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RURAL HEALTH CLINICS

Rising Program Expenditures Not Focused on Improving Care in Isolated Areas

Statement of Bernice Steinhardt, Director,
Health Service Quality and Public Health Issues

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Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our recent report on the Rural Health Clinic (RHC) program.[1] This program, established two decades ago, allows higher Medicare and Medicaid reimbursement as a way to support health care professionals, including nurse practitioners and physician assistants, in underserved areas that may be too sparsely populated to normally sustain a physician practice. The RHC program is one of the few federal programs that addresses underservice in small communities that do not have a traditional health care system in place.

The program is administered by the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which must certify as RHCs all Medicare-certified primary care providers requesting such status if they practice in a rural and underserved area. At the time of our review, there were nearly 3,000 RHCs in the program and their numbers were growing by more than 30 percent a year. At this rate of growth, Medicare and Medicaid will pay RHCs more than $1 billion a year by 2000. This rapid growth has raised concerns about the benefits that program expenditures are providing.

At this Subcommittee's request, we undertook our review, which used available national statistics that we supplemented with a detailed review of 144 RHCs in four states—Alabama, Kansas, New Hampshire, and Washington. We focused our review on two main questions:

- Is the program serving a Medicare and Medicaid population that would otherwise have difficulty obtaining primary care?
- Are adequate controls in place to ensure that Medicare and Medicaid payments to RHCs are reasonable and necessary?

In brief, the answer to both questions is no. The program needs to be refocused. While some clinics clearly meet the program's initial focus of serving Medicare and Medicaid populations having difficulty obtaining primary care in isolated rural areas, most clinics are in fairly well-populated areas that already have extensive health care delivery systems in place. Controls over the amounts that these clinics receive from Medicare and Medicaid are weak or nonexistent, resulting in reimbursements that are in some cases over five times higher than those

[1]Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996).

paid to other providers. These financial benefits are provided indefinitely, even after an area may no longer be rural or underserved.

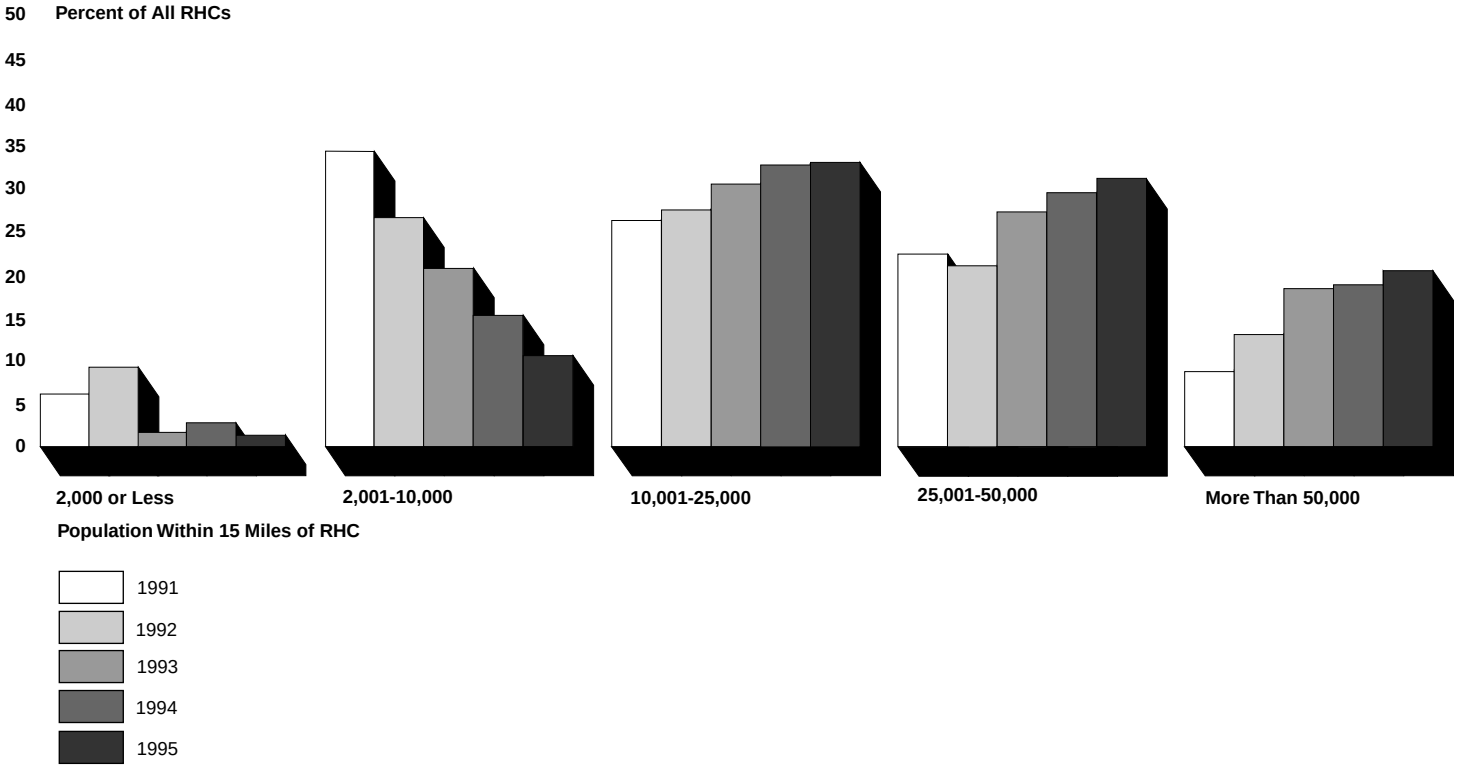
Program Often Is Not Targeting Underserved Populations

Some RHCs clearly provide benefit to rural communities. Such RHCs were generally those in communities without Medicare or Medicaid providers or in sparsely populated areas such as those with fewer than 5,000 people. For example, Wadley, Alabama, a community of just over 500, was unable to support a primary care practice until a nearby hospital set up an RHC staffed by a part-time nurse practitioner. Nearly 40 percent of the clinic's Medicare patients reduced their distance to care by a median of 18 miles. Similarly, a hospital district in eastern Washington uses three family physicians and two physician assistants to operate an RHC and two satellite clinics 15 to 30 miles away, reducing distance to care for at least 80 of the 507 Medicare patients by a median of 48 miles.

We did not find much evidence of efforts to establish RHCs in such locations, however. In the four states we reviewed, neither HCFA nor the state rural health offices were aware of any efforts to actively target and establish RHCs in areas with 5,000 people or less, though many of these areas had no Medicare or Medicaid primary care provider.

While sparsely populated areas of the country may be underserved, as shown in figure 1, RHCs are increasingly being certified in larger communities, many with 50,000 or more people living within 15 miles of the clinic.

Figure 1: RHCs by Population and Year Certified, 1991-95



We found that these larger communities already have a number of health care providers and facilities in place. For example, one clinic we reviewed was recently certified in a location that had 25,000 people, 17 practices with primary care providers, a number of specialty practices, a hospital, two skilled nursing facilities, a mental health facility, a hospice, and a home health agency.

Also, RHCs generally do not appear to enhance the availability of health care in these larger communities. In the four states where we reviewed clinics, the availability of health care did not change appreciably for at least 90 percent of the Medicare and Medicaid patients using them. A significant reason was that two-thirds of the RHCs were simply conversions of existing physician practices. For most clinics, the primary change was

the higher level of Medicare and Medicaid payments that they received, and not the number and mix of patients treated.

Broad Eligibility Criteria Allow Growth in Areas Where Need Is Minimal

Why are many RHCs being approved in areas where they are unlikely to improve access to care? One reason is the broad criteria used for defining rural. While the Bureau of the Census generally defines rural areas as those with fewer than 2,500 people, the law authorizing the program allows for including areas with up to 50,000. However, the census boundaries may not account for all the people living within 15 miles of the RHC, which HHS has defined as the maximum distance people should have to travel for care under the worst road conditions. Therefore, the law allows RHCs to be near other cities that constitute an even larger patient base, as many as 1 million or more.

A second reason, that we have pointed out in other recent work,[2] is that the definitions of underserved areas results in an undercount of the number of medical providers already present. To become certified, an RHC must be located in an area that HHS has determined to have health care shortages. However, we found that more than half the underservice designations may be invalid because they are outdated or do not count a significant number of primary care providers, such as nurse practitioners or physician assistants.

A third reason is that there is no requirement to use the benefits of the RHC program to expand services to whoever is underserved in the community. While HHS often designates an entire community as underserved, most RHCs said that the uninsured poor make up the majority of underserved people in their community. Nevertheless, only 16 of 73 RHCs we contacted said that they offered services on a sliding fee scale, based on the patient's ability to pay for care. Similarly, over 85 percent of RHCs said that the program had no influence on the number or type of patients they serve, even when located in areas with specified underserved population groups such as migrant farmworkers or Medicaid patients.

[2]Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995).

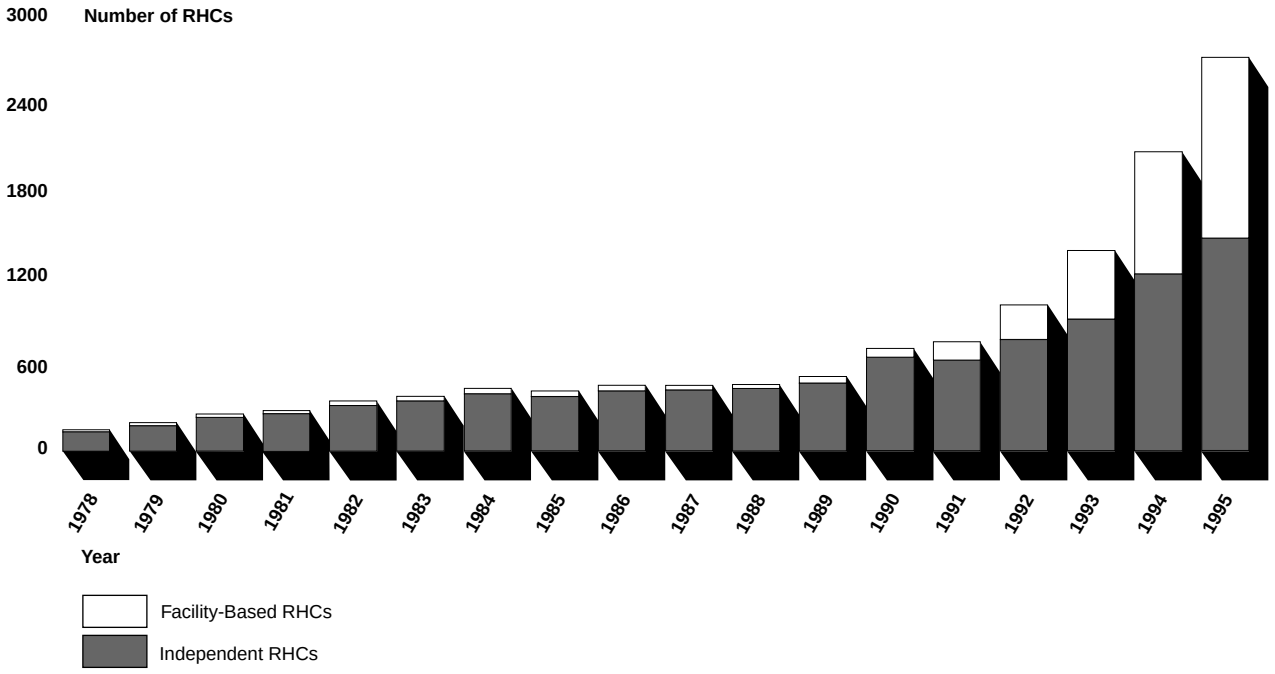
Controls Are Not in Place to Ensure Reasonable Costs and Effective Targeting of Funds

Despite the fact that many RHCs provide little additional benefit to Medicare and Medicaid patients, these RHCs continue to receive significant financial benefits from these programs. RHCs are generally reimbursed by Medicare and Medicaid for the costs they claim in providing services, rather than by the lower set fees for these services that would otherwise apply. Using 1993 claims data, we estimate that Medicare paid at least 43 percent more for services at RHCs than it paid to other providers, while Medicaid paid at least 86 percent more. Assuming that this same percentage held true in following years, the RHC program cost Medicare an additional $100 million and Medicaid about $195 million in 1996.

Because the RHC program is more generous, adequate controls over claimed costs are particularly important to safeguard Medicare and Medicaid expenditures. However, such controls are not in place to do so. RHCs that are independently operated are limited to an annually adjusted amount currently set at $56 per Medicare or Medicaid visit.[3] However, there are no limits on payments to RHCs operated as part of a hospital or other facility, even though almost half the RHCs are operated by such facilities, and this percentage is rapidly increasing (see fig. 2).

[3]This amount is still substantially higher than the average payment providers received for similar services on the Medicare fee schedules.

Figure 2: RHCs by Ownership Type, 1978-95



HCFA has not determined how much more Medicare and Medicaid pay for services at facility-operated RHCs as a result, but indications are that the costs are sometimes substantially higher. For example, our review of cost reports for 28 of these RHCs shows that they received up to $214 per visit, or four times the maximum amount paid for a visit to an independent RHC. HCFA has established a working group that is addressing the issue of payment limits for facility-operated RHCs, but had no estimate of when regulations will be issued.

Second, HCFA has not implemented screening guidelines to assess whether claimed costs are reasonable. Because such guidelines were never implemented, RHCs have no apparent limits on the amount or type of costs they claim for Medicare and Medicaid reimbursement. Our review of 228 cost reports for independent RHCs found that one-fourth were paying physician salaries of up to 50 percent or more than the national mean of $127,000. Our review of 28 cost reports at facility-operated RHCs shows

that hospitals sometimes claimed overhead costs that were more than 100 percent of the direct costs of operating the clinic.

Third, under current law the RHCs receive the extra Medicare or Medicaid reimbursement indefinitely, even if the area is no longer rural or underserved. Many areas of the United States that were considered rural in 1978 are now part of an urbanized area, and areas considered underserved 15 years ago may now have an adequate number of primary care physicians. This aspect of the program—the lack of recertification—means that the program cannot effectively target reimbursement only to the clinics that need it. Most of the clinics we called said that they were financially viable without the added reimbursement, while some said that it was only needed in their first few years as a new clinic until an adequate patient base was established. Most clinics, however, thought that the higher reimbursement should continue because it helped them to compete for patients with other providers moving into the area and assisted in offsetting the negative effects of Medicare and Medicaid reimbursement reform.

Conclusions and Recommendations

Our work clearly demonstrates that the RHC program is adrift. It lacks a clear focus on its original goal of assisting underserved rural communities and also lacks controls over costs to the Medicare and Medicaid programs. As it continues to grow—often in populated areas with established health care systems—there is little evidence to demonstrate that this growth is directed at improving access to care on the part of Medicare and Medicaid beneficiaries or other underserved segments of the population.

What does the program need? One thing is a new definition for the types of areas that are eligible for the higher Medicare and Medicaid payments. The rural and underserved criteria by themselves are insufficient to ensure that its most attractive feature for providers—cost reimbursement—is used by clinics needing it to meet a clear program goal, rather than obtaining a competitive advantage or avoiding the effects of Medicare and Medicaid payment reforms. A second need is for controls over the reimbursement costs claimed by clinics to ensure that they are reasonable. Success in meeting the original purpose of RHCs requires more active management at the federal, state, and local levels to identify specific locations where clinics are needed and to determine when financial assistance can reasonably be discontinued.

Accordingly, our report contains recommendations for both the Secretary of Health and Human Services and the Congress to accomplish these needed improvements.

First, for those RHCs that continue to receive higher Medicare and Medicaid reimbursement, the Secretary of HHS should direct the Administrator of HCFA to revise Medicare payment policy to hold all RHCs to the same payment limits and reporting requirements and reimburse them for only the reasonable costs incurred in providing care to Medicare and Medicaid beneficiaries. HHS agreed with our recommendations and stated that it would begin to take actions to implement them.

In addition, we recommend that the Congress assist in refocusing the RHC program to meet its original purpose by

- restricting higher Medicare and Medicaid reimbursement to (1) RHCs in areas with no other Medicare or Medicaid providers or (2) RHCs that can demonstrate that existing providers will not accept new Medicare or Medicaid patients and that the funding will be used to expand access to them and
- requiring periodic recertification to continue higher payments only to the clinics that need it for this purpose.

This concludes my statement. I would be happy to answer any questions you have.

Contributors

This testimony was prepared under the direction of Bernice Steinhardt, Director, Health Service Quality and Public Health Issues, who may be reached at (202) 512-7119 if there are any questions. Other key contributors include Frank Pasquier, Assistant Director, and Lacinda Baumgartner and Stan Stenersen, Evaluators.

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