigan, North Carolina, and Texas.

Although these studies raised some useful questions, their conclusions are not necessarily based on the intent of the legislation establishing the RHC Program. The GAO, in particular, criticized the program for not being focused on improving care in isolated areas. The Rural Health Clinic Services Act did not specifically target isolated rural areas, rather it established a standard (requiring that a clinic be located in a non-urbanized area of less than 50,000) that covered a broader array of rural areas across the country. In addition, many of their concerns had less to do with the RHC program and more to do with the

existing shortage-area-designation process used to certify clinics for participation in the program. As a result, the conclusions reached by these earlier studies need to be evaluated in the context of the goals of the enabling legislation.

Despite the recent scrutiny given the RHC program, up-to-date information on the characteristics and operations of RHCs has largely been unavailable. As previously discussed, the National Association of Rural Health Clinics last conducted a national survey of RHCs in 1994. A limited number of states have conducted and published surveys of their RHCs. These have included Oklahoma *(Biard-Holmes, Brown, Eley, and Valdmanis, 1997)*, Texas *(Tessen, Dugi, and Reese, 1998)*, Oregon *(Redd, 2001)*, and Michigan *(Michigan Center for Rural Health, 1996)*.

This chartbook presents an analysis of the most recent data on rural health clinics, collected from a national survey of RHCs conducted during the summer and fall of 2000.

[4] The Census Bureau defines an urbanized area as comprising one or more places ("central place") and the adjacent densely settled surrounding territory ("urban fringe") that together have a minimum of 50,000 persons. A non-urbanized area is one in which the central place and related urban fringe have less than 50,000 people. A list of urbanized areas is available from the Census Bureau.

Study Methodology

In order to provide an updated comprehensive picture of the Rural Health Clinics program, we surveyed a randomly-selected sample of RHCs, equally stratified by clinic type (e.g., independent versus provider-based) using a mailed survey instrument. We identified the population of 3,477 RHCs using the September 1999 Online Survey, Certification, and Reporting (OSCAR) database maintained by the Centers for Medicare and Medicaid Services. We mailed written survey instruments to 1,600 RHCs. Extensive follow-up was conducted to encourage participation in the survey; including a second mailing of the survey instrument to those who had not responded and multiple follow-up telephone calls to those who did not respond to the second mailing.

Usable surveys were returned by 611 RHCs. Our original sample was adjusted to reflect the return of 151 survey instruments that could not be delivered due to clinic closure or incorrect addresses. Our response rate of 42.2 percent was based on the adjusted sample size of 1,449. The data provided by these RHCs were supplemented by data from the OSCAR database, the 2000 Area Resource File, and the Rural-Urban Commuting Area (RUCA) Zip Code Approximation file, Version 1.1 produced by the WWAMI Rural Health Research Center at the University of Washington. Over 83 percent of the surveys were completed by the clinic administrator, an employee of the parent organization, or another member of the clinic's administrative or clinical staff. Twenty-three percent were completed by either a physician, nurse practitioner, or physician assistant.[5]

Our survey population closely resembles the overall population of RHCs along a number of important characteristics. Of the 3,477 clinics in operation as of September 30, 1999, 52 percent were classified as independent and 48 percent were classified as provider-based. In comparison, 53 percent of our survey population were classified as independent and 47 percent were classified as provider-based. Over 75 percent of all RHCs were concentrated in the Atlanta (IV), Chicago (V), Dallas (VI), and Kansas City (VII) federal regions compared to 68 percent of the survey respondents. In terms of corporate structures and ownership patterns, 41 percentof both populations operated as non-profit corporations, 29 percent of the total population and 27 percent of the survey population operated as for-profit corporations; 16 percent of both populations operated under the auspices of local, state, or federal governments; 10 percent of the total population of RHCs and 12 percent of the survey population operated under individual ownership; and 5 percent of both populations operated as partnerships.[6] Finally, 73 percent of the total population and 75 percent of the survey population were located in counties that were either wholly or partially

designated as Health Professional Shortage Areas. Approximately 24 percent of both groups were located in counties designated as Medically Underserved Areas. Less than 1 percent of both populations are located in counties that are Governor Designated Shortage Areas. Three percent of the total population and 2 percent of the survey population are located in counties no longer designated as shortage areas.

Version 1.1 of the RUCA Zip Code Approximation file allowed us to assess the rurality of the communities in which RHCs are located at the zip code level. The RUCA system is a ten-tiered classification system of population sizes and commuting relationships based on census tract geography using 1990 Census data. The Zip Code Approximation file crosswalks census tracts to the relevant zip codes; thereby, allowing this information to be linked easily to databases containing address information. Using, a four-tiered consolidation of the larger RUCA classification system developed by the Washington State Office of Community and Rural Health *(Washington Department of Health, 2001),* we were able to classify the communities in which RHCs are located into the following categories: urban core areas (urbanized areas with a population of 50,000 or more), suburban areas (areas with high commuting relationships to urban core areas including large town, small towns, and isolated rural areas), large town areas (towns with populations between 10,000 and 49,999), and small town/isolated rural areas (towns with populations below 10,000 and other isolated rural areas). Unfortunately, the process of updating the RUCA taxonomy to the 2000 Census had not been completed as of the publication of this chartbook. We expect that the classification of the communities in which RHCs are located may change when Version 2.0 of the RUCA codes is released; however, we were unable to estimate the extent of the change prior to publication.

In the first section of this chartbook, we describe RHCs by a number of characteristics including provider type, location, ownership issues, corporate structure, conversion history, and hours of operation. In Section II, we address staffing and recruitment issues faced by RHCs. Section III describes the financial operations of RHCs. Section IV and V explore the location of RHCs relative to underservice; and access problems in rural communities, and their proximity to other RHCs and primary care services. Section VI addresses the safety net role of RHCs. Sections VII through IX describe the participation of RHCs in health professions education, the networking activities of RHCs, and the participation of RHCs in managed care programs, both public and private. Finally, Section X discusses the policy implications of our findings.

Although this chartbook provides the most up-to-date information available on the status of RHCs nationally, it cannot be considered an exhaustive exploration of the issues related to the RHC program. Further research is needed to fully understand the role of RHCs in expanding access to primary care services for the residents of rural communities.

Our goal in preparing this chartbook was to provide a resource for national and state policymakers on the status of the RHC program. We have carefully selected a range of data, presented through graphs and narrative, to "tell the story" of the Rural Health Clinics program; document the performance of the program relative to the policy goals; explore concerns that have been raised about it; and to suggest opportunities for further research and analysis necessary to understand and support this important rural program.

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[5] These totals exceed 100 percent as multiple individuals participated in the completion of some surveys

[6] Due to rounding, the sum of these categories do not equal 100 percent..

Section I

Characteristics of Rural Health Clinics

This section of the chartbook presents data on a broad range of characteristics of RHCs, provided by our survey respondents, and our analysis of the overall population of RHCs. Within this section, we provide a descriptive picture of RHCs according to clinic type (e.g., independent versus provider-based), geographic location, corporate structure, ownership, changes in ownership, and hours of operation. In addition, we explore issues related to the conversion of existing primary care practices to Rural Health Clinic status.

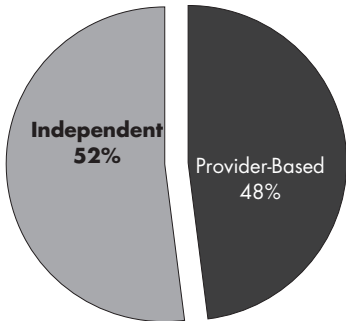
The GAO and OIG raised questions about the conversion of existing primary care practices to RHC status. They were concerned that some of these practices might not need the enhanced reimbursement provided by the RHC program to remain in operation, nor use the benefits of the program to expand care to the underserved. Through our survey data, we were able to examine issues related to the conversion of existing practices to RHC status and related changes to professional staffing patterns. Although our survey data did not allow us to determine whether or not the responding practices would have closed without the additional reimbursement provided under the RHC program, we have been able to determine that practices converted to RHC status expanded their professional staffing post conversion; thereby, improving access to services.

Key Findings

- As of September 30, 1999, 3,477 RHCs were in operation nationally. Of these clinics, 52 percent (1,814) were classified as independent. The remaining 48 percent were classified as provider-based.
- The CMS/HCFA regions with the heaviest concentration of RHCs were Atlanta (Region IV), Dallas (Region VI), Kansas City (Region VI), and Chicago (Region V). These four regions contained more than 75 percent of the RHCs in the country.
- The most common corporate structures were non-profit corporations (41 percent of the total population), for-profit corporations (29 percent), and governmental entities (16 percent).

- Independent clinics were most commonly owned by physicians (49 percent), other individuals or corporate entities (29 percent), hospital corporations (15 percent), NPs, PAs, or CNMs (7 percent), or RHC administrators (1 percent).
- Provider-based clinics are owned by hospitals of less than 50 beds (50 percent), hospitals of more than 50 beds (40 percent), and nursing homes and other owners (10 percent).
- RHCs exhibit stable ownership patterns. Based on data contained in the OSCAR files, only 12 percent of RHCs have changed ownership since the date of their original certification. Seven percent of all RHCs have changed ownership only once. The remaining 5 percent have changed ownership two or more times.
- Among the survey respondents, 68 percent reported that the clinic had been established by the existing owner. Of the remaining 32 percent, 72 percent (N=101) converted to RHC status after acquisition of the clinic.
- Fourteen percent of the respondents report operating as other than an RHC (e.g., they provide services to patients outside of their operations as an RHC).
- On average, RHCs are open approximately 41 hours per week. The most typical hours of operation are Monday through Friday. Comparatively few offer Saturday hours (19 percent) and even fewer (3 percent) offer Sunday hours.

Distribution of RHCs by Clinic Type
OSCAR Data (N=3,477)

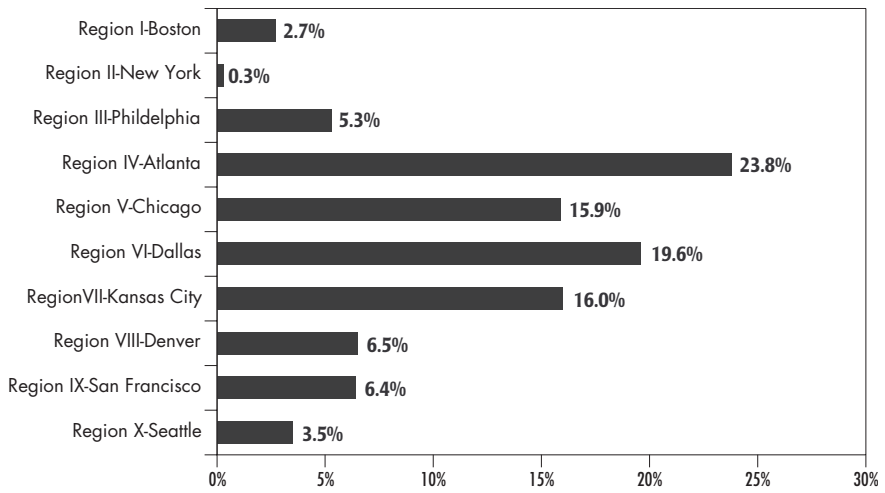


Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

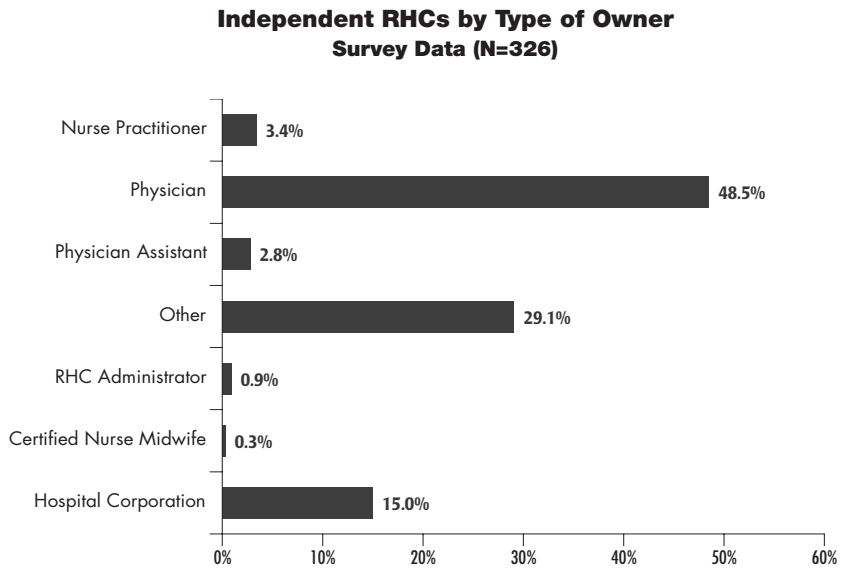
- Sixty percent of respondents (N=361) indicated that their RHC had converted from some other type of provider organization.
- Of these 361 clinics, 74 percent reported converting to RHC status from a private physician practice, 12 percent converted from a hospital outpatient clinic, 7 percent converted from a community-owned clinic, and 7 percent converted from another practice type.

- The large percentage of RHCs that had converted from private physician practices (74 percent of those clinics that had converted from another type of practice) suggests that the additional reimbursement available under the RHC program may help to stabilize private practices that do not have the resources and support available to hospital or community owned clinics. Additional study is needed to better understand the role of cost-based reimbursement in sustaining small rural practices.

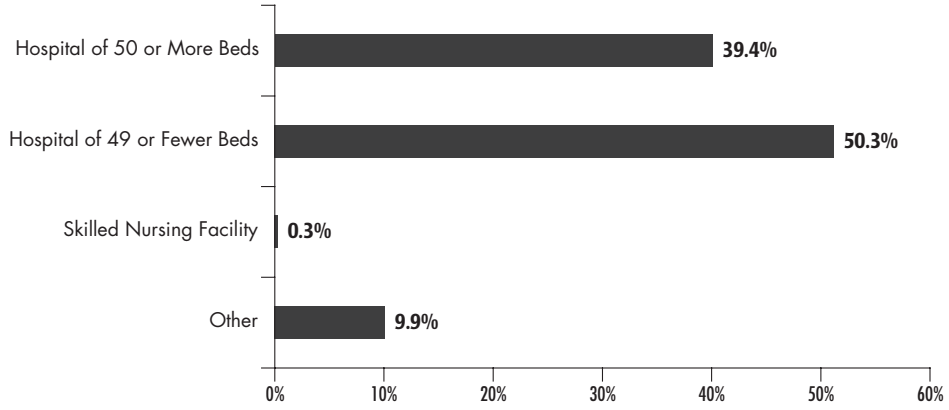
- Conversion to RHC status improved the availability of services through the expansion of existing staffing levels and the addition of new staff to these clinics.
  - Average physician staffing increased from 1.5 to 2.8 FTEs.
  - The number of clinics employing NPs, PAs, and/or CNMs increased by a factor of 2.3 from 168 clinics to 281.
  - The number of clinics employing mental health practitioners increased from 4 to 31 clinics.



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

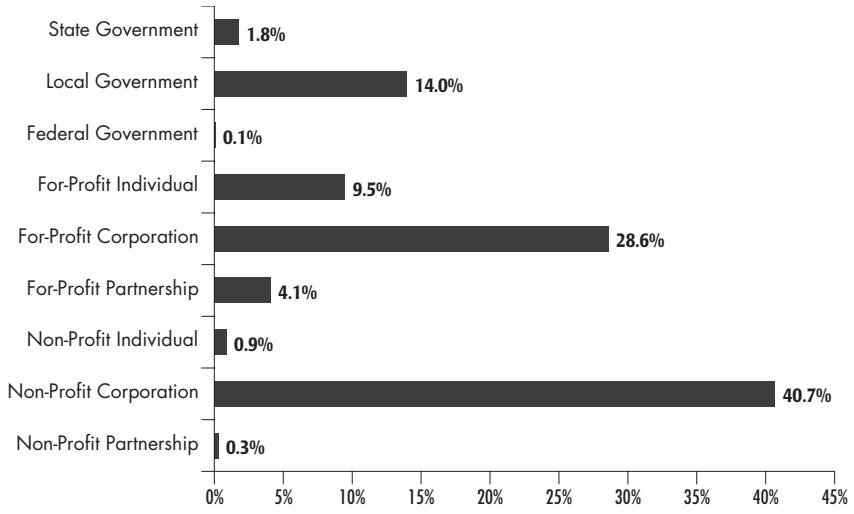


Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



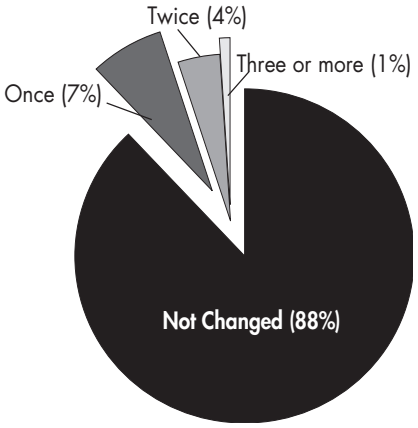
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Distribution of RHCs by Corporate Structure
OSCAR Data (N=3,477)



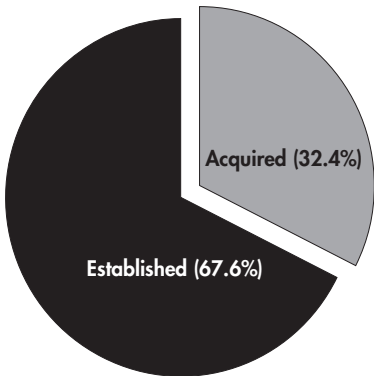
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Frequency of Changes in Ownership
OSCAR Data (N=3,477)



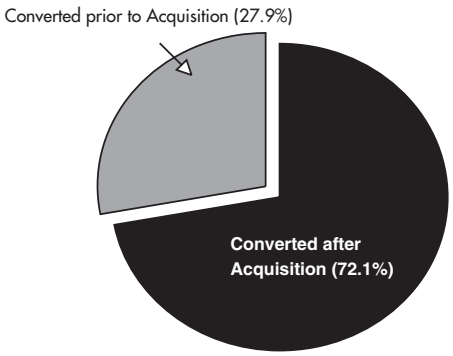
Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service,
University of Southern Maine

Was the RHC Established by Current Owner or Acquired from Another Owner?
Survey Data (N=395)



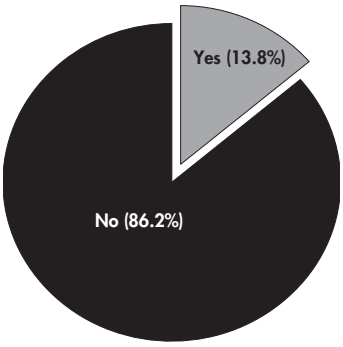
Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service,
University of Southern Maine

If Acquired from Another Owner, When Did RHC Conversion Occur?
Survey Data (N=140)



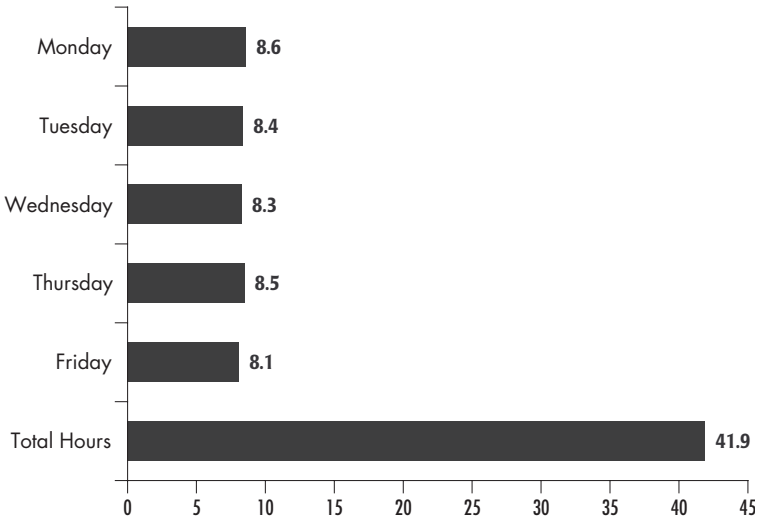
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Are Facilities Operating as Other than an RHC?
Survey Data (N=589)



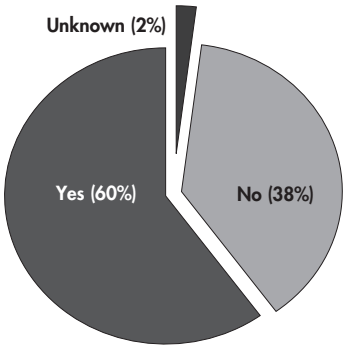
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Average Weekly Hours of Operation
Survey Data (N=401)

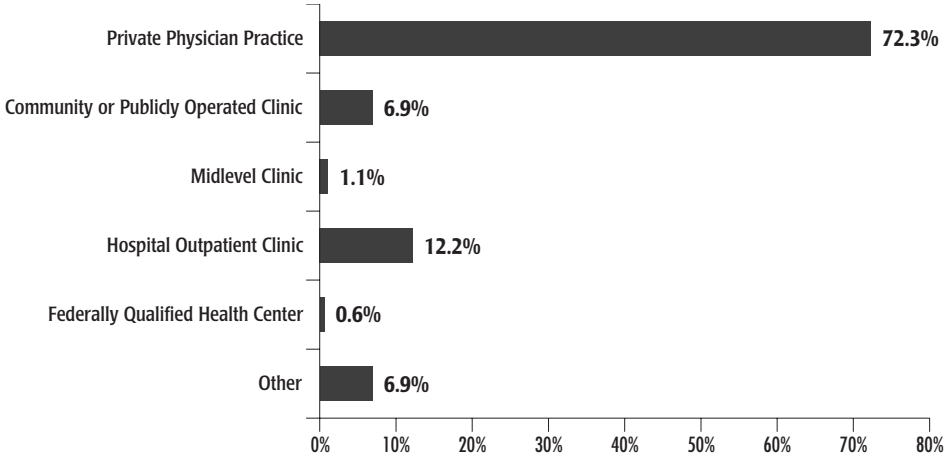


Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Did RHCs Convert from Some Other Type of Provider Organization?
Survey Data (N=601)



Type of Provider Entity from which RHC Converted
Survey Data (N=361)



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Changes in Staffing for RHCs that Converted from Existing Practices
Survey Data

	Prior to Conversion		At Date of Survey	
Provider Types	**FTEs**	**N**	**FTEs**	**N**
Physicians	1.5	296	2.8	311
Physicians Assistants	1.2	91	1.2	176
Nurse Practitioners	1	69	1.1	198
Certified Nurse Midwives	1.3	8	1	7
PhD Level Clinical Psychologists	0.1	1	0.6	9
Master's Level clinical Psychologists	0	0	0.7	6
Clinical Social Workers	1	3	0.7	12

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Section II

Staffing and Recruitment Issues

Background

Staffing and recruitment issues are a major concern for RHCs. To qualify for RHC certification, a clinic must be located in a non-urbanized area as defined by the U.S. Bureau of the Census **and** an area designated as a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or a Governor's Designated Shortage Area (GDSA). RHCs face staffing difficulties created by distribution patterns in which providers are less likely to practice in rural areas, by shortages of health professionals, and competition with other rural health care providers. For example, 20 percent of the nation's population live in rural areas. Less than 11 percent of the nation's physicians, however, practice in these areas *(NRHA, 1998)*. Although shortages of NPs, PAs, CNMs, registered nurses, and allied health professionals have an impact on all providers, they have a disproportionate impact on rural communities *(U.S. Congress, Office of Technology Assessment, 1990)*. As a result, RHCs are forced to compete with rural health care providers for this limited pool of health care providers who are interested in, and willing, to practice in rural areas.

In order to identify the staffing and recruitment issues faced by RHCs, we surveyed RHCs on their professional staffing patterns, vacancies, and recruitment difficulties. Additional work is needed to determine the ability of RHCs to compete with other rural providers for staff, particularly those rural providers that receive cost-based reimbursement without payment caps (e.g., Critical Access Hospitals and RHCs owned by hospitals for hospitals of less than 50 beds).

Rural Health Clinic Staffing Patterns Survey Data

	Number of FTEs	N	Range
Physicians	1.7	503	0.05-15
Physicians Assistants	1.2	305	0.05-8
Nurse Practitioners	1.1	303	0.05-6
Certified Nurse Midwives	0.09	10	0.2-2
Overall Mid-Level Staffing	1.3	561	.07-8
Other Clinical Staff	3.3	49	0.1-15
Clinical Psychologists: PhD	0.06	13	0.1-1
Clinical Psychologists: Masters	0.06	13	0.1-1
Clinical Social Workers	.07	22	0.1-2

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

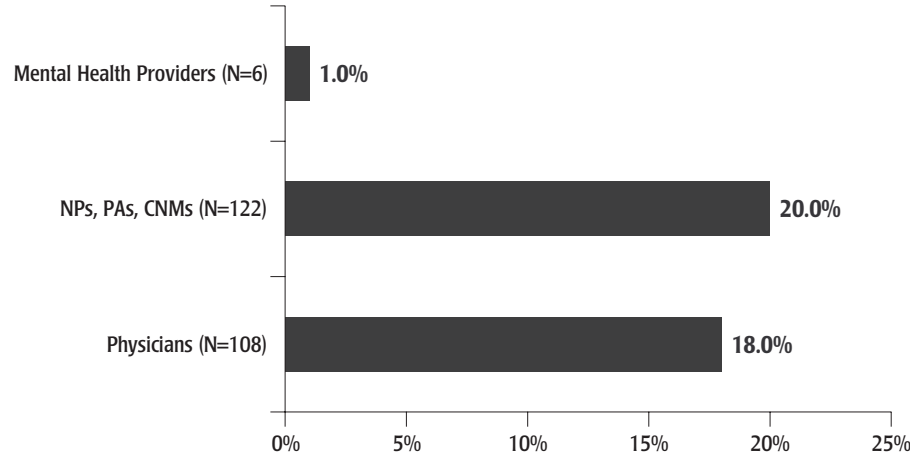
Key Findings

- The average RHC employs 1.7 FTE physicians and 1.3 FTE midlevel providers (PAs, NPs, and/or CNMs). Staffing patterns are similar across independent and provider-based RHCs.
- Despite regulatory changes that allow RHCs to receive cost-based reimbursement for the services of clinical psychologists and clinical social workers, very few have chosen to do so. Of our survey respondents, only 13 indicated that they employed a PhD-level psychologist; another 13 employed a master's-level psychologist, and 22 employed a clinical social worker.
- Eighteen percent of responding clinics indicated that they had a vacant physician position during the last year. Of those RHCs with physician vacancies, 77 percent indicated that they had trouble recruiting and filling the position. The average physician vacancy was open 10 months before being filled.
- Twenty percent indicated that they had a vacant NP, PA, or CNM position during the past year. Of those clinics with vacant NP, PA, and CNM positions, 40 percent had trouble recruiting a replacement. The positions remained open 4.7 months before being filled.
- Although based on small numbers (six vacancies), 83 percent of RHCs attempting to fill mental health vacancies (master's-level psychologists, PhD-level psychologists, and/or and clinical social workers) reported trouble with recruiting. Mental health positions remained vacant an average of five months before being filled.

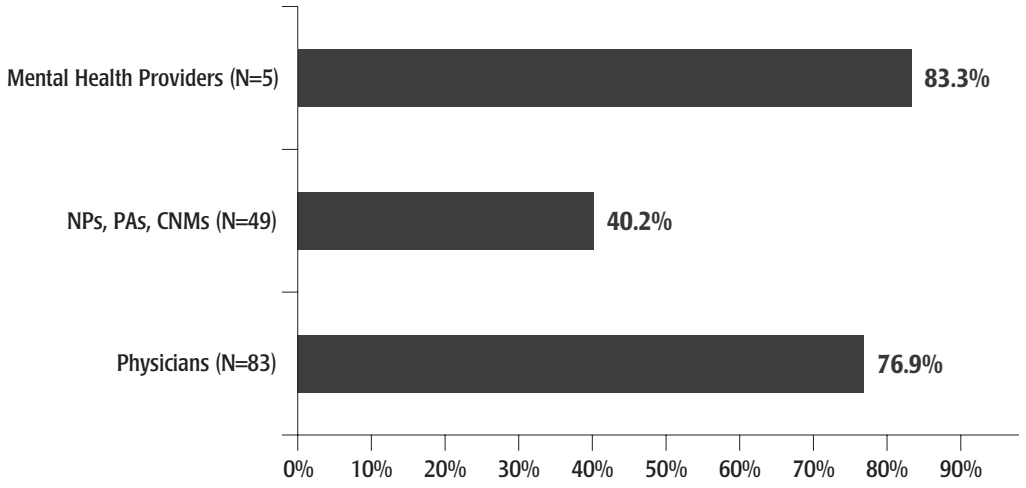
RHCs Reporting Vacancies and Recruitment Difficulties during the Past Year Survey Data

	Vacant Positions		Trouble Recruiting?		Average Number of Months Vacant	
	N	%	N	%	N	%
Physicians	108	18%	83	77%	101	10.3%
NPs, PAs, and/or CNMs	122	20%	49	40%	99	4.7%
Clinical Psychologists: PhD, Clinical Psychologists: Masters, and/or clinical Social Workers	6	1%	5	83%	5	6.9%

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

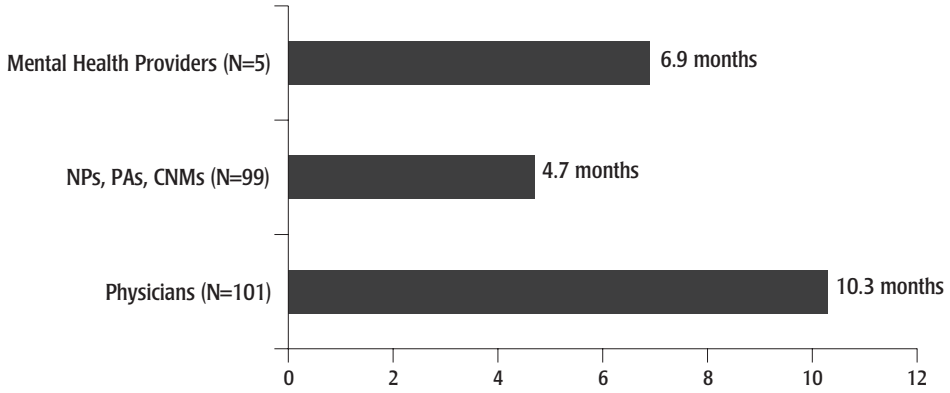


Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Average Length of Vacancy in Months by Type of Clinician during the Past Year
Survey Data



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Section III

Financial Operations

Background

At the time of our survey, one of the major incentives offered by the RHC program is Medicare and Medicaid cost-based reimbursement.[1] RHCs are paid a cost-based, all-inclusive per-visit rate. Independent RHCs, and provider-based RHCs owned by hospitals of 50 beds or more, were subject to a reimbursement rate cap of $60.40 in 1999 and $61.85 in 2000. Provider-based RHCs owned by hospitals of less than 50 beds are not subject to a cap on reimbursement. For purposes of reimbursement, the per-visit rate covers all applicable RHCs services rendered to a patient on a given day by one or more health professionals employed by the RHC.

The per-visit rate is based on the applicable costs of providing covered RHC services. The RHC is paid the lesser of their costs (as expressed by the per-visit rate) or the per-visit reimbursement rate cap. Independent RHCs must submit the Medicare Cost Report for Independent Federally Qualified Health Centers/Rural Health Clinics (HCFA 222) form annually to document their costs, productivity rates, and other minimum statistical data necessary to calculate the RHCs cost per-visit. Costs for provider-based RHCs are established from the cost report of the sponsoring provider.

Independent RHCs are subject to a baseline productivity standard of 6,300 annual Medicare and Medicaid annual visits for each medical team (the Calculated Minimum Standard), consisting of one full-time equivalent (FTE) physician and one FTE mid-level provider *(Travers, Ellis, and Dartt, 1995)*. This rate is prorated to reflect differing FTE staffing patterns for each clinic. The greater of the individual RHC's productivity rate, or the Calculated Minimum Standard (CMS) for productivity, is used to calculate the clinic's per-visit rate. Clinics that do not meet the CMS standard for their given level of staffing are penalized through the use of the higher CMS rate in the calculation of their per-visit rate. Provider-based RHCs are not subject to these productivity standards.

Although cost-based reimbursement is an important benefit for RHCs, it must be viewed in the context of the overall payer mix for RHCs. RHCs are heavily dependent on Medicare and Medicaid as payer sources for a large percentage of their patients. It should also be remembered that cost-based reimbursement covers only the costs of providing RHC services to Medicare and Medicaid patients. It does not provide for profit nor cover the costs of treating uninsured or indigent patients. In light of the cap on reimbursement for many RHCs, many RHCs administrators argue that they are still not covering their costs, despite the receipt of cost based reimbursement.

In an effort to shed some light on these issues, we asked a series of financial questions on our survey related to the adjusted cost-per-visit reported by the RHC, total expenses, total revenues, payer mix, and the receipt of outside funding to support the clinic.

As the BIPA 2000-mandated Medicaid PPS payment methodology was implemented subsequent to our survey, we are unable to discuss the impact of this change on the financial status of RHCs. Further research is needed to understand the impact of this payment methodology on RHCs, as well as on the access to services for Medicaid patients served by them.

Key Findings

- On average, RHCs reported that total expenses exceed total revenues for both independent and provider-based RHCs.
  - Annual total expenses for independent RHCs ($731,174) exceeded total revenues ($690,669) by $40,505 (N=148).
  - Annual total expenses for provider-based RHCs ($590,617) exceeded total revenues ($522,176) by $38,441 (N=81).
- Independent RHCs reported an adjusted cost-per-visit of $66.31 compared to $81.01 for provider-based clinics. As mentioned earlier, per-visit reimbursement for independent RHCs and provider-based RHCs owned by hospitals of 50 or more beds was capped at $60.40 in 1999 *(United Government Services, LLC., 1999)* and $61.85 in 2000 *(Health Care Financing Administration, 2000)*.
- The lower shortfall in revenues for provider-based RHCs can be explained, in part, by the fact that RHCs owned by hospitals of less than 50 beds are not subject to the cap on per-visit reimbursement that applies to independent RHCs and provider-based RHCs owned by hospitals of 50 beds or more.
- Medicare and Medicaid account for slightly more than 54 percent of RHC volume when measured as a percentage of revenues (just under 56 percent when measured as a percentage of patient visits).
- Commercial and private insurances account for just under 30 percent of RHC revenues (slightly more than 28 percent of patient visits).
- Uninsured, private-pay and free/reduced-cost care patients account for slightly less than 15 percent of RHC revenues and patient visits.

- Many RHCs have difficulty distinguishing between revenues generated by private-pay patients and revenues generated by indigent patients. Similarly, they have difficulty distinguishing charges written off as bad debt from charges written off for free/reduced-cost care.

- Comparatively few RHCs receive outside funding to support their efforts. Twenty percent of independent RHCs report receiving some form of outside funding compared to 16 percent of provider-based RHCs.

- The most common form of outside funding received by RHCs (as measured by the number of respondents indicating that they received these funds) were:
  - State funds (N=25)
  - Municipal and county funds (N=17)
  - Other funds (N=17)
  - Foundation and private grants (N=12)
  - Individual voluntary contributions (N=12)
  - Federal funds (N=9)

- For these respondents, outside funds represented between 4 and 27 percent of total revenues.

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[1] As discussed earlier, BIPA 2000-mandated that Medicaid payments be made RHCs under a prospective payment system methodology effective January 1, 2001. Under BIPA 2000, states may elect to use an alternative payment methodology as long as the payments made under the alternative methodology are equal to or exceed the payments that would be made under the BIPA 2000-mandated PPS methodology, and the alternative methodology is agreed to by each individual RHC to which the state wishes to apply the methodology.

Total Revenues, Expenses, and Adjusted-Cost-Per-Visit
Survey Data

	Total Revenues	N	Total Expenses	N	Adjusted Cost Per Visit	N
All RHCs	$641,683	229	$681,457	229	$71.51	229
Independent RHCs	$690,669	148	$731,174	148	$66.31	148
Provider-Based RHCs	$552,176	81	$590,617	81	$81.01	81

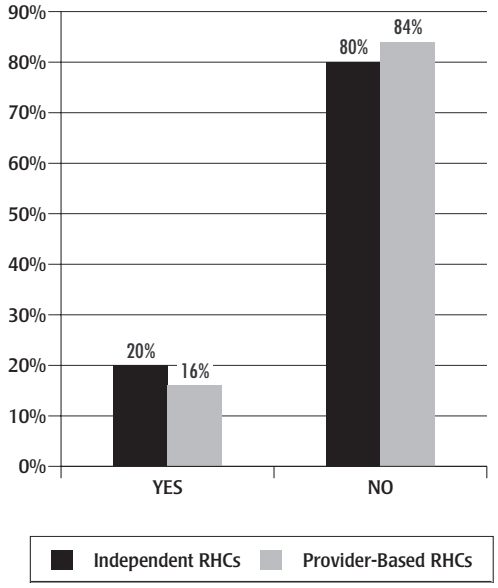
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Proportion of Revenues and Patient Visits by payer Type
Survey Data

Payer Type	Percent of Revenues	N	Percent of Patient Visits	N
Medicare	29.9%	315	30.8%	440
Medicaid/SCHIP	24.4%	313	25.0%	330
Uninsured/Private Pay/Free Cost Care	14.7%	299	14.6%	410
Commercial/Private Insurance	29.5%	299	28.4%	422
Other	4.2%	312	3.9%	374

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Are RHCs Receiving Outside Funding to Support Patient Care Activities?
Survey Data (N=390)



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Percentage of Revenues Received from Outside Funding Sources
Survey Data

	All RHCs		Independent RHCs		Provider-Based RHCs	
	N	Percentage of Revenues	N	Percentage of Revenues	N	Percentage of Revenues
Individual Voluntary Contribution	12	4.4%	10	4.2%	2	25.5%
Federal Funds	9	26.8%	5	30.7%	4	22.0%
State Funds	25	23.6%	17	21.0%	8	29.1%
Municipal/County Funds	17	22.5%	9	22.8%	4	22.1%
Foundation/Private Grants	12	13.2%	8	7.6%	4	24.3%
Other	17	17.7%	13	18.4%	4	15.3%

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Section IV

Location of RHCs Relative to Underservice and Access Problems of Rural Communities

Background

The RHC program, as created in 1977 by P.L. 95-210, is intended to increase access to primary health care services for residents of rural medically underserved areas. To qualify for RHC certification, a clinic must be located in a non-urbanized area as defined by the U.S. Bureau of the Census **and** an area designated as a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or a Governor's Designated Shortage Area (GDSA). Although the Federal regulations do not require RHCs to provide services to specific populations, the program is based on the assumption that maintaining the health care infrastructure in rural communities will result in improved access for vulnerable populations (e.g., Medicare beneficiaries, Medicaid recipients, low income patients, and uninsured patients).

With the significant growth in the number of RHCs during the mid-1990s, Medicare officials, state Medicaid directors, the General Accounting Office (GAO), and the Inspector General of the Department of Health and Human Services (OIG) have increasingly scrutinized the level of federal and state funding for the program. Reports issued by the GAO and the OIG in 1996 criticized the program and suggested that the increased Medicare and Medicaid payments to RHCs did not result in improved access to care in isolated areas.

Specifically, the GAO was concerned that: "the Program had lost its focus on serving Medicare and Medicaid populations experiencing difficulty obtaining primary care in isolated rural areas" *(U.S. General Accounting Office, 1996)*. Although, as previously discussed, the original legislation did not solely target the program to isolated rural areas. Based on their analysis of RHCs in four states (Alabama, Kansas, New Hampshire, and Washington), the GAO suggested that the additional payments provided to RHCs by the Medicare and Medicaid programs increasingly benefited clinics in suburban areas that already had extensive health care delivery systems in place *(U.S. General Accounting Office, 1996)*. They further noted that the program's benefits were best exemplified by RHCs located in small rural communities. Finally, they observed that the broad eligibility criteria allowed program growth in areas where the need was minimal.

The OIG had similar concerns based on data obtained from CMS's OSCAR database, interviews with state Medicaid agencies, and case studies of three states (Illinois, Mississippi, and Texas). In regards to access, the OIG found that RHCs appeared to be filling a need for primary care in some rural areas, but they did not always increase access to primary care as the law intended. They also found there were no reliable data quantifying the impact of RHCs on access to care.

In addition, both reports raised concerns about the process used to identify and designate health professional shortage areas. They also criticized the grandfathering provision contained in the original act that allowed an RHC to retain its certification regardless of the loss of its rural status or shortage area designation. The GAO had raised some of these same issues in an earlier report that questioned the usefulness of shortage area designations in directing resources to underserved areas *(U.S. General Accounting Office, 1995)*. They found that the value of shortage area designations in targeting underserved areas was undermined by two primary flaws in the shortage area designation process. The first flaw related to the fact that half of the underservice designations were outdated and, therefore, might not accurately portray the availability of health care professionals in those areas. The second flaw involved the methodology used to determine shortage areas designations. The existing methodology did not (and still does not) count important primary care providers, such as nurse practitioners, physician assistants, and certified nurse midwives when calculating population to full-time equivalent primary care provider ratios; thereby, potentially underestimating the available supply of primary care providers.

In response to these two studies, HCFA (now CMS) contracted with Mathematica Policy Research, Inc. to evaluate the program. Mathematica conducted a pre-post examination of 18 clinics designated in 1992 and 1993 in six states (California, Kansas, Maine, Michigan, North Carolina, and Texas). In contrast to the GAO and OIG studies, Mathematica found that the program did improve access to care at substantial, but not unreasonable cost *(Cheh and Thompson, 1997)*. Specifically, they found that clinics added health care providers to the community and increased service use; Medicaid recipients living in larger rural communities experienced the greatest improvements in access; emergency room use declined in communities with new RHCs; and increases in Medicare payments were primarily due to enhanced payment rates, while increases in Medicaid payments were primarily due to improved access.

The Balanced Budget Act of 1997 *(BBA 1997)* contained provisions to address some of the concerns with the RHC Program. Specifically, it contained provisions to refine the definition of what constitutes a qualifying rural shortage area for purposes of RHC certification. Under the proposed rules implementing the provisions of BBA 1997, clinics must be located in non-urbanized areas that have been designated (or had

their shortage area designation renewed) within the past three years to be certified as a RHC, or retain their existing certification *(Federal Register, 2000)*. Those RHCs that are located in areas no longer classified as non-urbanized will automatically lose their certification under the proposed rules. Furthermore, those clinics that are located in areas whose shortage area designations are more than three years old will also lose their certification, unless the designation is updated or they qualify under one of five exceptions identifying the RHC as an "essential provider." As of October 31, 2002, the proposed rules were still under review by the Center for Medicare and Medicaid Services.

We used multiple approaches to understand where RHCs are located relative to the underservice and access problems of rural communities. These included analyses that: examined the rurality of the areas in which RHCs are located using the Rural Urban Commuting Area Codes, Zip Code Approximation file developed by the WWAMI Rural Health Research Center at the University of Washington;[1] identified the status of the shortage area designation for the areas in which RHCs are located using the 2000 Area Resource File; described the economic and policy characteristics of the counties in which RHCs are located using the county typology codes developed by the Economic Research Service of the U.S. Department of Agriculture *(Cook and Mizer, 1994)*;[2] and described the reported difficulty in accessing primary care and specialty services, based on data collected through our survey.

Readers should be cautious in interpreting these data as they are only descriptive measures of the areas in which RHCs are located. As with earlier studies, our study suffers from the same lack of reliable data quantifying the impact of this program on access. On the other hand, our measures of rurality, shortage area designations, and county typology codes are based on the total population of RHCs (3,477 at the time of our study) rather than the more-limited sample used by earlier studies.

Key Findings

- Over 69 percent (2,407) of all RHCs are located in zip codes classified as small towns (with populations of less than 10,000) or isolated rural areas. Slightly less than 17 percent (581) are located in zip codes classified as large towns (with populations of 10,000 to 49,999). Just under 13 percent (438) are located in zip codes classified as suburban areas (large, towns, small towns, or isolated rural areas with strong commuting ties to an urban core area), although they still meet the definition of non-urbanized areas as required by the RHC Act. Finally, 1.5 percent (51) are located in areas currently classified as urban core areas (urbanized areas with populations of 50,000 or more).[3]

- Thirty-three percent of all RHCs are located in whole county Health Professional Shortage Areas (HPSAs). Another 40 percent are located in partial county HPSAs. Twenty-four percent are located in Medically Underserved Areas (MUAs). Less than 1 percent are located in Governor Designated Shortage Areas. Almost 3 percent are located in areas that are no longer designated as shortage areas.

- Thirty percent (1,041) of all RHCs are located in counties classified as "adverse" according to the economic typology codes. Of this group, 18 percent (620) are in counties classified as "farming dependent," with extremely high ratios of dependent populations to working-age adults and deteriorating economic bases; 5 percent (175) are in counties classified as "mining dependent" that experienced significant outmigration and economic decline during the 1980s; and 7 percent (246) are in counties classified as "government dependent," with levels of economic well-being that are lower than that for all non-metro counties.

- Fifty-one percent (1,753) of all RHCs are located in counties classified as "adverse," according to the policy typology codes. Of this group, 23 percent (792) are in counties classified as "persistent poverty" counties, with poverty rates of 20 percent or higher; 17 percent are in "transfer dependent" counties that depend heavily on unearned income from government transfer payments; and 11 percent (387) are in "commuting" counties, in which the level of economic activity within the local economy is less than that for all non-metro counties due to the outflow of workers.

- According to our survey respondents, indigent patients in their communities have the most difficulty obtaining primary care, with over 32 percent indicating difficulty levels of significant to extreme. Thirty-four percent of the respondents

thought that both Medicaid and self-pay patients experienced moderate to extreme difficulty in accessing primary care services. Medicare and commercial patients were reported to have the least difficulty, with 75 percent and 80 percent respectively, indicating difficulty levels of minimal to limited.

- Respondents indicated that all five payer classes experienced a greater degree of difficulty in obtaining specialty-care services (compared to primary care services) in their communities. Sixty percent reported that indigent-care patients experience significant to extreme difficulty in obtaining specialty-care services. Forty-four percent reported that both Medicaid and self-pay patients experienced significant to extreme difficulty in obtaining specialty care. As with primary care, Medicare and commercial patients were thought to have the least amount of difficulty, with 44 and 50 percent respectively falling into the minimal to limited categories.

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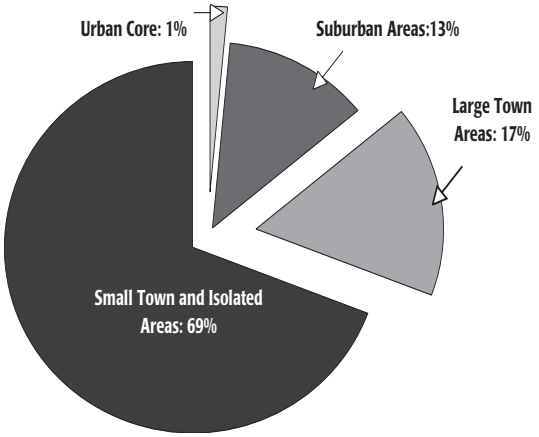
[1] Version 1.1 of the Rural Urban Commuting Area Codes, Zip Code Approximation File are based on 1990 Census data. The process of updating the RUCA taxonomy to the 2000 Census had not been completed as of the publication of this chartbook.

[2] The county typology codes identify 11 types of nonmetropolitan counties according to either the primary economic activity or other themes of social policy significance. The economic county typology codes are divided into six mutually exclusive classifications defined by primary economic activity. They can be further categorized as economically adverse (farming dependent, mining dependent, and government dependent) or favorable (manufacturing dependent, service dependent, and non-specialized counties) based on the economic performance of these counties. The policy typology codes are divided into five overlapping classifications defined by applicable themes of special policy significance. They may also be categorized as adverse (persistent poverty, transfer-dependent, and commuting counties) or favorable (retirement or federal lands counties based on the impact of these policy characteristics on the county.

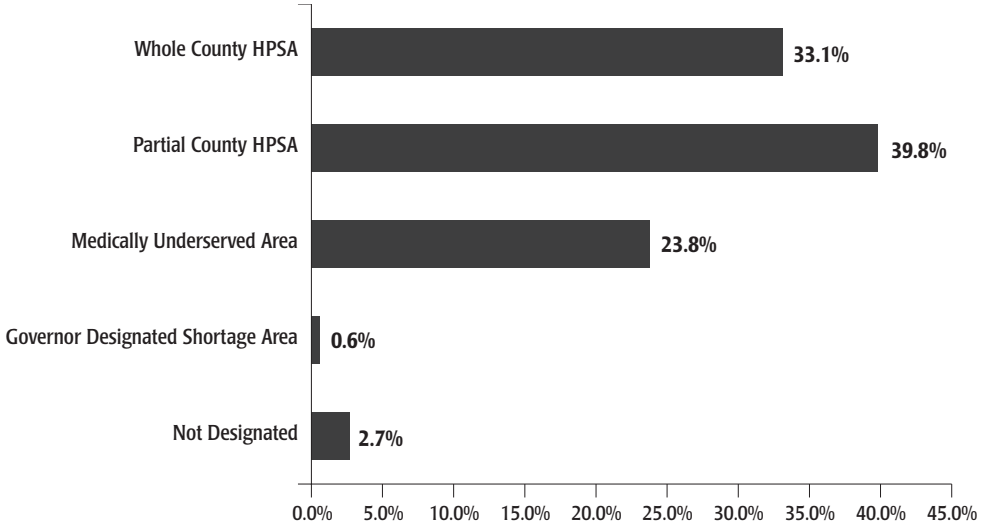
[3] This estimate was made using Version 1.1 of the Rural Urban Commuting Area codes which are based on 1990 Census data. Indications are that this number may be significantly higher when 2000 Census rural and urban classifications are available, although this has yet to be verified.

Distribution of RHCs by Georgraphic Location
OSCAR Data (N=3,477)



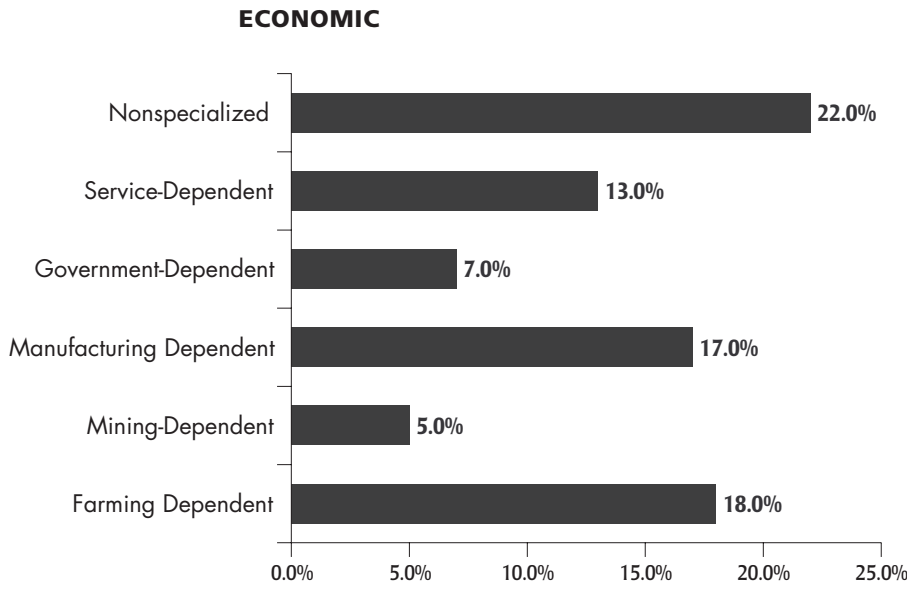
Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

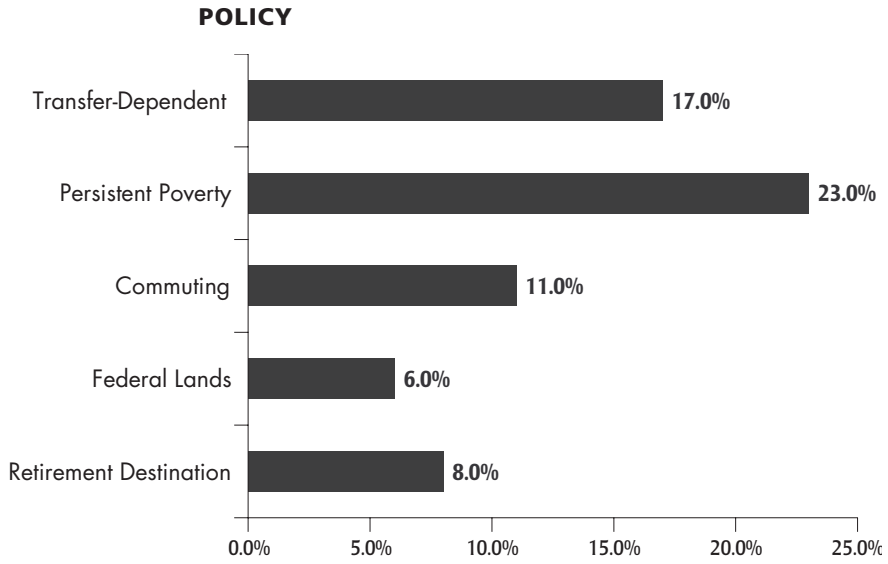
Shortage Area Designations for the Counties in which RHCs Are Located
OSCAR Data (N=3,477)



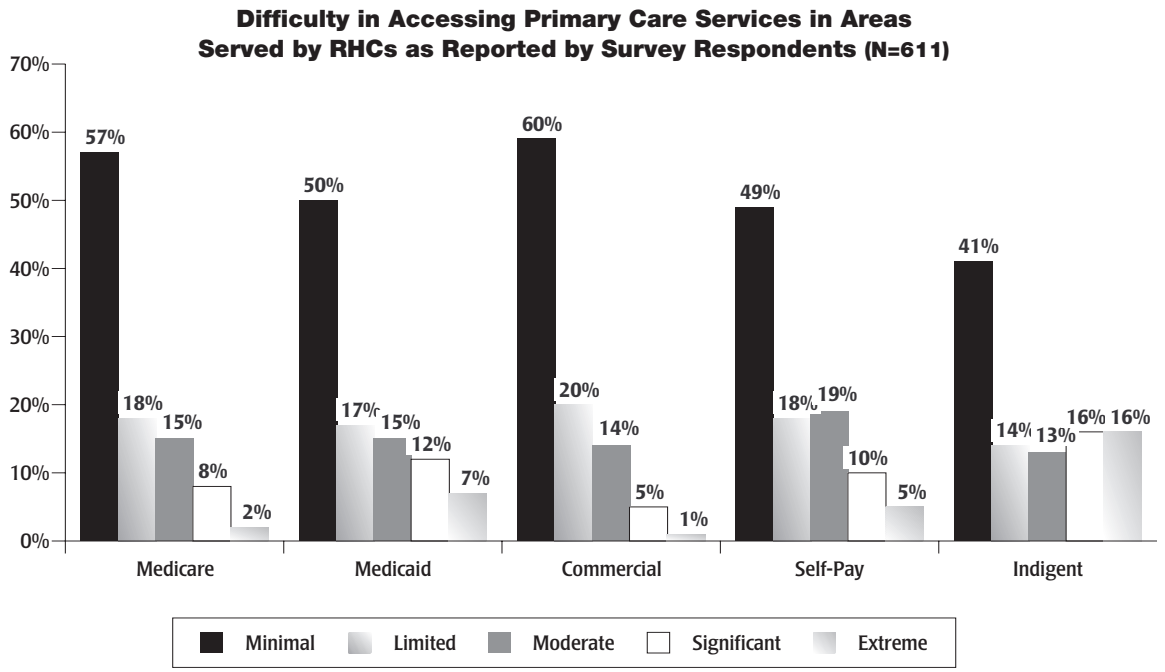
Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Location of RHCs by County Typology Code
OSCAR Data (N=3,477)

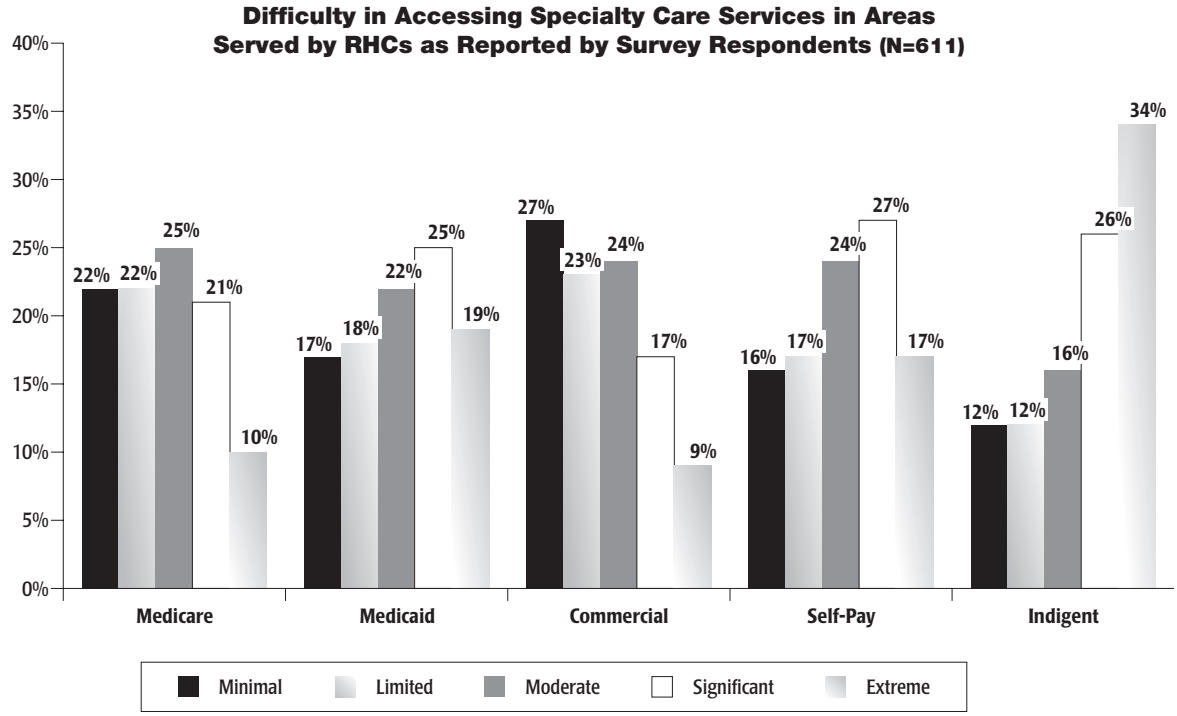




Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Section V

Proximity to Other RHCs and Primary Care Services

Background

The GAO and the OIG have raised concerns about situations in which multiple RHCs were located in the same community, or in which RHCs were located in communities with established health care infrastructures. In addition, the OIG raised concerns about the potential for RHCs, as a result of their preferential Medicare and Medicaid reimbursement, to compete unfairly with private practices, community health centers, and federally qualified health centers. Using data from OSCAR on the population of RHCs, we were able to look at the issue of where RHCs are located and how they are distributed on a national basis. In addition, our survey data allow us to describe the health care infrastructure of the communities in which RHCs are located.

Readers should be cautious when interpreting the data related to the health care infrastructure of the communities in which RHCs are located. The data on the providers, facilities, and agencies in a given community were reported by the survey respondents. The number of respondents that did not provide data on their communities was quite high, ranging from 16 to 46 percent overall. In addition, the distribution of the responses exhibited two patterns that influenced the calculation of the mean or average response. First, a high percentage of the respondents who answered this question reported "none" when asked about the number of different types of providers in their communities. The percentage ranged from a low of 12 percent for dentists to a high of 45 percent for school-based clinics. Second, some respondents reported unusually high numbers for different types of providers. As a result, we have reported both the mean (or average) number of providers, as well as the median (or midpoint) response. We have used the median, or most common response, for each category to describe the health care infrastructure in the communities in which RHCs are located.

The presence of other health care providers does not necessarily mean that RHCs are not improving access in rural communities. The impact on access within these communities cannot be determined without further study, using Medicare and Medicaid claims data and patient utilization patterns within individual communities.

Key Findings

- Over 81 percent (2,242) of the zip codes in which RHCs are located have only one RHC. Less than 19 percent (513) of the zip codes have more than one RHC located within them.
- The average number of RHCs located in zip codes with more than one RHC is 2.4.
- The typical health care infrastructure of the communities in which RHCs are located consists (based on the median response) of a hospital, an outpatient clinic, a primary care physician/practice, a public health clinic, a mental health agency, a home health agency, and two dentists.

Distribution of RHCs by Zip Code
OSCAR Database

Mean # of RHCs in zip codes with more than one RHC	2.4	
Percent of zip codes with multiple RHCs (Total Number of zip codes = 2,755)	N=513	18.6%
Percent of zip codes with only one RHC	N=2,242	81.4%
Range of RHCs in single zip code	1	7

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

The Health Care Infrastructure of Communities in which RHCs Are Located
Survey Data (N=611)

Provider Type	Mean	Median	N	Range of Responses	Percent Reporting "None"	Percent "No Response"
Hospitals	0.9	1	514	0-20	26%	16%
Outpatient Clinics	0.8	1	427	0-10	30%	30%
Primary Care Physicians/Practices	3	1	450	0-50	20%	26%
Specialty Care Physicians/Practices	2.8	0	371	0-50	33%	39%
Public Health Clinics	0.7	1	442	0-7	24%	28%
School-Based Clinics	0.2	0	310	0-6	45%	49%
Other RHCs	0.7	0	389	0-6	33%	36%
FQHCs	.30	0	331	0-7	41%	46%
Mental Health Agencies	0.7	1	416	0-5	26%	32%
Family Planning Agencies	0.5	0	379	0-3	33%	38%
Home Health Agencies	1.3	1	465	0-30	19%	24%
Dentists	3.0	2	483	0-50	12%	21%

Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Section VI

Safety Net Role of RHCs

Background

RHCs are increasingly viewed as safety net providers *(Gaston, 1997, Buto, 1997, and Gage, 2000)* given their role in serving Medicare, Medicaid, and other vulnerable populations in rural areas. Unfortunately, the application of this term to RHCs has created potentially unrealistic expectations for the program. This is due to the general lack of agreement on which providers comprise the safety net. Similarly, there is a general lack of understanding on what constitutes safety net services.

The Institute of Medicine (IOM) in **America's Health Care Safety Net: Intact But Endangered** *(Lewin and Altman, 2000)* acknowledged this general lack of agreement. In an effort to bring clarity to the situation, the IOM proposed its own definition of safety net providers as:

"Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations."

The IOM further identified a subset of the safety net that is described as "*core safety net providers."* According to the IOM, core safety net providers have two distinguishing characteristics: first, they have a legal mandate or explicit mission to offer access to services to patients regardless of their ability to pay; second, a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable populations.

By virtue of the process for certification, RHCs meet the IOM's definition of safety net providers, due to their location in rural areas that have also been designated as shortage areas. Although they are not required to provide services to uninsured and indigent patients nor are they paid to do so, a subset of RHCs may also qualify as core safety net providers according to the IOM's definition based on ownership, corporate structures, institutional mission, and/or patient populations.

As mentioned, RHCs are not obligated to provide services to vulnerable and underserved populations. Although self pay, uninsured, and low income patients make up a significant portion of the patient base of many RHCs, these facilities receive no specific reimbursement for the delivery of services to these populations. As discussed in Section III Financial Operations, many RHCs continue to struggle financially despite the provision of cost-based reimbursement.

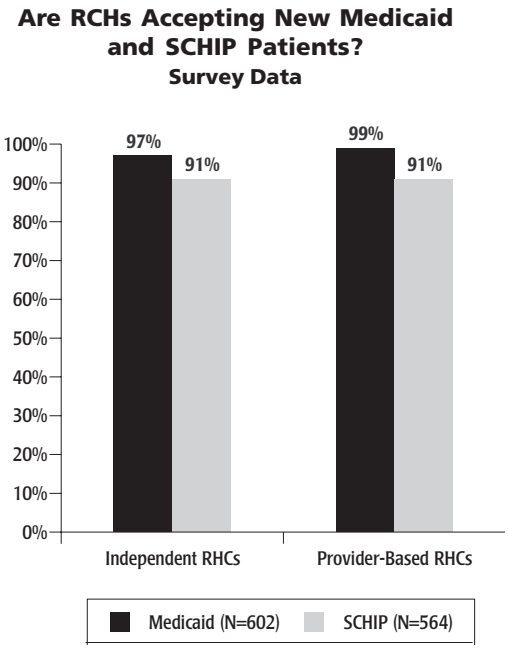
In addition, many RHCs do not have the necessary financial reporting systems to distinguish between write offs for bad debt and free/reduced-cost care. As a result, they are unable to provide accurate data on the amount of free/reduced-cost care they deliver. Therefore, it is difficult to clearly quantify the level of free/reduced-cost care rendered by RHCs nationally.

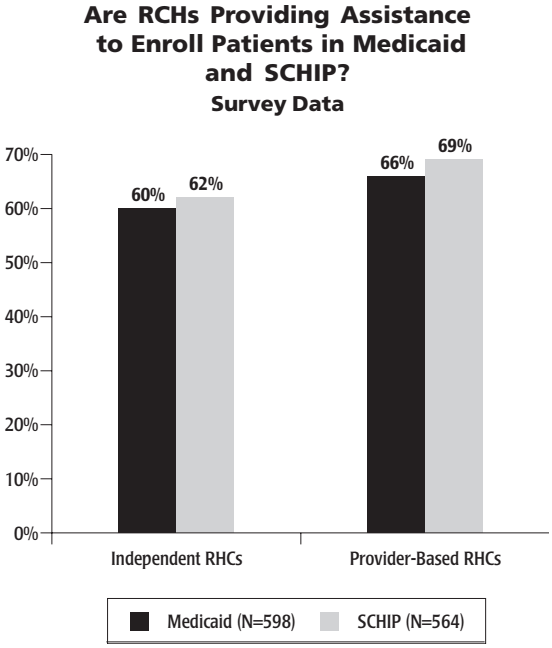
Despite the fact that RHCs can be identified as part of the health care safety net, comparatively little is known about the safety net functions they perform and, due to the reporting issues discussed above, the amount of charity and indigent care they render. In an effort to begin to describe the safety net role of RHCs, we added a number of safety net-related questions to our survey.

Key Findings

- Ninety-seven percent of independent and 99 percent of provider-based RHCs clinics report that they are accepting new Medicaid patients. In addition, 91 percent of both types of clinics are accepting new patients enrolled in State Children's Health Insurance Programs (SCHIP).
- Slightly more provider-based RHCs provide assistance to enroll potentially-eligible patients in Medicaid (66 percent verses 60 percent) and SCHIP (69 percent compared to 62 percent) than do independent RHCs. This may be due to the fact that provider-based RHCs are able to use the registration policies and support staff of their sponsoring hospitals.
- Most commonly, RHCs provide Medicaid and SCHIP application forms (39 and 40 percent of independent and provider-based RHCs respectively) and assistance in completing those forms (37 and 39 percent of independent and provider-based RHCs respectively). Comparatively few RHCs (7 and 6 percent of independent and provider-based RHCs respectively) work to enroll patients directly in these programs.
- More provider-based RHCs (69 percent) have either formal or informal polices covering the provision of free/reduced cost care to low income patients than do independent RHCs (55 percent). The difference may be due to the fact that provider-based RHCs are likely to have access to the policies and systems developed by their sponsoring hospitals.
- Of these facilities, 81 percent of independent and 79 percent of provider-based clinics report that they are accepting new applications from patients for free/reduced-cost care.

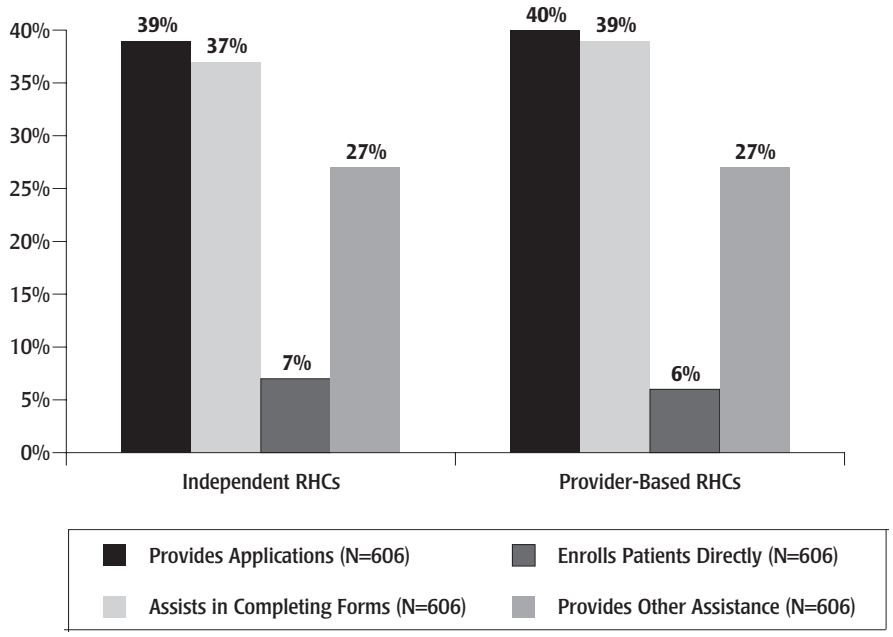
- The most common method for determining eligibility for free/reduced-cost care is an income based sliding fee scale used by 61 percent of independent and 65 percent of provider-based RHCs respectively.
- In contrast, 14 percent of independent RHCs and 9 percent of provider-based RHCs conduct no eligibility determinations.
- The remaining RHCs use a variety of eligibility criteria to qualify patients for the free/reduced-cost care.
- Fifty-one percent of independent RHCs and 55 percent of provider-based RHCs wrote off between 0 and 4 percent of total charges as free and reduced-cost care during the past year. Another 24 percent of independent and 18 percent of provider-based RHCs wrote off between 5 and 9 percent of total charges. Twelve percent of independent RHCs and 11 percent of provider-based RHCs wrote off between 10 and 14 percent of charges. Close to 13 percent of independent RHCs and more than 16 percent of provider-based clinics wrote off 15 percent or more of total charges as free/reduced-cost care.
- Independent RHCs estimated that 9 percent of monthly visits received free or reduced-cost care compared to 7 percent for provider-based RHCs.





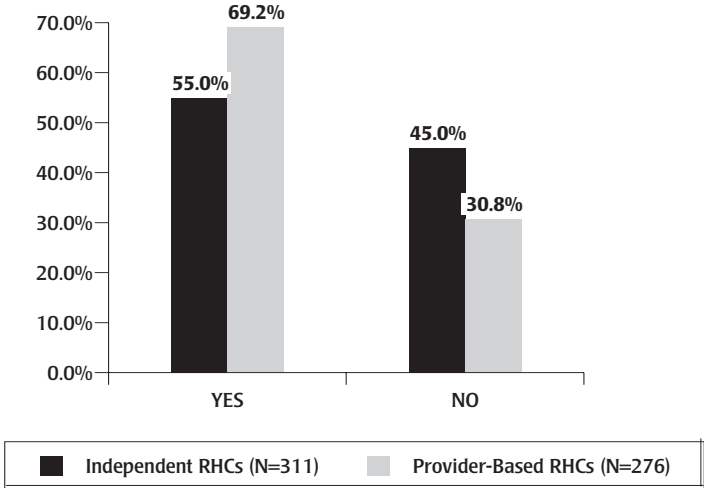
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Types of Assistance Provided to Enroll Medicaid/SCHIP Eligible Patients
Survey Data



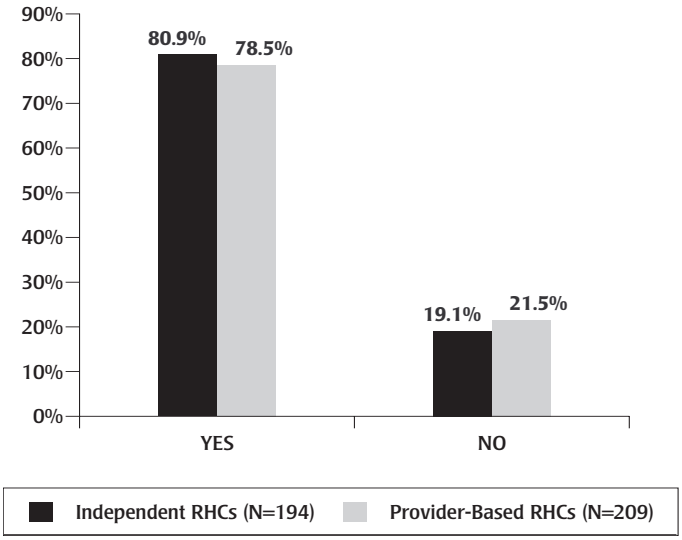
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Do RHCs Have Policies covering the Provision of Free and Reduced-Cost Care?
Survey Data (N=587)



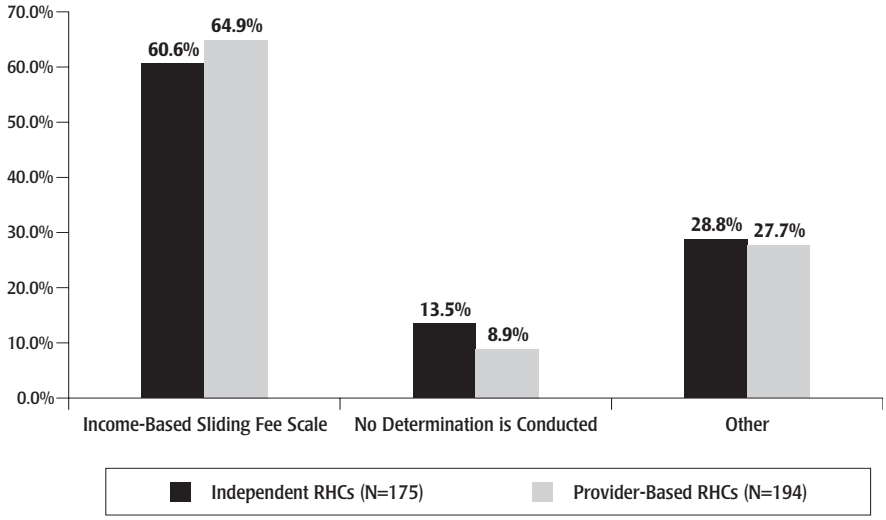
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Are RHCs Accepting Applications for Free and Reduced-Cost Care?
Survey Data (N=403)



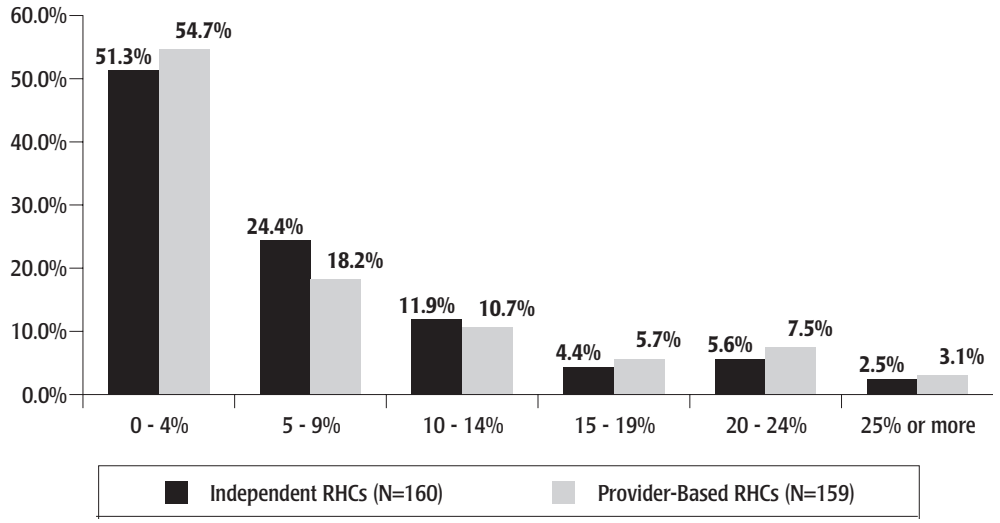
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

How is Eligibility Determined for Free/Reduced-Cost Care?
Survey Data (N=369)



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Percentage of RHC Charges Written Off as Free/Reduced-Cost Care during the Past Year
Survey Data (N=319)



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Percentage of Monthly Visit That Received Free/Reduced-Cost Care during the Past Year
Survey Data (N=319)

	% of Visits	N	Range
All RHCs	7.8%	292	0 to 98%
Independent RHCs	8.7%	148	0 to 98%
Provider-Based RHCs	7.0%	144	0 to 80%

Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Section VII

Participation of RHCs in Health Professions Education

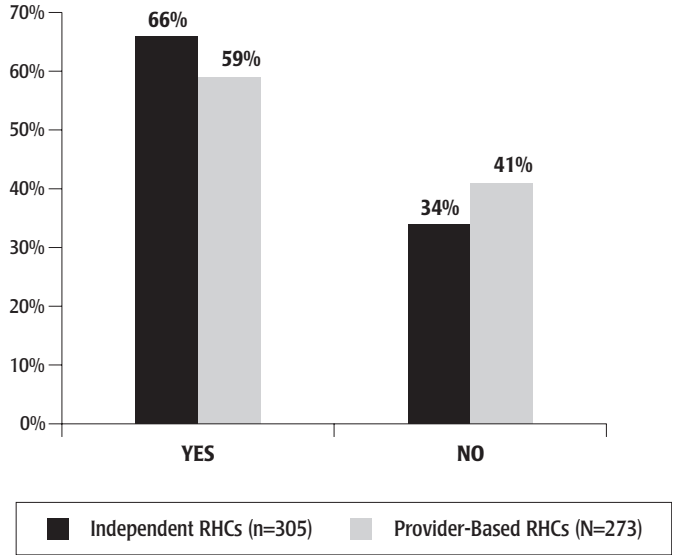
Background

In light of the difficulties faced by RHCs in recruiting and retaining health professionals (physicians, midlevel providers, registered nurses, and others), policymakers have expressed interest in the extent to which RHCs participate in the education of health professionals, who may later choose to practice in rural areas as a result of their training experience. To date, there has been little if any information on the participation of RHCs in health professions education. To rectify this gap in our knowledge, we asked a series of questions regarding the participation of RHCs in health professions education and the number of health professions students rotating through their RHCs during the course of a year. Additional research is needed to determine how many students, who rotate through RHCs actually practice in rural areas over time.

Key Findings

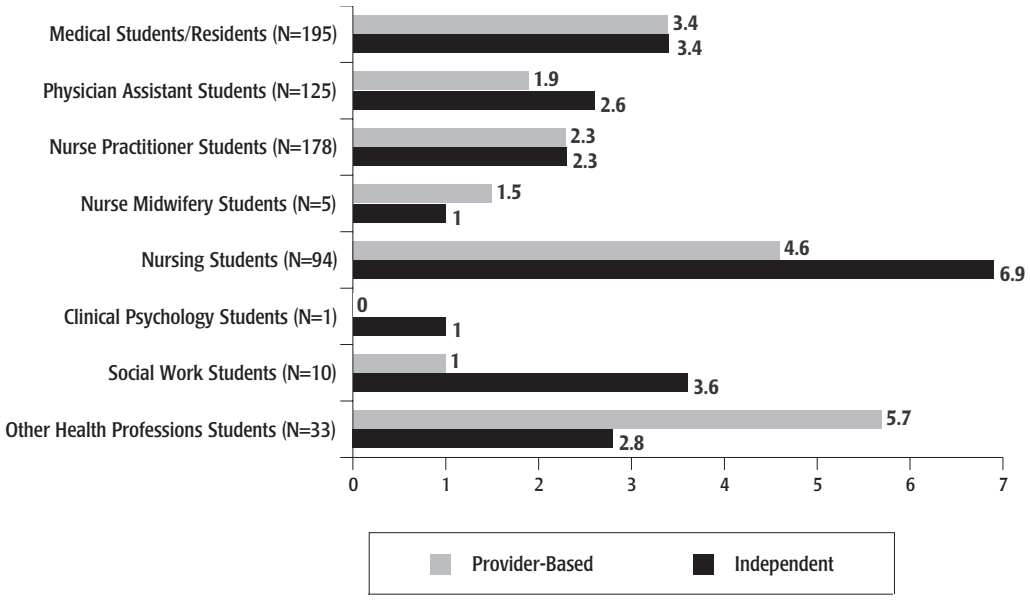
- Sixty-three percent of the survey respondents who answered this questions report that their RHCs participate in health professions education.
- Sixty-six percent of independent RHCs participated in health professions education compared to 59 percent of provider-based facilities.
- An average of 3.4 medical students/residents rotated through both independent and provider-based RHCs per year.
- On average, 2.6 physician assistant students rotated through independent RHCs per year compared to 1.9 through provider-based clinics.
- On average, 2.3 nurse practitioner students rotated through both types of clinics per year.
- On average, 6.9 nursing students rotated through independent RHCs yearly compared to 4.6 through provider-based clinics.

Are RHCs Serving as Training Sites for Health Professions Students?
Survey Data (N=578)



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Average Number of Health Professions Students Rotating through RCHs by Clinic Type
Survey Data



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Section VIII

Networking Activities of RHCs

Background

The Rural Health Clinic Act established the RHC program to support and expand the primary care infrastructure in rural communities through the expansion of coverage for mid-level providers, and the provision of cost-based reimbursement for core RHC services. The program's impact on the health care infrastructure in rural communities occurs on a clinic-by-clinic basis.

Since the establishment of the RHC program in 1977, the concept of networking has emerged as an important strategy for improving access to health care services in rural communities. Although the RHC program provides no specific incentives for networking, RHCs are likely candidates to benefit from ongoing networking activities. However, little, if any, information has been available on the extent to which RHCs are engaging networking activities, the types of health care providers with whom they are networking, and the specific focus of those efforts.

The survey represents an initial exploration of RHC networking efforts. Further research is needed to understand the nature of those efforts, the benefits realized by the participants, the costs involved, the impact of these initiatives on the rural health care infrastructure, and the policy implications of these activities.

Key Findings

- Seventy percent of RHCs are participating in networking activities.
  - Twenty-six percent of all RHCs are engaged in 1 to 2 different types of networking activities.
  - Twenty-one percent are engaged in 3 to 4 networking activities.
  - Sixteen percent are engaged in 5 to 6 activities.
  - Seven percent are engaged in 7 or more activities.

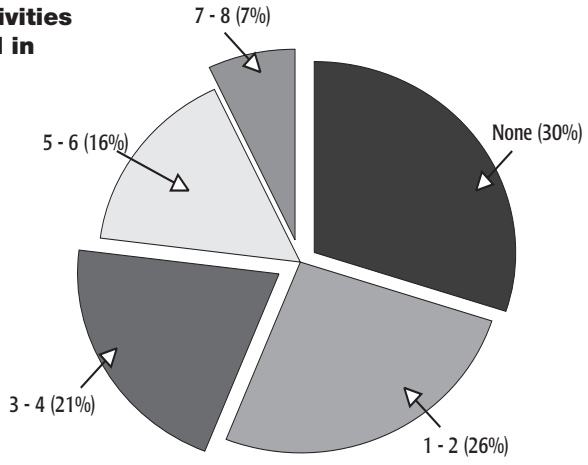
- Shared management, human services activities, and clinical and quality-related activities are the most common networking activities in which the responding RHCs are engaged (47 percent, 44 percent, and 35 percent respectively). Other common networking activities include participation in physician hospital organizations (30 percent), referral agreements (27 percent), and managed care contracting arrangements (30 percent).

- Rural hospitals and rural hospital systems are the most common partners with which RHCs are networking.[1]

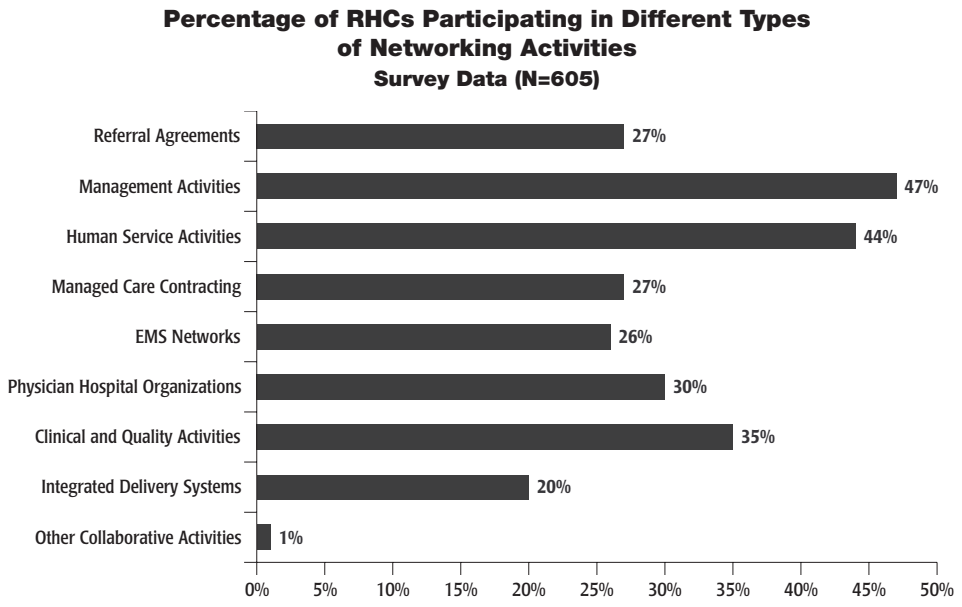
  - Fifty percent of all RHCs engaged in networking efforts are working with rural hospitals and/or rural hospital systems.
  - Thirty percent are working with private practice and other providers.
  - Twenty-four percent are networking with urban hospitals and urban hospital systems.
  - Thirteen percent are working with other RHCs and FQHCs.

[1] Individual RHCs may be engaged in multiple networking activities with multiple partners.

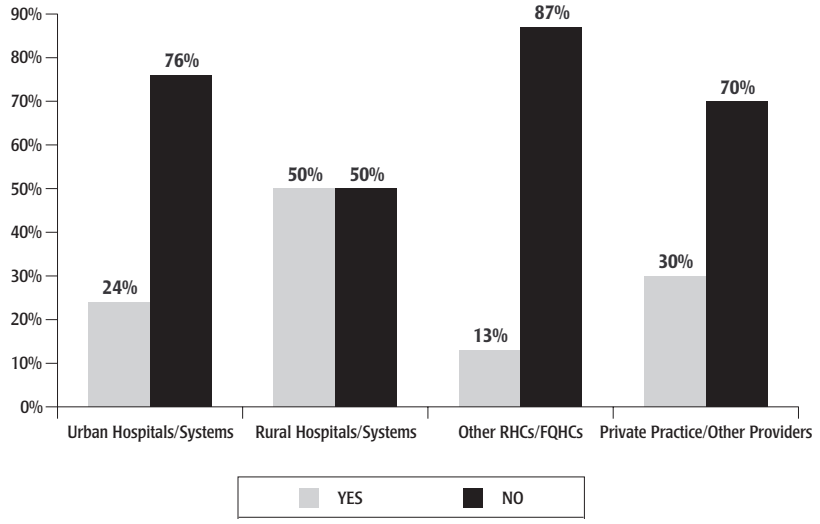
Number of Networking Activities That RHCs Are Engaged in by Different Types
Survey Data (N=605)



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine

Types of Networking Activities in Which RHCs Are Engaged by Type of Networking Partner
Survey Data (N=605)

	Urban Hospitals or Systems		Rural Hospitals or Systems		Other RHCs/FQHCs		Private Practice and Other Providers	
	N	%	N	%	N	%	N	%
Referral Agreements	46	8%	104	17%	23	4%	67	11%
Management Activities	67	11%	176	29%	43	7%	85	14%
Human Service Activities	80	13%	180	30%	29	5%	46	8%
Managed Care Contracting	41	7%	104	17%	15	3%	43	7%
EMS Networks	36	6%	115	19%	5	1%	24	4%
Physician Hospital Organizations	56	9%	130	22%	8	1%	20	3%
Clinical and Quality Activities	58	10%	144	24%	15	3%	29	5%
Integrated Delivery Systems	35	6%	90	15%	11	2%	14	2%
Other Collaborative Activities	3	1%	3	1%	0	0%	4	1%

Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Section IX

Participation of RHCs in Managed Care Programs

Background

Managed care presents a challenge for RHCs, given their heavy dependence on Medicare and Medicaid and their comparatively limited commercial insurance bases. As discussed in Section III: Financial Operations, Medicare and Medicaid account for 55 percent of the payer mix of most RHCs. In contrast, commercial and other private insurances account for just under 30 percent of the average payer mix, when measured as a percentage of revenues. Despite cost-based reimbursement under Medicare and Medicaid, most RHCs are struggling financially *(see Section III)*.

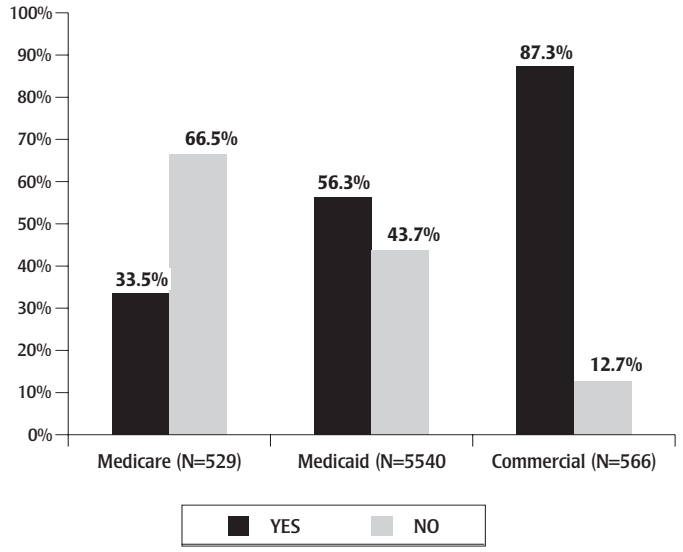
Managed-care programs can compromise the tenuous financial status of RHCs by demanding discounts from RHCs and/or potentially excluding them from their provider networks. Given their dependence on Medicaid and Medicare revenues and the fact that Medicaid and Medicare managed care plans are not required to reimburse RHCs on a cost basis, RHCs may have little choice but to accept the discounted rates offered by these plans, or risk the loss of their patient base.

Although managed care has declined in many markets, it is still an important source of coverage in some markets and in a number of state Medicaid programs. As such, it is necessary to understand the impact of managed care on RHCs. Although, we have begun to document the extent to which RHCs are involved with managed-care plans, further research is needed to fully understand the financial and operational impact of managed care on RHCs.

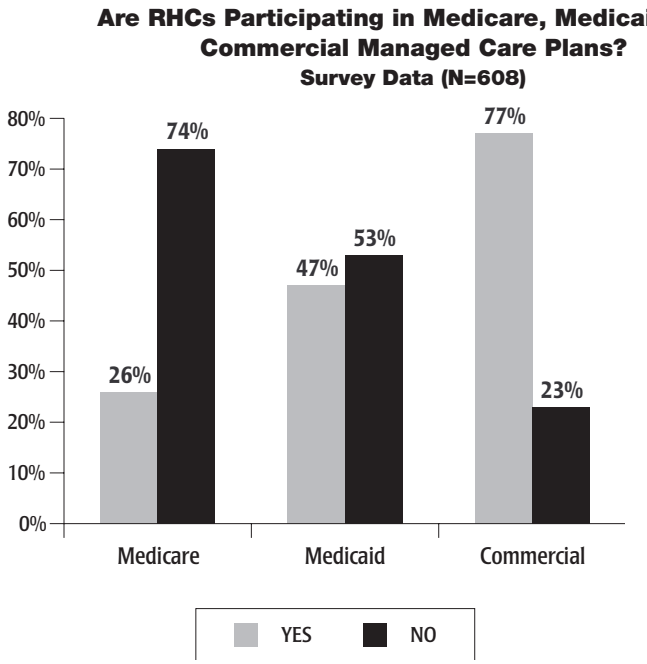
Key Findings

- Eighty-seven percent of the responding RHCs reported that commercial managed-care plans were available to patients in their markets. Seventy-seven percent of the survey respondents reported that their RHC participated in one or more commercial managed care plans.
- Over 33 percent reported that Medicare managed-care plans were available to patients in their markets. Twenty-six percent of the survey respondents reported that their RHC participated in one or more Medicare managed care plans in their market area.
- Fifty-six percent reported that Medicaid managed care plans were available to patients in their markets. Forty-seven percent of the survey respondents reported that their RHC participated in one or more Medicaid managed care plans.
- Although Medicaid managed-care plans are not required to reimburse RHCs on a cost basis, almost 41 percent of the RHCs that participated in Medicaid managed care plans (N=285) reported that they received cost-based reimbursement. Close to 30 percent were being paid either on a full- or partial-capitated basis. Just under 26 percent were being paid on a discounted fee-for-service basis. Slightly less than 8 percent were being paid through a variety of other methods.[1]
- Twenty-five percent received wrap-around payments from the state to supplement payments received from Medicaid managed care plans.
- RHCs that participated in managed care plans received 24 percent of revenues from commercial managed care plans, 21 percent from Medicaid managed care plans, and 14 percent from Medicare managed care plans.
- Of those RHCs participating in managed care plans, 70 percent reported participating in preferred provider organizations, 63 percent in health maintenance organizations and/or point of service plans, 33 percent in primary care case management plans, and two percent in other forms of managed care plans.

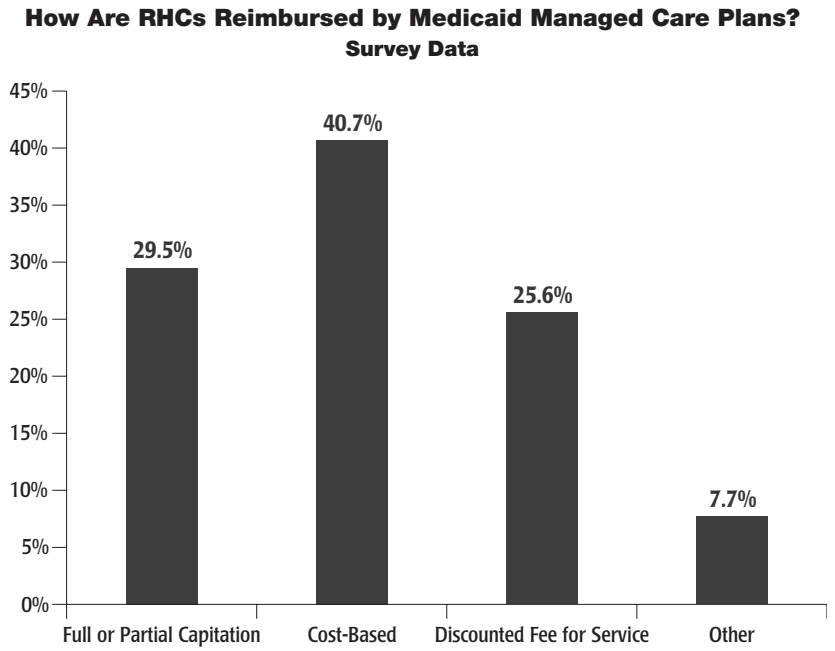
[1] These percentages exceed 100 percent as some RHCs reported receiving multiple forms of reimbursement from Medicaid managed care plans.



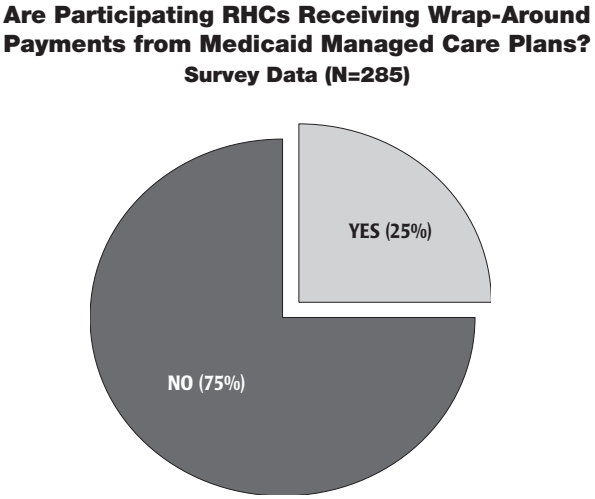
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



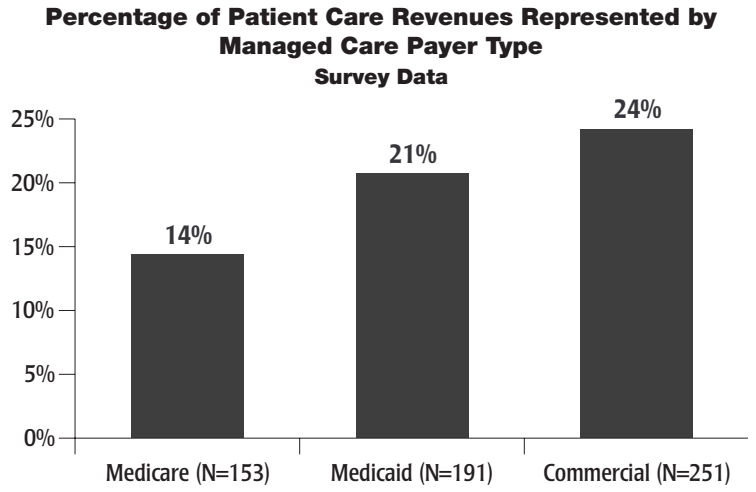
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



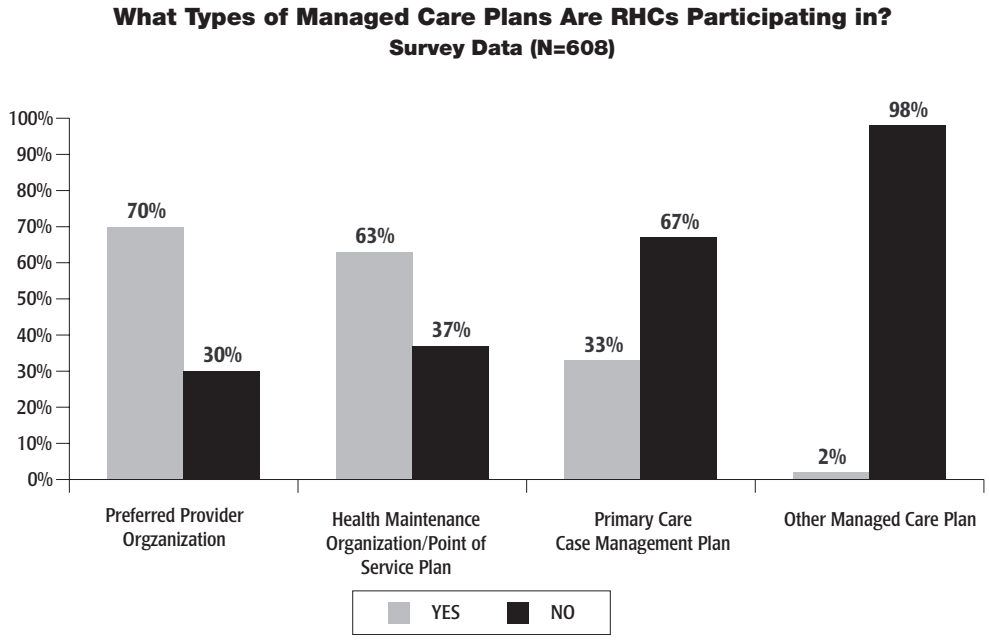
Source: 2000 National Survey of Rural Health Clinics, Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine



Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine

Section X

Policy Implications

Rural Health Clinics have become an important part of the rural health care infrastructure with 3,477 clinics (at the time of our survey) serving patients in rural communities across the country. The original intent of the program was to support and enhance the availability of primary care services in rural, underserved communities (defined as non-urbanized areas with populations of less than 50,000 and carrying a HPSA, MUA, or GDSA designation) through the provision of cost-based reimbursement for care delivered to Medicare and Medicaid patients, and through the provision of coverage for NPs, Pas, and CNMs. With the exception of changes to the methodology for the Medicaid reimbursement mandated by BIPA 2000, the interventions employed by the RHC program remain the same.

Despite the enhanced reimbursement provided by the RHC program, many RHCs face continued challenges in providing primary care services to rural, underserved residents, not the least of which are changing expectations by state and federal policymakers regarding the role of RHCs as safety net providers; regulatory changes mandated by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000; and the ongoing operational difficulties stemming from their location in rural communities. These latter difficulties include serving populations with higher rates of uninsurance and underinsurance, greater dependency on Medicare and Medicaid reimbursement, and recruitment and retention difficulties. These challenges and difficulties speak directly to the issues of supporting the primary care infrastructure in rural communities and should not be overlooked by policymakers when considering changes to the program. Accordingly, we present the following considerations that should be taken into account in efforts to support the delivery of primary care services to underserved and vulnerable populations in rural communities through the Rural Health Clinics Program.

A. Most RHCs continue to serve rural, underserved communities as defined by the program regulations.

Just under 99 percent of RHCs in operation at the time of our survey were located in rural areas as defined by the Rural Health Clinic Services Act. Over 69 percent of the clinics at the time of our survey were located in areas classified as small towns with populations of under 10,000 or isolated areas. Another 17 percent were located in areas classified as large towns with populations of under 50,000. Just under 13 percent are located in areas classified as suburban primarily due to their commuting ties to urban core areas. As these suburban areas may be large towns, small towns, or isolated areas,

they still meet the rural definition established for the program. Over 97 percent continue to be located in areas designated as health manpower shortage areas.

Caution should be used when interpreting these data as estimates are based on 1990 Census data. Indications are that classification of the areas in which RHCs are located may change when the RUCA codes are updated to the 2000 Census, although we are unable to estimate the extent of the changes at this time.

B. The potential impact of the refinements to the shortage area requirements mandated by the Balanced Budget Act of 1997 remains unclear.

The potential impact of the BBA 1997-mandated refinements to the shortage area requirements for RHCs remains unclear for four primary reasons. First, the regulations implementing the provisions of BBA 1997 have not been finalized as of October 2002. Second, the RUCA codes, which were used to estimate the rurality of the communities in which RHCs are located, are based on 1990 Census data.[1] Third, existing data sets containing information on partial county HPSAs, MUAs, and GDSAs are not easily linked to our file of RHCs as the shortage areas are defined by a variety of geographic designations, including census tracts, minor civil divisions, and townships. No translation file exists to match the location of RHCs to the boundaries of these partial county shortage areas. Finally, the shortage area data contained in the Area Resource File, as used in our analysis, do not include the date of designation nor the fate of the most recent update of existing shortage areas. As the proposed regulations require that RHCs be located in an area that has been designated as a shortage area or had its shortage designation updated within the past three years, this information is required to accurately estimate the impact of these regulatory changes.

In light of these limitations, the following estimates of the impact of the proposed shortage area refinements should be considered as both tentative and conservative. Based strictly on the first draft of the proposed regulations, 1.5 percent (51 clinics) may be at risk for losing their RHC certification because the areas in which they are located are no longer classified as nonurbanized.[2] Three percent are at risk for losing their certification due to the lost of their shortage area designation, unless they qualify for an exception under one of the five essential provider tests established by the proposed regulations. Again, it should be remembered that additional clinics may be at risk depending on the dates of their shortage area designations or updates.

C. RHCs are functioning as safety net providers by serving a substantial number of uninsured, Medicaid, and other vulnerable populations; by delivering free and reduced cost care to indigent patients; and by providing assistance to enroll eligible patients in Medicaid, State Children's Health Insurance Programs, and other assistance programs for which they might be eligible.

The Institute of Medicine has defined safety net providers as "those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable populations." RHCs clearly fall under this definition as services delivered to Medicaid, uninsured, self-pay, and free/reduced-cost care patients account for approximately 45 percent of their overall volume, whether measured as a percentage of revenues or as a percentage of patient visits. Ninety-nine percent of the survey respondents reported that they are accepting new Medicaid patients. Ninety-one percent are accepting new patients enrolled in State Children's Health Insurance programs.

Over 32 percent of survey respondents indicated that indigent patients experience significant to extreme difficulty in accessing primary care in their communities, while 43 percent indicated that Medicaid and self-pay patients experienced moderate to extreme difficulty. These populations would likely experience even greater difficulty in obtaining primary care services if the RHCs in their communities were to close.

Despite not receiving financial support to do so, 24 percent of independent and 18 percent of provider-based RHCs that responded to our survey wrote off between 5 and 9 percent of their total charges as free- and reduced-cost care. Another 51 percent of independent RHCs and 55 percent of provider-based clinics wrote off up to 4 percent of their total charges. Almost 12 percent of independent RHCs and 11 percent of provider-based RHCs wrote off between 10 and 14 percent of total charges. Finally, 13 percent of independent and 16 percent of provider-based RHCs wrote off 15 percent or more of total charges as free/reduced-cost care to low income and indigent patients.

Fifty-five percent of independent and 69 percent of provider-based RHCs have either formal or informal policies governing the provision of free- and reduced-cost care. Of these facilities, 81 percent of independent and 79 percent of provider-based clinics report that they are accepting new applications from patient for free- and reduced-cost care. Most commonly, independent and provider-based RHCs use a sliding fee scale (61 percent and 65 percent respectively) to determine eligibility for these services.

In addition, many RHCs provide assistance to enroll eligible patients in Medicaid (60 percent of independent and 66 percent of provider-based clinics) and SCHIP programs (62 percent of independent and 69 percent of provider-based clinics). This

assistance includes the provision of Medicaid and SCHIP application forms (39 and 40 percent of independent and provider-based clinics respectively) and assistance in completing those forms (37 and 39 percent of independent and provider-based clinics respectively).

As mentioned earlier, RHCs do not receive specific funding to support the provision of safety net services to vulnerable populations. We encourage policymakers to explore ways to support RHCs in their roles as safety net providers. Possible policy interventions may include: the collection and analysis of data nationwide on the level of free- and reduced-cost care provided by RHCs; the provision of financial support for the uncompensated care delivered to indigent patients; and policies to expand the abilities of RHCs to participate in the enrollment of eligible patients in Medicaid, SCHIP, and other support programs.

D. Recruitment and retention of professional staff is a problem for many RHCs.

Eighteen percent of responding clinics indicated that they had a vacant physician position during the 12 months prior to our survey. Twenty percent indicated that they had a vacant nurse practitioner, physician assistant, or certified nurse midwife position within the same period. Of those RHCs with physician vacancies, 77 percent had trouble recruiting for, and filling, their vacant positions. Vacant physician positions were open for an average of 10 months before being filled. Forty-nine percent of RHCs with NP, PA, or CNM vacancies had trouble filling their vacancies. These positions remained open almost five months before being filled. Given the requirement that RHCs be located in designated health manpower shortage areas, this difficulty in recruiting should not be surprising. These vacancies compromise access to services within the surrounding area and the financial viability of these clinics. Federal and state policymakers should consider ways in which existing Federal programs, such as the National Health Service Corp and state level recruitment initiatives, can be used to support Rural Health Clinics.

E. Despite reimbursement enhancements provided by the RHC program, some RHCs continue to face significant financial challenges.

Although the Rural Health Clinics Services Act provided for cost-based reimbursement under Medicare and Medicaid, some RHCs continue to face significant

financial challenges. Our survey respondents reported that, on average, total expenses exceeded total revenues. Independent RHCs reported that, on average, total expenses exceeded total revenues by $40,505, with an adjusted cost per visit of $66.31. Provider-based RHCs reported that total expenses exceeded total revenues by $38,441, with an adjusted cost per visit of $81.01. In comparison, the cap on per-visit reimbursement that applied to independent RHCs and provider-based RHCs owned by hospitals of 50 beds or more was $60.40 in 1999 and $61.85 in 2000.

RHCs remain heavily dependent on Medicare and Medicaid, as sources of funding for patient care with these two payer sources accounting for 55 percent of RHC revenues. In contrast, commercial and private insurances account for less than 30 percent of revenues. Uninsured, private pay, and free/reduced-cost care patients account for slightly less than 15 percent of revenues. RHCs located in areas with lower levels of employer-sponsored health insurance, or greater levels of uninsured or underinsured residents, may be more dependent on Medicare and Medicaid than the overall population of RHCs.

Unfortunately, our data do not allow us to understand the impact of reimbursement caps, the Medicaid prospective payment system, and other financial policies on the overall population of RHCs and sub-populations of RHCs that may be subject to greater levels of financial pressure because of their location in more isolated or economically-distressed areas. We encourage policymakers at both the federal and state levels to consider these issues prior to making further changes to reimbursement policies affecting RHCs. We also encourage them to conduct the analysis needed to better understand the impact of their decisions on RHCs, and to explore policy options to support RHCs in the delivery of primary care services to underserved residents in rural communities.

F. Most RHCs have not taken advantage of opportunities to employ mental health professionals as allowed under the terms of the program.

Although amendments to the Rural Health Clinic Services Act added the services of clinical psychologists in 1987 and clinical social workers in 1989 to the core services eligible for cost-based reimbursement, only 0.12 percent of the survey respondents reported that their clinic employed either a PhD or Master's level psychologist and 0.07 percent employed a clinical social worker. Given the shortage of mental health services available in rural communities, the RHC program represents an unrealized opportunity to provide important services needed by rural residents.

In many ways, the RHC is an ideal vehicle to expand the availability of mental health services in rural areas. As the primary care providers employed by RHCs identify mental health issues among their patients, the presence of a clinical psychologist or clinical social worker on-site would facilitate their ability to refer those patients for services. At the same time, the location of these mental health providers within the RHC would serve to minimize the stigma associated with the receipt of services. Unfortunately, we don't know why more RHCs have not added the services of clinical psychologists or clinical social workers to their core service offerings. Further research is needed to understand the barriers to doing so, and to develop the necessary policies to encourage more RHCs to consider this option.

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[1] The RUCA taxonomy will not be updated to the 2000 Census until the later part of 2002.

[2] Indications are that this number may be significantly higher when 2000 Census rural and urban classifications are available, although this has yet to be verified.

References

American Academy of Physician Assistants. (1997). *Policy Brief: Rural Health Clinics,* [Online]. Available: http://www.aapa.org/gandp/rhc.html. [2001, July 23].

Baird-Holmes, D., Brown, M., Eley, C. and Valdmanis, V. (1999). Rural health clinics in Oklahoma: An exploratory study. *Texas Journal of Rural Health, 17*(1):18-26.

Buto, K. (1997, Feb. 13). *Statement of Kathleen A. Buto, Associate Administrator for Policy, Health Care Financing Administration on Rural Health Clinics: Before the House Committee on Government Reform and Oversight Subcommittee on Humans Resources and Intergovernmental Relations,* [Online]. Available: http://www.cms.hcfa.gov/testimony/1997/t970213d.asp., [2001, Nov. 7].

Center for Medicare & Medicaid Services State Medicaid Directors' Letter (2001, Jan. 19). *State Medicaid Director's Letter* (SMDL # 01-014), [Online]. Available: http://cms.hhs.gov/states/letter/smd119a1.asp. [2002, Sept. 10].

Cheh, V. and Thompson, R. (1997). *Rural Health Clinics: Improved access at a cost. Executive summary. (MPR Reference No. 8293)* Princeton, NJ: Mathematica Policy Research, Inc.

Cook, P.J., and K.L. Mizer. (1994). *The revised ERS County Typology: An overview.* (Rural Development Research Report 89). Place: U.S. Department of Agriculture, Economic Research Service.

Finerfrock, B. (1999, Nov. 9). *Medicaid and Rural Health Clinics – The Untold Story.* Paper presented at the annual meeting of the National Association of Rural Health Clinics, Washington, DC.

Finerfrock, B. and Petersen, J. (1994). Rural Health Clinics explode across U.S. *Rural Health News, 1*(3), 5.

Gage, L. (2000, Mar. 23). *Statement of Larry S. Gage, President, National Association of Public Hospitals and Health Systems: Before the Senate Health, Education, Labor and Pensions Subcommittee on Public Health,* [Online]. Available: http://naph.activematter.com/Content/ContentGroups/Advocacy_Issues/Statements_And_Testimony/IAST-LarrySGageTest.pdf. [2002, July 2].

Gaston, M. (1997, Feb. 13). *Testimony on Safety Net Health Care Programs: Before the House Committee on Government Reform and Oversight, Subcommittee on Human Resources,* [Online]. Available: http://www.hhs.gov/asl/testify/t970213b.html. [2001, Nov. 7].

Health Care Financing Administration. (2000, Jan.). *Program Memorandum Intermediaries: Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) payment rate increases and policy clarifications and guidance for services furnished by RHCs and FQHCs,* (HCFA-Pub. 60A), [Online]. Available: http://cms.hhs.gov/manuals/pm_trans/a003060.pdf. [2002, Sept. 10].

Lewin, M. and Altman, S., (Eds.). (2000). *America's health care safety net: Intact but endangered*. Washington, D.C.: National Academy Press.

McBride, T. & Mueller, K. (2002). Effects of Medicare payment on rural health care systems. *Journal of Rural Health*. 18(S), 147-163.

Medicare program: Rural Health Clinics: Amendments to participation requirements and payment provisions; and establishment of a quality assessment and performance improvement program, 65 Fed. Reg. 39 (Feb. 28, 2000) (to be codified at 42 C.F.R., parts 405 and 491).

Michigan Center for Rural Health. (1996). *A survey of Michigan's Rural Health Clinics: Information and data highlighting the volume and complexity of Rural Health Clinics in Michigan.*, [Online]. Available: http://www.com.msu.edu/micrh/survey.htm. [2000, Nov. 1].

National Rural Health Association. (1997). *Rural Health Clinics in Rural America*. [Online]. Available: http://www.nrharural.org/dc/issuepapers/ipaper8.html. [2002, Aug. 2].

National Rural Health Association. (1998). *Physician Recruitment and Retention*, [Online]. Available: www.nrharural.org/dc/issuepapers/ipapers13.html. [2002, Aug. 2].

Redd, Diane. (2001). *Oregon's Rural Health Clinics*, [Online]. Available: http://opca.org/clinics.html. [2002, Aug. 2]

Tessen, R., Dugi, D. and Reese, R. (1998). Access, utilization, and effects of Rural Health Clinics in Texas. *Texas Journal of Rural Health 16*(1); 29-40.

Thometz, A. (1994). *A summary report of the first national survey of Rural Health Clinics.* Office of Rural Health Policy, Bethesda, MD: Global Exchange, Inc.

Travers, K., Ellis, R., and Dartt, L. (1995). *Comparison of the Rural Health Clinic and Federally*

Qualified Health Center Programs, Revised July 1995. Washington, DC: National Association of Community Health Centers.

United Governmental Services, LCC. (1999, May 24). *Medicare Memo: Rural Health Clinic (RHC) and FQHCs Policy Clarification, [No. FQHC1999-1]*. Available: http://www.ugsmedicare.com/medicare%20memo's/1999/memos99/052499.pdf. [2002, Sept. 10].

U.S. Congress, Office of Technology Assessment, *Health care in rural America*. (OTA-H-434) Washington, DC: U.S. Government Printing Office, Sept. 1990.

U.S. House. 105th Congress, 1st Session. (1997, Jan. 7). *H.R. 2015, An Act to Provide for Reconciliation*

Pursuant to Subsections (b)(1) and (c) of Section 105 of the Concurrent Resolution on the Budget for Fiscal Year 1998, [Online]. Available: http://hippo.findlaw.com/SubtitleC.html, [2002, Aug. 2].

U.S. General Accounting Office. (1995). *Health care shortage areas: Designations not a useful tool for directing resources to the underserved*. (Pub. No. GAO/HEHS-95-200). Report to Congressional Committees. Washington, DC: GAO.

U.S. General Accounting Office. (1996). *Rural Health Clinics: Rising program expenditures not focused on improving care in isolated areas*. (Pub. No. GAO/HEHS-97-24). Report to the Chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Reform and Oversight, House of Representatives. Washington, DC: GAO.

U.S. Office of the Inspector General (OIG). (1996). *Rural Health Clinics: Growth, access, and payment*. (Pub. No. OEI-05-94-00040). Washington, DC: U.S. Department of Health and Human Services.

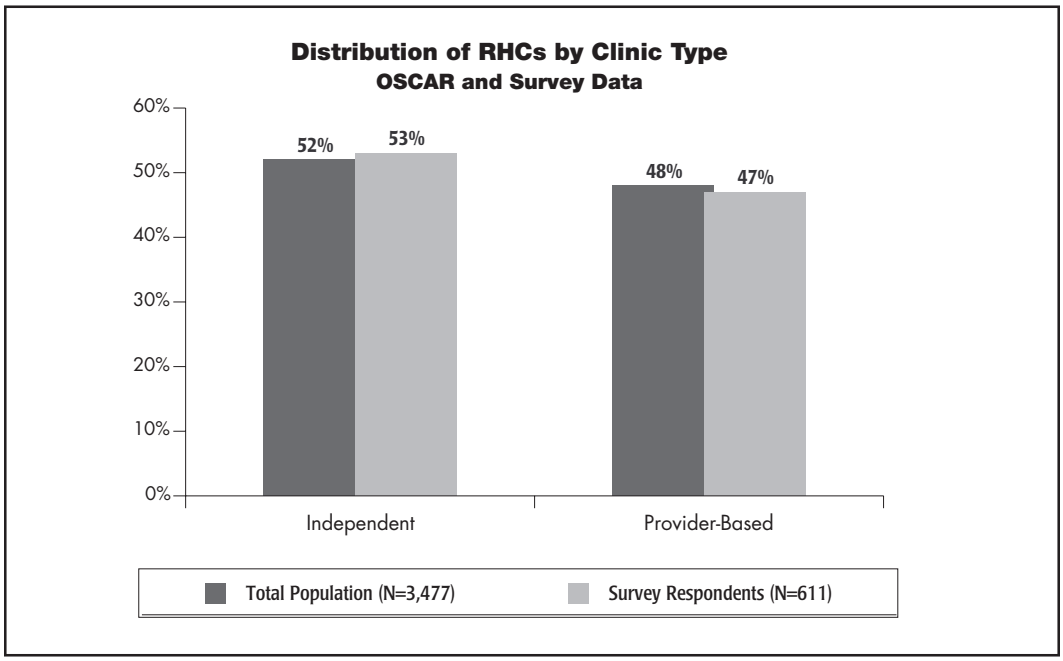
Washington, P. and Kushner, C. (1991). *The Rural Health Clinic Services Act: Public Law. 95-210*. Washington, DC: Office of Rural Health Policy, U.S. Department of Health and Human Services.

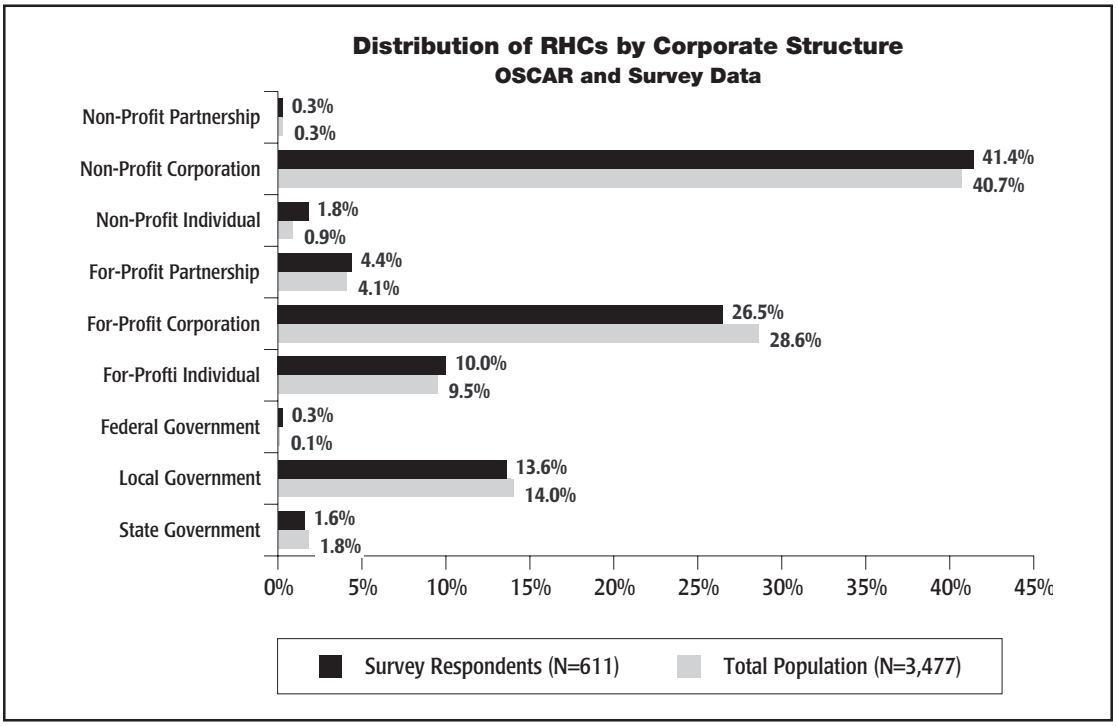
Washington State Department of Health. (2002). *Guidelines for using rural-urban classification systems for public health assessment*, [Online]. Available: http://www.doh.wa.gov/data/guidelines/ruralurban.htm. [2002, Aug. 2].

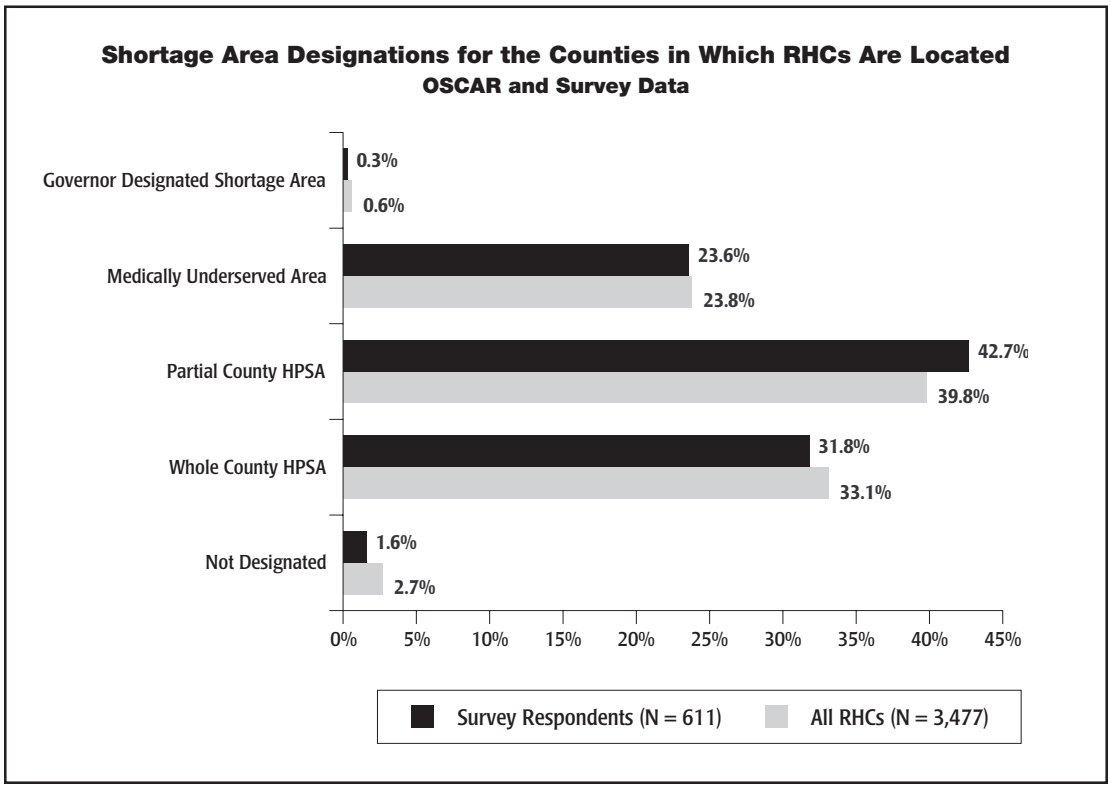
Appendix I

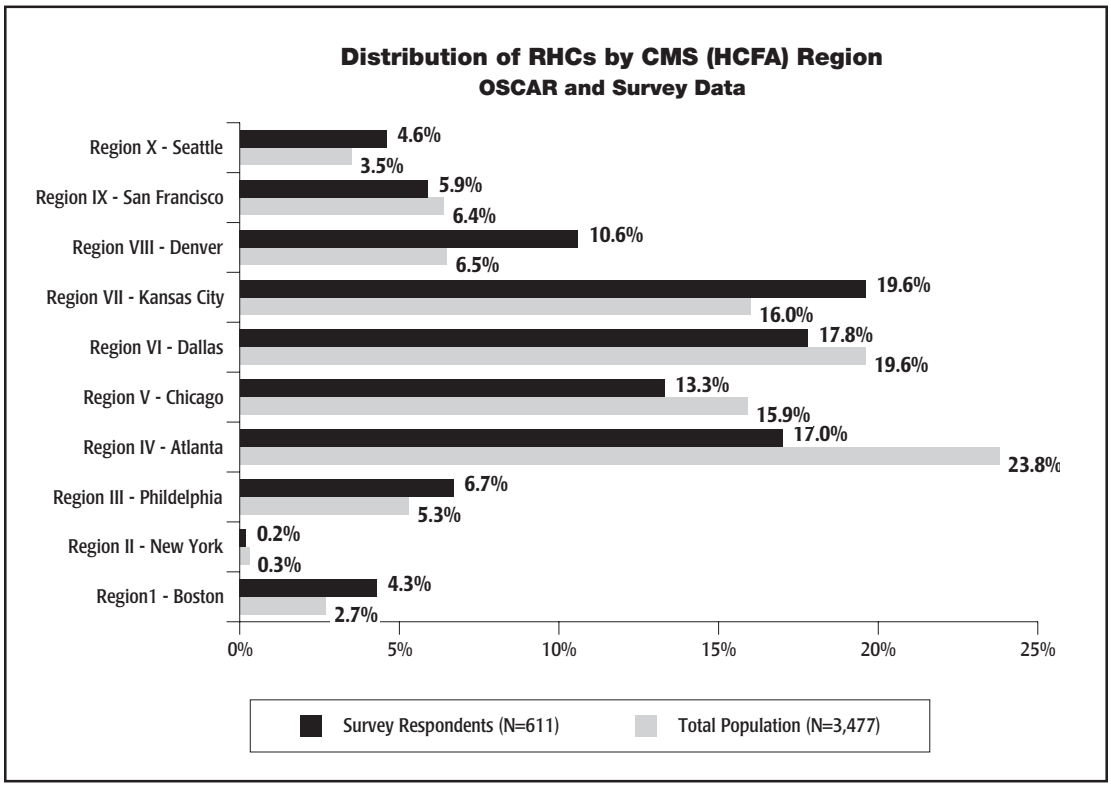
Methodology

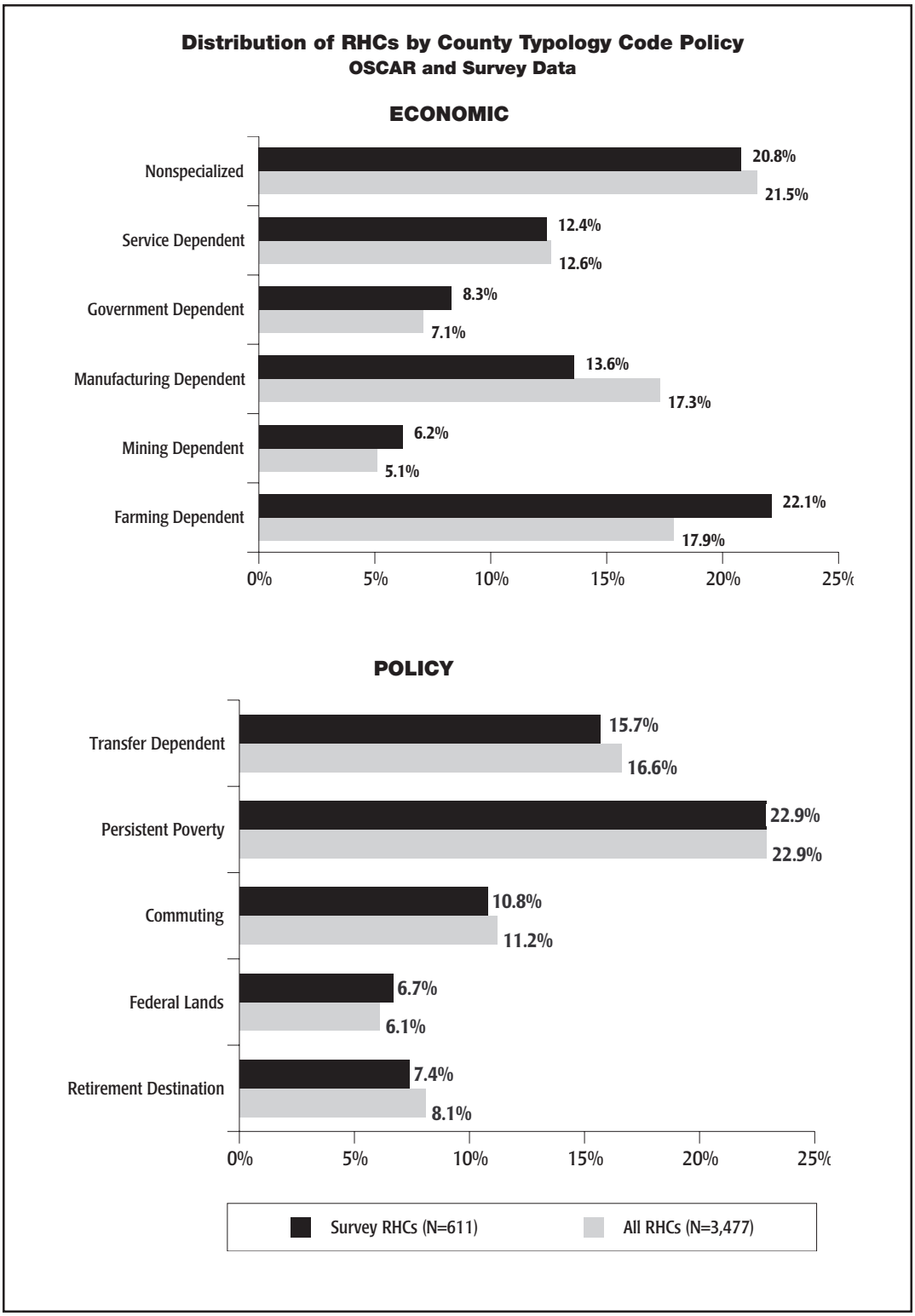
Source: 2000 National Survey of Rural Health Clinics,
Muskie School of Public Service, University of Southern Maine






Shortage Area Designations for the Counties in Which RHCs Are Located
OSCAR and Survey Data
Governor Designated Shortage Area
0.3%
0.6%
Medically Underserved Area
23.6%
23.8%
Partial County HPSA
42.7%
39.8%
Whole County HPSA
31.8%
33.1%
Not Designated
1.6%
2.7%
0% 5% 10% 15% 20% 25% 30% 35% 40% 45%
Survey Respondents (N = 611)
All RHCs (N = 3,477)


Distribution of RHCs by CMS (HCFA) Region
OSCAR and Survey Data
Region X - Seattle
4.6%
3.5%
Region IX - San Francisco
5.9%
6.4%
Region VIII - Denver
10.6%
6.5%
Region VII - Kansas City
19.6%
16.0%
Region VI - Dallas
17.8%
19.6%
Region V - Chicago
13.3%
15.9%
Region IV - Atlanta
17.0%
23.8%
Region III - Phildelphia
6.7%
5.3%
Region II - New York
0.2%
0.3%
Region1 - Boston
4.3%
2.7%
0% 5% 10% 15% 20% 25%
Survey Respondents (N=611)
Total Population (N=3,477)


Distribution of RHCs by County Typology Code Policy
OSCAR and Survey Data
ECONOMIC
Nonspecialized
20.8%
21.5%
Service Dependent
12.4%
12.6%
Government Dependent
8.3%
7.1%
Manufacturing Dependent
13.6%
17.3%
Mining Dependent
6.2%
5.1%
Farming Dependent
22.1%
17.9%
0%
5%
10%
15%
20%
25%
POLICY
Transfer Dependent
15.7%
16.6%
Persistent Poverty
22.9%
22.9%
Commuting
10.8%
11.2%
Federal Lands
6.7%
6.1%
Retirement Destination
7.4%
8.1%
0%
5%
10%
15%
20%
25%
Survey RHCs (N=611)
All RHCs (N=3,477)

Position of Survey Respondent
Survey Data

Position of Survey Respondent	N	%
Administrator	233	38%
Physician	60	10%
Employee of Parent Organization	88	14%
Other Administrative or Clinical Staff	181	30%
Physician Assistant	33	5%
Nurse Practitioner	46	8%
Consultant	1	0.3%