

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**RURAL HEALTH CLINICS:  
GROWTH, ACCESS, AND PAYMENT**



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# EXECUTIVE SUMMARY

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## PURPOSE

Analyze the recent growth of rural health clinics and its implications for the Federal Government and States.

## BACKGROUND

The Rural Health Clinic program, created in 1977 by Public Law 95-210, is intended to increase access to health care for rural medically underserved areas and expand the use of midlevel practitioners (nurse practitioners, physician assistants and certified nurse midwives) in rural communities. Rural health clinics (RHCs) receive cost-based reimbursement from Medicare and Medicaid. The Health Care Financing Administration (HCFA) is responsible for certification and oversight of RHCs.

Recently, several States have expressed concern about the growth of RHCs in their States and the associated Medicaid costs. They have asked for written guidance and/or the authority to regulate RHCs with regard to a number of aspects.

This report is intended to refine our general understanding of the extent, location, and impact of the growth of rural health clinics, and to identify vulnerabilities for immediate attention and issues for further investigation. It is based on quantitative data from several sources, comments from States, and conversations with over 200 people at 27 rural health clinics in 3 States, State and local government agencies, the National Association of Rural Health Clinics, and a HCFA workgroup on RHCs.

## FINDINGS

**RECENT GROWTH.** Rural health clinics and associated Medicare and Medicaid expenditures have grown substantially since 1990.

Rural health clinics grew 650 percent from the end of 1990 to October 1995. Projected growth for 1994 and 1995 could be 150 percent. Expansion in 30 States could be 100 percent or more in that 2-year period; in 13 States, RHCs could increase by over 200 percent.

Medicare and Medicaid expenditures for rural health clinics have more than doubled since 1991. In fiscal year (FY) 1995, Medicare expenditures increased from \$78 million to \$125 million, and Medicaid expenditures, from \$325 million to \$439 million. Medicaid outlays for FY 1992 through 1995 (\$876 million) were about three times Medicare outlays (\$296 million). Forty percent of States with RHCs reported increases of 50 percent or more in RHC Medicaid expenditures in a 1-year period.

**REASONS FOR GROWTH.** Four interrelated factors appear to be driving the recent growth of rural health clinics: providing access to care, reimbursement, managed care, and the certification process.

Our respondents mentioned the first three factors most often when describing the reasons they established an RHC. We conclude that the certification process also is driving RHC growth because it operates similarly to that of an entitlement program, where any entity meeting certain broad criteria is automatically certified.

We cannot be certain of whether the recent spurt of growth in RHCs represents a positive development, in terms of opening access to care, or a negative one, in terms of cost or excess capacity. However, we do have reason to raise some concerns for immediate action or further study.

**ACCESS TO CARE.** Rural health clinics may be increasing access to care in some areas but not in others. We found no reliable data quantifying the impact of RHCs on access to care.

We visited some RHCs that appear to be increasing access to care as the law intended. However we also believe that RHCs in some areas are not increasing access, for several reasons. They may not be located in true medically underserved areas because underserved designations are outdated or inappropriate. Or, providers currently serving the medically underserved population may simply convert to RHC status when no additional incentives were needed to retain them. Rural health clinics may be concentrated together or in areas with other providers serving a similar population, thereby duplicating services already amply available.

**REIMBURSEMENT.** Rural health clinics are paid based on their costs, which may be inflated or inappropriate but are difficult and sometimes impossible to verify or audit without significant resource expenditure by the Government.

Vulnerabilities inherent in the cost reimbursement system are apparent in the rural health clinic program. There is little or no incentive for efficiency, there are opportunities for inflated and inappropriate payments (especially given the lack of itemized billing for most independent RHCs), and the process overall is cumbersome, complex, and difficult and expensive to oversee. Federal and State oversight of RHCs is sorely lacking.

## **RECOMMENDATIONS**

**CERTIFICATION PROCESS.** The HCFA, with the Health Resources and Services Administration, should modify the RHC certification process to increase State involvement and ensure more strategic placement of rural health clinics.

This responds to State concerns and promotes a more rational and strategic placement

of RHCs to ensure that government dollars translate into increased access. We suggest a variety of ways in which HCFA could implement the recommendation.

**REGULATIONS.** The HCFA should expedite the issuance of regulations now under development.

This responds to States' requests for guidance, in such matters as commingling and provider-based reimbursement, to assist them in monitoring and evaluating RHCs.

**REIMBURSEMENT METHODOLOGY.** The HCFA should take intermediate steps to improve the oversight and functioning of the current cost reimbursement system, with the long term goal of implementing a different payment method.

This addresses problems we identify relative to the current cost reimbursement system for RHCs, both now and in the long term. It would lead to the implementation of a new payment method which would provide an incentive for primary care in rural areas and eliminate the vulnerabilities inherent in cost reimbursement.

## **COMMENTS**

The Health Care Financing Administration, the Health Resources and Services Administration (HRSA), and the Assistant Secretary for Planning and Evaluation (ASPE) submitted written comments on the draft report. Copies of the comments are in Appendix A. They all concur generally with the recommendations, but expressed concerns and suggestions regarding various aspects of the steps proposed to carry them out. We look forward to future discussions with HCFA and HRSA concerning their action plans for implementing the recommendations.

Comments from ASPE also posed questions related to the nature of RHC growth, the relationship between RHCs and access to care, and how RHCs might be affected by the growing involvement of Medicare and Medicaid in managed care. These are important issues, but unfortunately are beyond the scope of this study. We hope that these issues will be addressed in future studies of the rural health clinic program by ASPE, HCFA, or others.

The National Association of Rural Health Clinics and the National Rural Health Association also submitted extensive comments. They view the report as unduly critical of RHC growth and stress the continuing need for incentives to retain and attract primary care to underserved rural areas. However, they also recognize that many of the problems raised in the report merit attention. Like HCFA, HRSA, and ASPE, they support our recommendations while disagreeing with some of the steps proposed to implement them. We have provided copies of their comments to HCFA, HRSA, and ASPE.

We thank everyone for their comments on this report. We have made changes in the text in response.

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# INTRODUCTION

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## PURPOSE

Analyze the recent growth of rural health clinics and its implications for the Federal Government and States.

## BACKGROUND

Nationally, rural health clinics (RHCs) grew from 29 in 1978 to 2,199 in March 1995, when this study was initiated. Half of all RHCs in the U.S. were certified in the 18 months between October 1993 and March 1995.

Public Law 95-210 created the Rural Health Clinic program in 1977. The program is intended to increase access to health care for rural medically underserved areas and to expand the use of midlevel practitioners (nurse practitioners, physician assistants and certified nurse midwives) in rural communities. The law created cost-based Medicare and Medicaid reimbursement for RHCs. Between 1987 and 1993, Congress passed several amendments to the Act intended to overcome various obstacles to participation in the program.

The Health Care Financing Administration (HCFA) is responsible for certification and oversight of RHCs. Following a State survey funded by HCFA, an RHC is certified as Medicare-eligible by HCFA. Medicaid certification follows automatically.

An RHC must be engaged primarily in providing outpatient primary medical care. Covered (core) services are: services provided by a physician, physician assistant, nurse practitioner/midwife, clinical psychologist, or clinical social worker; services and supplies incident to the services of these providers; pneumococcal and influenza vaccines and their administration; and visiting nurse home health services (in specially designated areas). An RHC may be independent (owned by a physician, nurse practitioner, physician's assistant, or private company), or provider-based (an integral part of a hospital, nursing home or home health agency).

An RHC must be located in a rural area<sup>1</sup> that is medically underserved. A medically underserved area is an area designated as medically underserved by a Public Health Service formula, a health professional shortage area, or a shortage area designated by a governor. Also eligible are areas including a population group which has a health professional shortage, and high migrant impact areas. Rural health clinics retain their RHC status even if their location is subsequently determined to no longer be rural or medically underserved.

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<sup>1</sup> For purposes of this program, "rural" is defined as "non-urbanized," that is, lying outside of "urbanized" areas. The U.S. Bureau of the Census defines an urbanized area as a "central city (or cities) and its contiguous closely settled territory with a combined population of at least 50,000."

Rural health clinics receive cost-based reimbursement for the core services listed previously. Independent RHCs receive Medicare and Medicaid reimbursement limited to their actual costs, not to exceed \$55.53 per visit (a "face to face *encounter*" between a patient and a "covered service health care practitioner") in 1995. This cap is adjusted annually according to the Medicare Economic Index. Provider-based RHCs receive the lower of reasonable costs or charges, and unlike independent RHCs, are not subject to either a reimbursement cap or productivity standard (a minimum number of visits per year physician or midlevel practitioner).

In addition, RHCs may bill fee-for-service for certain State-specific Medicaid non-core ambulatory services (such as dental services or pharmaceuticals). Also, a practice is allowed to operate part of the time as an RHC and part as a fee-for-service practice.

In connection with expressing concerns about the rapid growth of RHCs and their associated Medicaid costs, some States have asked for written guidance and/or the authority to regulate RHCs with regard to a number of aspects. In response to these concerns and questions, HCFA established a rural health clinic workgroup in 1994. This group has been involved, among other things, in the development of regulations for the program.

## **SCOPE AND METHODOLOGY**

This report provides an analysis of the growth of rural health clinics. It identifies vulnerabilities for immediate attention and broader issues for further investigation. It is based on data from several sources.

The HCFA's On Line Survey, Certification and Reporting System provided data on the number of RHCs by State. The HCFA regional offices and States provided us the number of RHC applications pending. State Medicaid agencies gave us data on Medicaid expenditures for RHCs, sometimes with additional comments about RHC growth and its impact.

We also conducted a case study of three States (Illinois, Mississippi, and Texas) where RHC growth has been high, visiting State agencies and 27 RHCs in these States, located in counties where RHCs have proliferated. We sought a cross-section of each county's RHCs in terms of type (independent versus provider-based; general practice versus specialty), ownership, operation by a physician versus a midlevel practitioner, size of practice, location, and years of operation. Thus the sample included RHCs as varied as large group practices with many physicians and midlevel practitioners and over 50,000 visits a year, and clinics operated by solo midlevel practitioners with remote physician supervision and as little as 1,277 visits a year. We also analyzed 25 cost reports for these RHCs.

Field visits included discussions with clinic owners and staff, review of data, and personal observation. Clinic tours gave a sense of general clinic atmosphere, patient



flow, personal characteristics of staff and patients, and administrative procedures at the RHCs. Additionally, for a sense of the geographic and demographic characteristics of each area, we drove around each county in our sample to view every RHC - their size and appearance, whether they appeared busy, the general setting, and the proximity of other medical facilities, especially hospitals, clinics, and physician offices. In some cases where primary care appeared to us to be readily available, we supplemented our observations and conversations with a review of the Yellow Pages of the telephone book ("Physicians"). We sometimes talked to local staff of welfare, public health or other agencies for a sense of how the RHCs in our sample were viewed, and a description of health care availability and access in the area.

In addition to our observations on site, formal data collection, and interviews, we read or heard unsolicited comments about RHC growth from a number of sources: letters to HCFA from States, comments volunteered to us by States submitting Medicaid data, comments by States on our design questions, and even discussions and questions at a national conference on rural health. In all, we spoke or heard in writing from over 200 individuals, by telephone and in person, about RHC proliferation and its implications. These include people<sup>2</sup> at the 27 RHCs in the case study, officials of State and local government agencies, consultants, representatives of the National Association of Rural Health Clinics, and HCFA's workgroup on rural health clinics.

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<sup>2</sup> owners, medical directors, physicians, midlevel practitioners, and others.

# FINDINGS

**RECENT GROWTH.** Rural health clinics and associated Medicare and Medicaid expenditures have grown substantially since 1990.

*Growth of RHCs began to accelerate rapidly in 1990. The national growth rate for 1994 and 1995 combined could be almost 150 percent.*

Most of the growth of RHCs nationally has occurred since 1991. Eighty-seven percent of the RHCs operating in October 1995 were certified after 1991. Figure 1 shows national growth from the end of 1990, when there were 314 RHCs, to October 1995, when there were 2,350. This is an increase of about 650 percent.

Growth accelerated notably in 1994 and continues at a fast pace today.<sup>3</sup> Figure 2 on the next page shows projected RHC growth, broken down by State, in calendar years 1994 and 1995 combined.

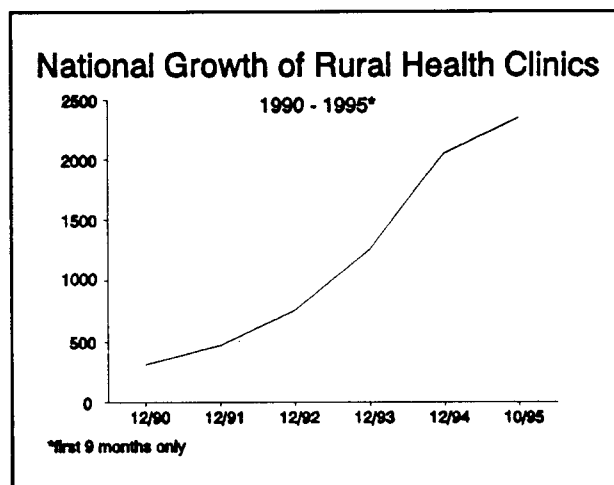


Figure 1

Nationally, RHCs more than doubled (103 percent) in the 15 months from January 1994 through October 1995. This increase will be nearly 150 percent if the 580 applicants awaiting certification as of October 1995 are certified by year's end.

The projected RHC growth rate<sup>4</sup> varies widely by State. However, 30 States could experience growth of 100 percent or more in the 2-year period, and 13 States could see expansion exceed 200 percent. Ten States will likely have at least 100 RHCs by the end of 1995. These 10 States would then comprise more than half (56 percent) of the RHCs in the U.S. Between January 1, 1994 and December 31, 1995, the average growth rate of RHCs in these States is projected to be 161 percent; 7 States may experience growth of 170 percent or more. Texas, with by far the highest number of RHCs (almost three times more than California, the next highest State), could see growth of 181 percent in that period.

<sup>3</sup> There is no difference in the growth of independent versus provider-based RHCs nationally, although differences across States undoubtedly exist.

<sup>4</sup> Projected growth equals the number of RHCs certified from January 1994 to October 1995, plus the number of applications pending as of October 1995.

Figure 2

ACTUAL AND PROJECTED GROWTH OF RURAL HEALTH CLINICS: 1994 AND 1995  
 (Descending order by total projected as of 12/95)

STATE	ACTUAL AS OF 1/94	ACTUAL AS OF 10/95	APPLICATIONS PENDING 10/95	PROJECTED AS OF 12/95	PROJECTED GROWTH 1/94 TO 12/95
TEXAS	193	367	175	542	181%
CALIFORNIA	93	146	44	190	104%
ILLINOIS	48	113	41	154	221%
KANSAS	77	133	16	149	94%
MISSISSIPPI	49	139	6	145	196%
MISSOURI	46	115	14	129	180%
IOWA	33	98	16	114	245%
NORTH CAROLINA	68	105	5	110	62%
SOUTH CAROLINA	22	52	53	105	377%
FLORIDA	37	98	2	100	170%
ARKANSAS	41	95	0	95	132%
GEORGIA	40	90	1	91	128%
OKLAHOMA	28	78	12	90	221%
MICHIGAN	38	82	7	89	134%
LOUISIANA	7	49	35	84	1100%
NORTH DAKOTA	47	69	6	75	60%
ALABAMA	23	61	12	73	217%
TENNESSEE	36	70	2	72	100%
NEBRASKA	26	57	8	65	150%
WISCONSIN	18	33	29	62	244%
SOUTH DAKOTA	37	44	6	50	35%
PENNSYLVANIA	20	33	10	43	115%
WASHINGTON	22	32	10	42	91%
WEST VIRGINIA	30	41	0	41	37%
MINNESOTA	17	36	4	40	135%
COLORADO	16	26	13	39	144%
KENTUCKY	15	34	3	37	147%
VIRGINIA	7	27	8	35	400%
UTAH	12	14	18	32	167%
MONTANA	20	24	5	29	45%
MAINE	10	26	0	26	160%
IDAHO	16	22	1	23	44%
OREGON	20	21	0	21	5%
INDIANA	2	12	5	17	750%
WYOMING	5	13	4	17	240%
VERMONT	5	16	0	16	220%
NEW HAMPSHIRE	1	14	0	14	1300%
NEW MEXICO	8	10	4	14	75%
ALASKA	6	9	4	13	117%
NEW YORK	0	11	0	11	NA
ARIZONA	2	7	not avail.	7	250%
OHIO	4	4	1	5	25%
HAWAII	2	2	0	2	0%
RHODE ISLAND	0	1	0	1	NA
NEVADA	0	1	not avail.	1	NA
TOTAL	1,247	2,530	580	3,110	149%

\*CT, DE, MA, MD, NJ, WASHINGTON D.C.: 0 RHCs

***Combined Medicare and Medicaid expenditures for rural health clinics have more than doubled since 1991.***

Figure 3 shows the increase in combined Medicare and Medicaid expenditures for RHCs for fiscal years 1992 through 1995 from HCFA data.

Readers should be aware that the Medicaid data is not complete. Several States with RHCs (most notably Texas, the State with by far the most RHCs) are not included in HCFA data. Also, FY 1995 data is preliminary only. Despite gaps, however, these figures give some notion of the rate at which Medicaid expenditures on RHCs have increased.

<b>MEDICARE AND MEDICAID EXPENDITURES ON RHC'S</b> <b>Fiscal Years 1992-1995</b> <b>(\$1.1 billion)</b>						
Fiscal Year	Medicare Expend.	Percent Increase	Medicaid Expend.	Percent Increase	Total Expend.	Total Percent Increase
1992	\$ 37M	-	\$ 122M	-	\$ 159M	-
1993	\$ 56M	51%	\$ 193M	58%	\$ 249M	57%
1994	\$ 78M	39%	\$ 247M	28%	\$ 325M	31%
1995*	\$ 125M	60%	\$ 314M	27%	\$ 439M	35%
Percent Increase		238%		157%		176%

\* Preliminary/incomplete

Figure 3

Growth in RHC expenditures exceeded 200 percent for Medicare and 150 percent for Medicaid in this period. Annual Medicaid outlays were about three times greater than Medicare outlays in every year. For the 4 years combined, Medicare expenditures were \$296 million and Medicaid, \$876 million, for a total outlay of \$1.1 billion.

***Forty percent of States with RHCs Report Significant 1-Year Growth in Medicaid Expenditures.***

Thirty-two of the 46 States that have RHCs submitted data to us enabling the calculation of a 1-year change in their RHC Medicaid expenditures, shown in Figure 4. Most States provided a comparison of their fiscal years 1994 and 1995.

Figure 4

ONE YEAR CHANGE IN RHC MEDICAID EXPENDITURES REPORTED BY 32 STATES  
(Descending order by percent change)

STATE	YEAR	PAYMENTS	CHANGE FROM PREVIOUS YEAR	COMMENT
LOUISIANA	1995	1,977,798	1146%	
ALABAMA	1995	3,379,349	194%	
OKLAHOMA	1995	2,711,269	163%	
IOWA	1995	2,621,080	130%	
VERMONT	1994	1,340,923	116%	Jan-Sept '95 only: \$1,737,592
MISSISSIPPI	1995	12,089,000	107%	
SOUTH CAROLINA	1995	3,756,620	101%	State projects \$8M for '96
MISSOURI	1995	7,633,525	93%	
ARKANSAS	1995	2,622,341	90%	
KENTUCKY	1995	4,415,551	83%	
WISCONSIN	1995	1,060,875	80%	
MICHIGAN	1994	5,593,658	75%	
FLORIDA	1995	4,954,580	74%	
GEORGIA	1995	2,816,400	67%	
ALASKA	1995	95,541	62%	
MINNESOTA	1995	1,403,133	61%	
COLORADO	1994	873,181	60%	
KANSAS	1995	3,196,324	51%	
TENNESSEE	1994	1,435,050	50%	RHCs now in State managed care program
TEXAS	1994	22,130,101	47%	
NORTH CAROLINA	1995	8,400,346	31%	
WASHINGTON	1994	1,143,771	30%	
NORTH DAKOTA	1995	2,346,032	29%	
VIRGINIA	1994	375,059	21%	Jan-Sept '95 only: \$1.96M (up 400%+)
CALIFORNIA	1995	43,839,997	21%	
ILLINOIS	1995	8,300,000	17%	
IDAHO	1994	380,563	16%	Jan-June '95 only: \$429,156
UTAH	1995	199,128	8%	
MAINE	1995	716,591	1%	
NEW YORK	1995	944,521	1%	Extrapolated from State data
WEST VIRGINIA	1994	9,949,346	-20%	
OHIO	1995	1,183,329	-26%	5 of 12 RHCs converted to FQHCs

Nineteen of the 32 States experienced an increase of 50 percent or more in RHC expenditures, and 3 are close to 50 percent or well on their way to large increases for 1995. Eight States saw increases of more than 100 percent in 1 year.

Only two States reported a decline in RHC expenditures; in one, almost half of the RHCs converted to federally qualified health center status, which in essence only shifts costs from one category to another since those entities are also reimbursed at cost.<sup>5</sup>

<sup>5</sup> Medicaid expenditures in a third State, Tennessee, may also decline as a distinct provider group since all RHCs there have been folded into the State's managed care system.

Certain examples of recent growth stand out.

- In Kansas (133 RHCs at present), expenditures jumped 50 percent in 1995, and according to the State, are headed for another increase of at least 30 percent in 1996.
- In Virginia (27 RHCs), expenditures rose only 21 percent in 1994, but the State reported expenditures of nearly \$2 million for the first 9 months of 1995 alone, an increase of over 400 percent.
- Louisiana (49 RHCs) is experiencing spectacular growth, with a 63 percent increase in RHCs from May to October 1995, 35 applications pending, and a 1-year rise in expenditures from some \$159,000 to almost \$2 million.
- In South Carolina (52 RHCs), expenditures increased 101 percent to about \$3.7 million in 1995, and the State projects expenditures of \$8 million for 1996, another potential 1-year increase of 116 percent.

Some States, both those on this chart and others, may see a significant increase in FY 1996 because many of their RHCs are newly certified and just beginning to bill.

**REASONS FOR GROWTH.** Four interrelated factors appear to be driving the recent growth of rural health clinics: access to care, reimbursement, managed care, and the certification process.

Several factors appear to be driving the growth of RHCs. The first three are marketplace forces that, for many RHCs we visited, appear to have interacted to drive their creation. For example, a physician practice struggling financially with a high proportion of Medicare and Medicaid patients may be driven to become an RHC primarily for enhanced reimbursement, but may also be genuinely interested in serving more patients by adding a midlevel practitioner. Similarly, a rural hospital may be primarily concerned with surviving under managed care, but also be motivated by a desire to create an outpatient care presence in their area.

*Desire to create, expand, or maintain access to primary care in rural areas.* The next finding in this report describes RHCs we visited that appear to have enhanced access to care in various ways. Respondents at practices that had converted to RHC status said it enabled them to remain in their communities, to serve (more) Medicaid patients, or to serve more people by adding a midlevel practitioner. A few freestanding practices had been set up initially in areas with no other care. Respondents at provider-based RHCs tended to give other answers first when asked why they established the RHC.

We believe that the creation of the Office of Rural Health Policy, within the Public Health Service, in 1990 has also helped publicize and promote the potential for increasing access through the rural health clinic program. In some States, changes in

State laws governing the utilization of midlevel practitioners have also facilitated RHC growth.

*Promise of enhanced revenue through cost reimbursement.* This is the main reason given to us at physician practices that converted to RHC status. Our respondents told us that enhanced reimbursement has also led companies to buy and convert physician practices, and induced hospitals to establish new RHCs, either to compensate for reduced in-patient revenue or to divert emergency room patients to more appropriate (i.e., outpatient) care.

*Approach of managed care.* Managed care was of considerable interest or concern for many of our case study respondents, although few had any concrete notion of how it might arrive in their area, what form it might take, or how they might be affected.

Nine of the 10 provider-based (mostly hospitals) RHCs in our sample said that positioning for managed care was a major reason for their establishing an RHC, and most were part of a network of several RHCs in an area. Two of the largest independent RHCs (group practices) and a company that owns 11 RHCs in one State also mentioned this. Respondents said they expected their RHCs to help establish market share, create a referral base or network, or enhance community visibility of the parent provider generally.

The strength of managed care as a force behind creating an RHC may explain why the owner-representatives of 8 of the 10 provider-based RHCs said they are maintaining the RHCs despite losing money, in part due to low patient load.

*Certification process.* We view the RHC certification process itself as another factor in RHC growth. It is similar to that of an entitlement program, in that an applicant that meets certain location requirements (in this case, is in a rural federally or governor-designated medically underserved area) as well as certain federal health and safety requirements, is approved to participate in the Medicare and Medicaid programs. Applicants are not required to document the potential impact of establishing an RHC. No requirements exist that RHCs be created in areas of greatest need and no limits exist on the number of clinics that may be established in an area. Also, an RHC retains its status, including cost-reimbursement, even if its location is subsequently determined to no longer be rural or medically underserved. The next finding describes questionable situations that can arise as a result of failing to limit RHC growth in an area or target RHCs in a more strategic manner generally.

...

We cannot be certain of whether the recent spurt of growth in RHCs is a positive development, in terms of opening access to care, or negative, in terms of cost or excess capacity. However, as the next section of the report shows, a lack of good data, our observations on site, and feedback from some States all point to concerns for immediate action or further study.

**ACCESS TO CARE.** Rural health clinics may be increasing access to care as intended by law in some areas, but not in others. We found no reliable data quantifying the impact of RHCs on access to care.

*Some RHCs we visited appear to be filling a need for primary care in rural areas.*

In all three case-study States, we visited RHCs which appear to have retained or expanded primary care in rural areas. Some were the only source of primary care in their areas - or had been at the time they were established. They were located in very small towns in sparsely populated areas, many of them staffed by a lone midlevel practitioner. We visited specialty clinics (pediatrics; obstetrics and gynecology) which are the only providers of such care for miles around. We visited clinics where respondents said that hiring a midlevel practitioner had enabled them to expand office hours or services. We met midlevel practitioners who impressed us with their ties to the community. One such individual is a physician assistant who recently returned home after 20 years in the Air Force to staff a small RHC by himself, making occasional home visits to homebound patients and conducting health education campaigns at local football games, where he serves as the team medic.

Respondents gave several examples of how they think their RHCs have increased access to care. Their presence in the community alone has widened access. The enhanced reimbursement has kept them in business or enabled them to serve more Medicaid patients (specifically). They provide an alternative to inappropriate and more-expensive emergency room care (noted by provider-based RHCs). Midlevel practitioners at RHCs have increased the number of patients seen in existing practices and brought excellent primary care to rural areas, including preventive care and health education. Rural health clinics have resulted in increased acceptance of midlevel practitioners by patients and physicians alike.

While we believe that some of the RHCs we visited have increased access to care, we found no reliable documentation that quantified such increases.

*However, we also believe that RHCs may not always be increasing access to primary care as the law intended.*

Our visits and data analysis also revealed RHCs whose impact on access to care is questionable. We have identified four reasons why we believe that RHCs may not always be increasing access to care as intended: (1) They may not be located in true medically underserved areas, because designations are outdated or inappropriate; (2) Providers currently serving the medically underserved population may simply convert to RHC status when no additional incentives were needed to retain them; (3) RHCs may be concentrated together, or in areas with other providers serving a similar population, thereby duplicating services already amply available; and (4) RHCs may actually have a negative impact by driving out other providers from the area - either public health providers with greater accountability for serving the medically underserved, or primary care physicians. Each of these reasons is discussed below.



## Medically Underserved Designations

Medically underserved designations may be outdated and we question their validity in some areas. The Federal designations for many counties in our case study had not been updated for years. Two counties with 8 and 10 RHCs had only a governor designation, created years ago at the request of an individual (a different person in each case) desiring to establish an RHC. We also visited areas that appeared to have a more than adequate supply of both primary and specialty care: a city (3 RHCs) with a major university and medical school, and another (5 RHCs) with two hospitals and 10 yellow pages in the telephone book listing clinics and physicians, including numerous specialties (from cardiology to sports medicine.)

A General Accounting Office (GAO) report entitled "Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved," released in September 1995, recommends that the current designation process be abandoned in favor of program-specific criteria to be developed by the Public Health Service (PHS). The Health Resources and Services Administration, in PHS, has commented to GAO disagreeing with their conclusions and recommendations and describing measures they are taking to strengthen the existing designation process. They also disagree in its comments with GAO's statement that the RHC program was created for isolated rural communities unable to support a physician's practice. Their view is that Congress more broadly intended the program to sustain and increase the number of primary care providers, including midlevel practitioners, in rural underserved areas.

## Conversions

Physician practices (solo and group practices, large and small practices) are converting to RHC status but do not need to demonstrate whether they increase access to care as a result. Two of the freestanding RHCs in our sample were established in areas with no other primary care; the rest were existing practices that converted, many respondents noting that the promise of enhanced reimbursement was the driving force for conversion.

Conversion to RHC status for existing practices is not necessarily a bad thing. As noted previously, it may preserve or expand a financially shaky practice or bring additional care through midlevel practitioners. However, we found no documentation or indication of any kind, at the RHC or the State level, of how or the extent to which conversions have increased access to care.

## Concentration of Providers

Concentrations of RHCs have grown up in some places adjacent to or within large towns rather than rural areas. For example, we visited a small city of 44,000 with an RHC with 12 physicians and 4 midlevel practitioners, and 4 other smaller RHCs. Five more RHCs serve the other 35,000 people in the surrounding county.

States described, and we observed, other situations that raise questions about whether additional access is needed or provided: RHCs located next door to or across the street from each other; single providers who establish multiple sites in one community; an RHC located inside a hospital or next to an emergency room<sup>6</sup>; and three RHCs licensed at the same address.<sup>7</sup>

### Impact on Other Providers

Enhanced reimbursement was meant to be an inducement to providers to come to, or remain in, communities with a lack of primary care. However, in communities with more than one primary care provider, it gives the RHCs (whether independent or provider-based, new in the community or conversions of existing practices) a competitive advantage over the non-RHC practices.<sup>8</sup> Also, in some places we visited the clustering or concentration of RHCs appears to increase competition for the same patients more than demonstrably increase access for new patients.

The provider-based reimbursement mechanism, specifically, confers a significant financial advantage to this type of RHC compared to physician practices, whether RHCs or not. For example, demand has driven the salaries of midlevel practitioners very high in some areas; not subject to a reimbursement cap, provider-based RHCs can absorb these salaries more easily than independent RHCs. Also, provider-based RHCs which capture a significant share of Medicare and Medicaid patients may drive physician practices out of business, seriously reducing access to primary medical care. This concern is expressed by the National Association of Rural Health Clinics as well as some States.

In some areas, RHCs are being established very close to community health centers and federally qualified health centers. The concern we heard here is that RHCs may drive these entities out of business in the competition for patients, leaving uninsured and indigent patients without a critical source of care. Community health centers and federally qualified health centers are mandated to serve this population, but rural health clinics are not. One State sent us a map showing the clustering of these entities there, to illustrate this concern.

In two communities, competing hospital-based RHCs operate seeing just 10-12 patients a day because the population of the area is so sparse (1,700). Unlike

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<sup>6</sup> One question is: Is an in-house RHC, per se, any more likely to expand access than an outpatient department operating on a fee-for-service basis?

<sup>7</sup> The concern here is that a patient could be sent to all three clinics in one day for slightly different services, each visit paid at the encounter rate.

<sup>8</sup> Data we found from three States shows the comparison there between average Medicaid reimbursement per visit for RHCs versus physician offices: \$53.25 versus \$37; \$51.99 (independent) and \$76.84 (provider-based) versus \$28.33; and \$55.50 versus \$21.50. Another State reported that RHC reimbursement per visit there is "about double" fee-for-service reimbursement.

independent RHCs, they can survive despite this low volume because they are not subject to a productivity standard or a reimbursement cap. Each RHC naturally tries to steer patients towards its owner-hospital and away from other community hospitals in the area which may have been serving them. If this loss of business led one hospital to close, this might deprive the area of both primary and tertiary care.

*We found no reliable data quantifying the impact of RHCs on access to care.*

All RHCs are required to conduct an annual self-evaluation, including a review of the utilization of services, including the number of patients served and volume of services. However, we found that many of those we visited were either not aware of or did not understand the requirement, did not keep all of the data required, or lacked detailed data. Thus we could not accurately determine, from interviews or review of RHC records, how many patients were seen in a year, their payor status (including what proportion are uninsured/charity care), where patients lived in relation to the RHC, or what services they received and how often.<sup>9</sup> Neither could we make meaningful year-to-year comparisons.

State officials in our three case-study States also lack data on access and, like us, are eager to know what affect RHCs have had on access. One State public health agency had funded a study to document access, but the contractor was unable to proceed due to the nature and format of the Medicaid data available.

This program has never been evaluated, thus no national data is available on access. Recognizing this important information gap, both HCFA and the General Accounting Office (GAO) have begun studies of the RHC program focused on the issue of access.

**REIMBURSEMENT.** Rural health clinics are paid based on their costs, which may be inflated or inappropriate but are difficult and sometimes impossible to verify or audit without significant resource expenditure by the government.

Cost reimbursement is well understood as an extremely vulnerable mechanism by which to pay providers of service. It contains little or no incentive for efficiency, provides opportunities for inflated and inappropriate payments, is cumbersome and complex, and is difficult and expensive to oversee. Each of these vulnerabilities is discussed below as it pertains to the RHC program.

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<sup>9</sup> Available data, often incomplete, usually showed the number of annual visits by payor type, rather than an unduplicated count of patients. We learned early on that this might not be an accurate reflection of who the clinic is serving when the physician-owner of an RHC told us that Medicaid patients were 65 percent of all *patients* at his RHC, but constituted 80 percent of all *visits*.

### Little or No Incentive for Efficiency

In the three case-study States, from two-thirds to 100 percent of the independent RHCs are reimbursed at the capped rate. In one State, only 1 out of 28 independent RHCs in the 4 counties we visited received less than the cap. Also, 15 of the 17 cost reports for independent RHCs in our sample showed the RHCs receiving the capped rate, with their costs exceeding the cap; the other 2 reports show costs just under the cap. This comment by a State official echoed several others we heard: "There seems little incentive for RHCs to control their costs. As the Medicare cap increases each year, so do their costs."

Some States view cost reimbursement as inflationary. We heard of a few that are trying to control RHC costs in different ways. At least two States have imposed interim caps on provider-based Medicaid reimbursement and five have placed limits on the number of Medicaid visits per year to RHCs. We know of two States that require itemized billing (listing of services provided) from independent RHCs. (Provider-based RHCs reimbursed on charges already itemize their bills). Other States, via letters to HCFA or in conversations with us, seek increased authority to impose administrative and financial controls on RHCs generally.

We heard concerns that (uncapped) billing by provider-based RHCs, especially, is causing rapid increases in Medicaid costs in some places. In this light, one State reported that it may have to implement rate reductions for physicians and other provider groups in order to reimburse these types of RHCs; another State said that it may reduce prescription coverage or the number of allowable visits to a physician per year, or perhaps delete prescription coverage for the disabled and elderly. The eight cost reports we reviewed for provider-based RHCs in our sample showed costs higher than charges, meaning that the RHCs are reimbursed on charges.

### Inflated or Inappropriate Costs

We are concerned about the broad definition in the law of an RHC visit: a face-to-face encounter between a patient and a health care practitioner. Some RHCs we visited bill for some encounters where they only hand out prescription refills or test results. A Medicaid fraud control unit in one State uncovered such practices in a preliminary investigation of a few RHCs. The Medicaid agency there was developing a revised definition of an encounter to make sure that encounters are billed only when a patient is assessed by a health care professional.

The States where we made site visits and a few others express concerns about potential fraud and abuse by RHCs: manipulation of cost reports (cost-loading, cost-shifting, padding), double-billing, "ping-ponging" clients between related RHCs for unnecessary visits, billing for unnecessary visits, making unlimited or unnecessary visits to patients' homes or nursing homes, and duplicate billing (encounter plus fee-for-service). One State requested a written policy from HCFA on "commingling", where a practice operates part of the time as an RHC and part of the time as a fee-for-service

practice.<sup>10</sup> Another wrote HCFA expressing concern that clinics there are padding cost reports and billing fee-for-service for core RHC services (services meant to be covered within the encounter rate). A third State wrote to us noting cases where several RHCs were licensed at the same address, which they said could lead to abuse by sending a beneficiary to all three clinics on the same day for slightly different services.

Monitoring RHCs for these kinds of abuses in a cost-reimbursement system is extremely difficult from a practical standpoint given scarce oversight resources at local, State and Federal levels.

The lack of a reimbursement cap is reportedly driving the creation of provider-based RHCs in a number of ways. Small hospitals are establishing RHCs to shift costs in order to stay financially afloat. Hospitals are buying up and converting physician practices with promises of higher salaries. One State reported that in place of an emergency room, a hospital now has a 24-hour rural health clinic. In another case, the physician-owner of an independent RHC asked a local hospital to buy him out so that he could convert to provider-based status for enhanced revenue.

In our sample of cost reports from independent RHCs, annual salaries reported for midlevel practitioners ranged from \$18,983 to \$112,996. One example of questionable salary was brought to our attention by a State official where a physician assistant who owns two RHCs submitted a cost report showing his salary at \$140,000 for 7 months of work; an average annual salary for midlevel practitioners in the State is reportedly \$40-50,000. The official said that the \$140,000 was approved by the intermediary without an audit, but that the State views \$140,000 as excessive and has refused to pay, asking for HCFA guidance on "reasonable reimbursement" in the absence of regulations.

As noted previously, almost all the 25 cost reports for our sampled RHCs showed the costs of the RHC exceeding the capped rate (independent) or charges (provider-based). This could mean that the RHC is losing money treating Medicare and Medicaid patients, despite rapidly escalating Medicare and Medicaid costs. Or, costs might not be reported accurately, might be inflated to maintain a basis for higher billing, or could be shifted to the RHC portion of a practice that operates some of the time fee-for-service. Possibly, private-pay reimbursement is subsidizing treatment for Medicare and Medicaid patients. Whatever the reason(s), only a thorough audit of the cost reports would reveal why costs so often exceed charges.

Independent RHCs are not required to itemize billing. Also, if an RHC physician bills fee-for-service as well as the encounter rate, we cannot be sure that billing is

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<sup>10</sup> A physician we visited operates a pediatric practice as an RHC and a fee-for-service allergy practice in the same building. "Commingling" refers to the commingling of the assets, staff, records, and resources between the RHC and fee-for-service portions of such a practice, acknowledged by HCFA to hold potential for abuse. We understand that consultants sometimes advise physicians to maximize revenue by operating in this way.

appropriate and not duplicative. Only a medical record review and/or audit will identify what services these RHCs are providing, for what cost. Yet, reviews and audits are time-consuming and costly.

### Complexity of the System

Cost reports are complex and the cost reporting process cumbersome, especially for small independent RHCs, either newly established or conversions, which lack prior experience with cost reporting and do not contract with an accounting firm for this purpose. Some respondents in our case study reported difficulties understanding and correctly completing the reports, especially the first time they submitted them. An employee of a Medicare intermediary told us that many of the RHC cost reports he reviews are prepared by people who do not understand the requirements. We ourselves reviewed cost reports that were unsigned or where essential schedules needed to calculate reimbursement were incomplete. One report had been rejected by the intermediary. In order to settle RHC cost reports, it appears that intermediaries must often spend considerable time providing technical assistance to providers.

### Lack of Oversight

Some States, viewing Federal regulation, oversight, and evaluation of RHCs as lacking, have asked HCFA for written policy or administrative guidance on a number of issues such as reimbursement of provider-based RHCs<sup>11</sup> and commingling, noted previously.

No site visits are made by HCFA to an RHC after it has been certified. States may conduct resurveys, although this appears to be rare unless a State has questions about a specific provider.

It appears that none of the cost reports we reviewed had been thoroughly audited by the Medicare intermediary. Higher priorities (hospital, nursing home, or home health agency reviews, for example), plus the expense of full-scale audits, lead intermediaries to opt for desk-reviews of most RHC cost reports, where they generally compare costs from year to year to determine the percent of increase and request additional information, if needed, to document questionable costs. This is not necessarily a bad technique if the first cost report submitted has been thoroughly audited and base-line costs established. However, we understand that this is rarely done.

As for State oversight, it appears that most State Medicaid agencies rely heavily on Medicare's determination of the reimbursement rate, rarely reviewing cost reports themselves unless they receive complaints or have particular concerns about a specific provider.

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<sup>11</sup> The American Academy of Family Physicians also called upon HCFA to establish an equitable application of Medicare and Medicaid payment rules for independent and provider-based RHCs.

## RECOMMENDATIONS

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Rural health clinics and related Medicare and Medicaid expenditures are growing at a rapid pace. However, given the lack of data on the program, we do not know what we are paying for. This study reveals systemic weaknesses that lead to questions about whether the program is expanding access to primary care as the law intended, and whether cost reimbursement remains the best way to bring primary care to underserved rural areas. We make three recommendations to HCFA to address our concerns, some with suggestions of steps that could be taken to implement them. Some actions are administrative, others could require legislative changes. In any case, we hope they provide a focus for discussion about how this program can be strengthened.

Since the GAO and HCFA are now mounting studies on RHCs and the issue of access, we have not made a recommendation in this area. The Assistant Secretary for Planning and Evaluation might also be interested in funding more structured, longitudinal evaluations looking at this issue in the future.

**CERTIFICATION PROCESS.** The HCFA, with the Health Resources and Services Administration, should modify the certification process to increase State involvement and ensure more strategic placement of rural health clinics.

We recognize that some States have actively encouraged RHC growth or express no concerns about the program at this time, and we also believe that RHCs are needed in some places. However, our findings also convince us that greater effort is needed in this program to ensure that Government dollars translate into increased access. Growth should be a more rational and strategic process. Also, giving States more of a voice and increased control over RHC certification is consistent with the trend toward greater State flexibility in administering the Medicaid program generally. Some ways to implement this recommendation are:

- ▶ Implement the GAO recommendation to create specific underserved designation criteria for this program. Or, refine and oversee the existing system to ensure that designations are accurate and up-to-date and that areas are dedesignated as appropriate and in a timely manner.
- ▶ Find ways to expand the involvement of State officials (Medicaid and public health) in the certification process.
- ▶ Establish new criteria, in addition to rural, underserved designations, that will document need and impact on access of new RHCs.
  - . Require applicants to submit a plan documenting need and projected impact.
  - . Create geographic limits to eliminate concentrations of RHCs.

- . Remind States that they may implement their own criteria via a certificate of need or similar process they create.
- ▶ Require recertification of RHCs within a specific time limit (for example, 5 years), applying new criteria.

**REGULATIONS.** The HCFA should expedite the issuance of the regulations now under development.

This recommendation responds to States' requests for guidance in such matters as commingling and provider-based reimbursement. This will assist them in oversight of rural health clinics.

**REIMBURSEMENT METHODOLOGY.** The HCFA should take intermediate steps to improve the oversight and functioning of the current cost reimbursement system, with the long term goal of implementing a different method.

Intermediate steps could include:

- ▶ Require itemized Medicare billing for independent RHCs and encourage States to do the same for Medicaid billing. This allows HCFA to use payment safeguards currently in place for all fee-for-service billing. It would be useful in identifying fraud and abuse, and provide data on individual client services for evaluation at both the national and State level. Existing codes should be used, with a new code added to capture preventive and health education activities.
- ▶ Require RHCs to provide certified financial statements.
- ▶ Implement caps on provider-based RHCs, and allow States to do so. Or, find other ways to make reimbursement between provider-based and independent RHCs more equitable.
- ▶ Require provider-based RHCs to submit cost report worksheets providing the same data now required of independent RHCs.
- ▶ Implement controls such as a clearer definition of an encounter, itemized billing, and limits on visits per patient per year. Remind States that they may take such measures also.
- ▶ To institute consistency and uniformity in claims review, designate one Medicare fiscal agent, or one per region, to process all RHC bills (independent and provider-based).

Long term steps could include:

- ▶ Once itemized billing is instituted, conduct focused audits of RHCs to identify true costs as a basis for developing a new reimbursement mechanism.
- ▶ Ascertain what proportion of independent RHCs are reimbursed at the capped rate. If a strong majority, then consider proposing the elimination of



- ▶ cost reimbursement and reimburse all independent RHCs at a flat rate, requiring itemized billing. Increase the flat rate yearly as appropriate.
- ▶ Or, using data collected from itemized Medicare and Medicaid RHC bills, develop an enhanced fee schedule or a prospective payment system to reimburse all RHCs.

## COMMENTS

The Health Care Financing Administration, the Health Resources and Services Administration (HRSA), and the Assistant Secretary for Planning and Evaluation (ASPE) submitted written comments on the draft report. Copies of the comments are in Appendix A. They all concur generally with the recommendations, but expressed concerns and suggestions regarding various aspects of the steps proposed to carry them out. We look forward to future discussions with HCFA and HRSA concerning their action plans for implementing the recommendations.

Comments from ASPE also posed questions related to the nature of RHC growth, the relationship between RHCs and access to care, and how RHCs might be affected by the growing involvement of Medicare and Medicaid in managed care. These are important issues, but unfortunately are beyond the scope of this study. We hope that these issues will be addressed in future studies of the rural health clinic program by ASPE, HCFA, or others.

The National Association of Rural Health Clinics and the National Rural Health Association also submitted extensive comments. They view the report as unduly critical of RHC growth and stress the continuing need for incentives to retain and attract primary care to underserved rural areas. However, they also recognize that many of the problems raised in the report merit attention. Like HCFA, HRSA, and ASPE, they support our recommendations while disagreeing with some of the steps proposed to implement them. We have provided copies of their comments to HCFA, HRSA, and ASPE.

We thank everyone for their comments on this report. We have made changes in the text in response.

# APPENDIX A

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## AGENCY COMMENTS



**DATE** JUN 10 1996

**TO:** June Gibbs Brown  
Inspector General

**FROM:** Bruce C. Vladeck *Bruce Vladeck*  
Administrator

**SUBJECT:** Office of Inspector General Draft Report: "Rural Health Clinics: Growth, Access, and Payment," (OEI-05-94-00040)

We reviewed the above-referenced draft report which analyzes the recent growth of rural health clinics and its implications for the Federal government and states. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report.

Attachment

**Comments of the Health Care Financing Administration on Office of Inspector General  
Draft Report "Rural Health Clinics: Growth, Access, and Payment." (OEI-05-94-00040)**

**OIG Recommendation**

**Certification Process. The HCFA, with the Health Resources and Services Administration, should modify the certification process to increase State involvement and ensure more strategic placement of rural health clinics (RHC).**

- o Implement the GAO recommendation to create specific under served designation criteria for this program. Or, refine and oversee the existing system to ensure that designations are accurate and up-to-date and that areas are de-designated as appropriate and in a timely manner.**

**HCFA Response**

**We concur. The current shortage area designation system needs to be revised to ensure that designations of shortage areas are accurate and up-to-date and that areas are de-designated as appropriate and in a timely manner. It is our understanding that the Health Resources and Services Administration (HRSA) will be publishing regulations to revise the current designations system. We will continue to monitor this regulatory activity and provide appropriate comments regarding the impact of the regulations on the RHC benefit.**

- o Find ways to expand the involvement of state officials (Medicaid and public health) in the certification process.**

**HCFA Response**

**We concur. State Medicaid and public health officials should take a more active role in ensuring that RHCs are located in appropriately designated shortage areas. States currently have the authority to review areas for appropriate designations and de-designations. If a state believes that an area no longer meets the criteria for designation as a shortage area, the state can request that HRSA de-designate the area. We will notify states to be more active in this process, and we will assist states in monitoring requests to HRSA to de-designate an area.**

- o Establish new criteria, in addition to rural, under served designations, that will document need and impact on access of new RHCs. Require applicants to submit a plan documenting need and projected impact. Create geographic limits to eliminate concentrations of RHCs. Remind states that they may implement their own criteria via a certificate of need or create a similar process.**

**HCEA Response**

We disagree. We believe that with the implementation of the HRSA regulations to revise the designation system and more active state involvement in requesting the de-designation of areas, RHCs will be furnishing services to rural medically underserved residents consistent with the statutory intent of the RHC benefit.

- o Require recertification of RHCs within a specific time limit (for example, 5 years), applying new criteria.

**HCEA Response**

We disagree. Congress intended that once a RHC was approved and continued to participate in the Medicare/Medicaid program it could continue to do so even if the area lost its rural shortage area status. (See response to previous point.)

**OIG Recommendations**

**Regulations.** HCFA should expedite the issuance of the regulations now under development.

**Reimbursement Methodology.** HCFA should take intermediate steps to improve the oversight and functioning of the current cost reimbursement system, with the long term goal of implementing a different method.

**HCEA Response**

We concur with the above two recommendations and believe they are useful and meaningful suggestions for improvement of the RHC program.

**Technical Comments**

**Page 1, last paragraph -** An area with a medically underserved population group is not an eligible area for RHCs. Also, additional areas that are eligible but not mentioned in the paragraph are areas which include a population group which has a health professional shortage and high migrant impact areas.

**Page 9, certification process, 2nd sentence -** should read "... that meets certain broad location requirements and certain Federal health and safety requirements is approved to participate in the Medicare and Medicaid programs."



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

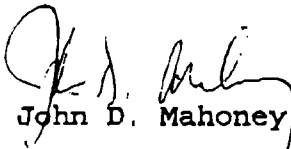
Health Resources and  
Services Administration  
Rockville MD 20857

MAY 24 1996

TO: Inspector General, OS, DHHS  
FROM: Deputy Administrator  
SUBJECT: Office of Inspector General (OIG) Draft Report  
"Rural Health Clinics: Growth, Access, and Payment"  
OEI-05-94-00040

Attached, in accordance with your March 29 request, are HRSA's comments to the subject draft report.

Staff questions may be referred to Paul Clark on  
(301) 443-5255.

  
John D. Mahoney

Health Resources and Services Administration Comments  
on the Office of Inspector General (OIG) Draft  
Report "Rural Health Clinics: Growth, Access, and  
Payment" (OEI-05-94-00040)

GENERAL COMMENTS

HRSA agrees with the OIG's premise that Rural Health Clinics (RHCs) should increase access to care. As stated by the OIG, RHCs are intended to increase access to health care for the rural medically underserved. We recognize that RHCs receive cost related reimbursement only for Medicaid and Medicare patients. Given the intent to increase access, RHCs should be expected to provide care for the uninsured and underinsured to the best of their abilities.

CERTIFICATION PROCESS

It should be understood that the ways in which the RHC certification process is modified will be determined in part by resource constraints. All units of government charged with certification or other monitoring responsibilities need adequate program support resources.

We have concerns with some of the strategies identified by the OIG for implementing the certification recommendation. For example, we do not concur with the creation of specific underserved designation criteria for the RHC program. The current designation system can work for the RHC program as well as other programs. We believe it would be inefficient to administer an additional designation system.

HRSA endorses several of the strategies identified by the OIG. We agree with the option to ensure that designations are accurate and up-to-date, and HRSA is currently working on that option. We also agree that there should be stronger methods of incorporating need and impact on access in the certification process. Certainly, need is a critical factor in determining where providers should be located. It should be recognized that the presence of other providers, in addition to a particular RHC, does not necessarily indicate an adequate primary care capacity. One aspect of determining need is a provider to population ratio analysis. We further concur with the OIG that consideration should be given to development of a recertification process. If a recertification process is not a viable alternative, other ways to monitor RHCs should be examined.

### REGULATIONS

We understand that States have requested guidance from HCFA regarding such matters as provider-based reimbursement, and commingling in a practice that operates part of the time as an RHC and part of the time as a fee-for-service practice. However, the statement on page iii of the report that the States' requests for guidance have been "to assist them in monitoring and evaluating RHCs" is too limited to sufficiently explain why States have requested guidance. It implies more consistency and rigor by States in monitoring and evaluating RHCs than currently exists. Furthermore, States' requests for guidance are related to their desire to limit RHC certifications and to curtail their rising RHC costs.

### REIMBURSEMENT METHODOLOGY

In the report, the OIG briefly discussed, but did not evaluate, cost related reimbursement. HRSA believes that the current cost reimbursement system should be improved. The current reimbursement cap for independent RHCs should be examined for reasonableness. Consideration should also be given to the use of a cap for provider-based RHCs. We believe HCFA should consider whether the cap for provider-based RHCs should be the same or different from that used for independent RHCs.

The OIG statement on page ii that the "vulnerabilities inherent in the cost reimbursement system are apparent in the RHC program" implies that implementation of cost related reimbursement will always have certain problems. The problems that the OIG cites are as follows: 1) no incentive for primary care in underserved areas, 2) little or no incentive for efficiency, 3) providing opportunities for inflated and inappropriate payments, and 4) an overall process which is cumbersome, complex, and difficult and expensive to oversee. As evidenced by MDS Associates, Inc. 1995 study, "Impact of Federally Qualified Health Centers Implementation of Community Health Centers Revenue and Utilization", the problems cited by the OIG are not inherent. This study provides evidence indicating that cost related reimbursement can be associated with improved access to care for Medicaid recipients and the uninsured. Furthermore, the study shows that there are



incentives to control costs and ways to guard against inflated and inappropriate payments. A means to address the vulnerabilities of cost related reimbursement is the use of tests of reasonableness of costs such as caps and productivity screens. There are various ways to implement cost related reimbursement with tests of reasonableness, including such options as prospective all-inclusive per visit rates without reconciliation and cost-related capitation rates. We believe that any change from cost related reimbursement should include a thorough analysis of potential effects on the RHCs' ability to remain in operation, and the impact on access to primary health care in underserved rural communities.

We also have concerns with the OIG suggestion to institute itemized billing because it is potentially in conflict with the desire to implement a process which is less cumbersome, complex, and difficult and expensive to oversee.

OIG RECOMMENDATION

The Health Care Financing Administration (HCFA), with the HRSA, should modify the certification process to increase State involvement and ensure more strategic placement of RHCs.

HRSA COMMENT

We concur. This recommendation is consistent with HRSA goals and objectives related to increasing access to primary care. This should result in more rigorous assessment of need and community impact and help prevent inappropriate proliferation of RHCs. Therefore, HRSA will collaborate with HCFA in determining how to increase State involvement in the certification process of RHCs and ensure more strategic placement of RHCs, giving appropriate consideration to the OIG's suggestions for implementing the recommendation.



JUN 12 1996

TO: June Gibbs Brown  
Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Report: "Rural Health Clinics: Growth, Access and Payment;" OEI-05-94-00040 -- COMMENTS

Thank you for giving us the opportunity to comment on this report which identifies structural and oversight difficulties associated with rural health clinics (RHCs). The report is timely and touches on issues State officials and others have raised regarding the proliferation of RHCs. We agree with the general direction of the report's recommendations and the topic areas they address, although not with every action which is proposed. It is disappointing that this report was unable to address the effect the growth in number of RHCs has had on access to care other than anecdotally. If information on the impact of RHCs on access becomes available, perhaps through the current HCFA evaluation, the report's recommendations, particularly those related to certification, should be revisited.

While we believe this report raises important questions, we believe it could be strengthened. Our specific comments follow:

#### BACKGROUND

- On page 2, it is mentioned that independent RHCs are subject to a "productivity standard". We recommend that this term be defined.

#### FINDINGS

- "Growth of RHCs" The report consistently uses the phrase "growth of RHCs" to refer to an increase in the number of RHCs, and various comparisons are made among States about increases in numbers and corresponding rates of "growth." We recommend that a discussion be added indicating that there is significant variety in the types of RHCs, and therefore that not all RHCs are interchangeable units. Nowhere does the report address trends in the number of Medicare and Medicaid patients using RHCs which would be an important and perhaps more significant component of "growth." Similarly, while the report on page 6 explores increases in Medicare and Medicaid expenditures for RHCs, it does not shed light on the degree to which these increases are tied to the increase in number of RHCs, as opposed to increases in expenditures among existing RHCs. While there are footnotes addressing the lack of reliable data on users and visits, some acknowledgment should be made of the limitations of using raw numbers of RHCs as the primary unit of analysis.

In the discussion of recent growth on pages 4-7 much information is provided which is lacking in context. For example, the fact that more than half the RHCs in the Nation are projected to be located in 10 States is not of itself significant. (More than half the Nation's population resides in the Nation's 10 most populous States.) What is important is that the number of rural residents (or, more to the point, rural residents living in underserved areas) in these States is not proportionate to their number of RHCs. In another example, on page 6, it is observed that Medicaid expenditures for RHCs are approximately three times those of Medicare, but there is no indication as to why this is important.

- Statutory versus Discretionary Requirements It would be helpful for the report, and in particular its recommendations on certification and reimbursement methodology, to identify more specifically which program flaws are the result of statutory requirements (which would require legislative changes) and which can be addressed through regulatory or policy changes.

- Editorial Clarifications

-- Page 9. The report compares the current RHC certification process to an entitlement program. While we understand the analogy being drawn, we think that the word entitlement has many connotations beyond the one being referred to here, and therefore suggest that the OIG consider using a different term.

-- Page 11. Some indication of the breakdown between Federal and State designations would be helpful, for both new and old RHCs.

-- Pages 12 -13. In the example of two competing RHCs, it is suggested that closing one of two hospitals in a rural area is clearly a negative outcome because it will reduce access to primary and tertiary care. This is not necessarily true, particularly in areas where there is overcapacity, as is suggested in this example. We recommend that this example be revised to take this issue into account.


## RECOMMENDATIONS

- Access to Care The introductory paragraph to this section notes that questions have been raised as to whether the intent of the law to expand access to care is being met. While the topic areas included in the recommendations should be pursued immediately, major redesign of RHC requirements would benefit from better information about their effect on access. The report should contain a recommendation addressing this point.
- Certification Process We agree that the certification process can be improved and that expanded involvement of State officials in the process would be beneficial. We would

prefer refinement and improvement of the existing system of designations rather than create of a new system to avoid duplication of effort, both at the Federal and State levels. Confusion that would result from two similar processes; and the time and start-up costs inherent in developing and implementing a new system need to be considered.

- Regulations An estimated date for publication would be helpful, if HCFA can provide this.
- Reimbursement Methodology We applaud the attempts to create greater financial accountability and narrow the differences in payment and reporting requirements treatment between provider-based and independent RHCs that are spelled out in the list of intermediate steps. However, we do not endorse the suggestion of capping visits per year. Finally, we do not understand the logic behind the last "intermediate step" recommendation. Specifically, why can Medicare use payment safeguards if there is only one fiscal agent per region or country, but not if there are more than one?

The long term steps are directed toward exploring the need for and structure of a new reimbursement structure. These possible changes need to be considered against Medicaid's, and increasingly, Medicare's, growing involvement in managed care and the participation of RHCs in managed care plans. Flat rate reimbursement and enhanced fee schedules may well become increasingly inappropriate in this changing environment.

  
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