RHCs at the Crossroad
National Rural Health Association Annual Meeting
Denver, CO
April 18, 2012

Muskie School of Public Service

Maine Rural Health Research Center
Learning Objectives

• Review of the program
• Identify the challenges faced by RHCs
• Alignment between program’s original intent and current needs of rural communities
• Review the RHC research related to their safety net functions and meaningful use of HIT
• Identify challenges and opportunities of health reform
• Discuss the need for national data to support the RHC program
Program Description

• One of the oldest continuously operating rural health support programs (since December 1977)
• Goal: Improve access to Services for Medicare and Medicaid beneficiaries living in rural designated shortage areas
• Legislation: Created federally-certified Rural Health Clinics, established Medicare and Medicaid cost-based reimbursement for RHCs, and expanded use of mid-level providers
RHC Certification Requirements

- Location in a Census Bureau-defined non-urbanized area and either a Health Professional Shortage Area; Medically Underserved Area; or Governor-Designated Shortage area
- Providing outpatient primary medical care
- Employ a mid-level provider at least 50% of time clinic is open
- Comply with applicable federal, state, and local requirements
- Under medical direction of a physician who reviews services of the mid-level providers, provides general medical supervision, and is on-site at least once every two weeks
Status of RHC Program

- 3,950 clinics (as of 1/2012) operating in 45 states
- Approximately 2133 (54%) are independent
- 1817 (46%) are provider based (operating as an integral part of another Medicare approved facility, primarily hospitals)
- States with greatest numbers of RHCs: Missouri (349), Texas (321), California (268), and Illinois (219)
- Ownership/organizational control: 1857 (47%) are for-profit, 672 (17%) are government-owned, 1422 (36%) are non-profit
An RHC is a facility located in a rural area designated as a shortage area and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases.

Sources: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 4, 2006.

Note: Alaska and Hawaii not shown to scale
RHC and Rural FQHC Patient Volume

- Based on data produced by Ron Nelson, NARHC
- Approximately 3800 RHCs vs. 1600 rural FQHCs
- 2008 Medicare activity
  - RHCs served more than 1.64 million Medicare patients
  - Rural FQHCs served slightly more 265,000 Medicare patients
- 2008 Medicaid activity
  - RHCs served more than 2 million Medicaid beneficiaries
  - Rural FQHCs served almost 920,000 Medicaid beneficiaries
Why Is the RHC Program at a Crossroad?

- Questions remain about the extent to which the Program is:
  - Improving access and serving vulnerable populations
  - Relevant to the current needs of rural communities (GAO 1996; OIG 1996 & 2005)
- Failure to implement provisions of BBA 97
- Increasing safety net demands
- States are exploring alternatives to cost-based reimbursement
- Demands of health reform and practice transformation
- Calls for accountability and transparency
Sound Familiar?

- Rural primary care access issues in 1977:
  - Inadequate physician supply serving rural Medicare/Medicaid enrollees
  - Difficulty recruiting and retaining providers in rural areas
  - Medicare/Medicaid fees schedules problematic for low-volume practices
  - Rural populations are older, poorer, and sicker than urban populations
  - Production of primary care workforce inadequate to meet demand

- More recent rural challenges:
  - Rural residents are more likely to be uninsured and under-insured
  - Coverage more likely to involve higher co-pays and deductibles
  - Many insured working poor are functionally “uninsured” until out-of-pocket cost requirements are met
Is the RHC Program Still Relevant?

- YES: Same challenges still plague rural areas – changes needed
- Distinguish between access and availability
- Better targeted program benefits to areas of greatest need
- Data is needed to quantify extent to which RHCs are improving/access and serving vulnerable populations
- Process is needed to de-certify clinics that may not be using program benefits to expand access for vulnerable populations
Safety Net Challenges Facing RHCs

• 2000-2010, # of uninsured Americans grew by 13 million due to economic downturn and losses in employer-based coverage
• Rural areas hardest hit as unemployment has remained higher and fewer employers provide health insurance
• Higher rates of underinsurance
• Greater demand for free/discounted care and reductions in provision of such care by private physicians (CSHSC 2011)
• Provision of charity care draws costs away from Medicare on cost report
Institute of Medicine Definition of the Safety Net

• “Providers that organize and deliver a significant level of health care and other health services to uninsured, Medicaid, and other vulnerable patients”

• Core safety net providers are a subset of the safety net that:
  – Maintain a “open door” to offer access to services for patients regardless of their ability to pay By legal mandate or explicit mission
  – Maintain a case mix with a substantial share of uninsured, Medicaid, and other vulnerable patients.”
Safety Net Characteristics of Independent RHCs

- 86% provide free or discounted care
- 81% are currently accepting free/discounted care patients
- 92% reported that their levels of free/discounted care remained the same or increased in past two years
- Free/discounted care & bad debt account for 13.2% of billings
- 27.3% of visits are paid by Medicaid
- 97% are accepting new Medicaid/SCHIP patients
- 47% offer help in enrolling in Medicaid/SCHIP
RHC Safety Net Activity

- 69% located in small towns or isolated areas
- Medicare, Medicaid, uninsured, private pay, charity care patients account for 70% of volume
- 80% accept applications for charity care
- 99% accept new Medicaid patients
- 91% accept new SCHIP patients

Gale & Coburn 2003
RHC Charity Care Activity

- 59% have formal or informal policies covering the provision of charity care (Gale & Coburn 2003)
- 80% accept applications from patients for charity care
- For comparison, 68% of private physicians reported providing charity care in 1994 (Cunningham and Tu, 1997)
## Revenue/Visits by Payer Type

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>% of Revenues</th>
<th>% of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>29.9%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Medicaid-SCHIP</td>
<td>24.4%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Uninsured, Private Pay, and Free/Reduced Cost Care</td>
<td>14.7%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Commercial/Private Insurance</td>
<td>29.5%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Other</td>
<td>4.2%</td>
<td>3.9%</td>
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</tbody>
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Gale & Coburn 2003
% of Monthly Visits Receiving Charity Care

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>All RHCs</td>
<td>7.8%</td>
<td>292</td>
</tr>
<tr>
<td>Independent RHCs</td>
<td>8.7%</td>
<td>148</td>
</tr>
<tr>
<td>Provider-Based RHCs</td>
<td>7%</td>
<td>144</td>
</tr>
</tbody>
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Gale & Coburn
RHCs and FQHCs - Competing Safety Net Roles?

- Presence of an FQHC in the same county/zip code not associated with differences in free or discounted care
- Proximity of an FQHC in same county/zip code was attributable to differences in % of Medicaid visits
- RHCs with an FQHC in their market were significantly less likely (38%) to have 30% of more of their patient visits attributable to Medicaid as opposed to those that did not (65%)
Are RHCs Part of the Safety Net?

- YES - given their location in rural, underserved areas and their service to uninsured, self-pay, Medicaid/SCHIP, and elderly patients, many (but not all) RHCs are safety net providers
- Most are not core safety net providers (per IOM definition)
- Limitation – hard evidence on the amount of free/discounted care provided and magnitude of services to vulnerable populations is not available
- Note: RHC Program was designed to address geographic, not financial access
Challenges Posed by Health Reform

• RHCs only mentioned 13 times in 961 pages
• Only direct benefit-RHCs are allowed to contract with FQHCs
• Planned reduction in health care spending rate
• If coverage expansions are successfully implemented: more patients and a greater demand for services
• Greater pressure to merge with or develop larger groups
• Greater demand for accountability and efficiency
• Payment reforms
New Delivery and Payment Models

- Accountable care organizations (ACOs)
- Patient-centered medical homes (PCMH)
- Bundled payments for acute care episodes
- Value-based payments-reward performance based on outcomes
- Reduction in payment growth-Medicare Advantage
- Case and disease management
- Comparative effectiveness
- Independent Payment Advisory Board (IPAB)
Potential Impact of Reform on RHCs

- More money (Medicaid is one of the best payers for RHCs and a large majority of new patients will be covered by Medicaid)
- More competition
  - FQHCs will receive significant funding to expand
  - More physicians will likely accept Medicaid if rates are increased in 2013/2014
- More patients will exacerbate primary care provider shortages
- Recruitment will become more difficult
Where Are We Headed?

- Market consolidation/integration
- Emphasis on value, not volume
- Transparency
- Clinical care administration via protocols
- Data sharing
- Provider accountability for performance (relative to low cost, high quality providers)
What Is Going to Happen?

• The status of health reform is up in the air due to:
  – Ongoing and unresolved deficit battles
  – Divisions in the views of voters from both parties
  – Strength of the Tea Party

• Budget battles will erode the scope of implementation

• 2012 election will resolve the future of the law

• Medicare reform will await the results of the next election

• Coverage expansion will likely be scaled back but efforts to improve transparency and accountability will not
Importance of HIT Under Health Reform

- Future of health care is linked to better HIT systems and is part of the solution regardless of what happens to health reform
- Necessary to participate in patient-centered medical homes, ACOs, pay for performance and other transformation initiatives
- Full adoption of HIT leads to:
  - Improved interaction with patients and caregivers
  - Transparency and the ability to document quality and performance
  - Improved treatment of chronic diseases
  - Improved operations
  - Improved collaboration among internal and external providers
Where Do RHCs Stand?

- Little national evidence exists to document status of RHC implementation of HIT
- Evidence from small physician practices suggests that RHCs may not be able to meet standards for meaningful use of HIT
- As Medicare meaningful use incentives are based on fee for service/Part B billings, many providers in RHCs won’t qualify
- Individual RHC providers may qualify for Medicaid incentives if “needy individuals” make up 30% of their patient volume
Electronic Health Record Implementation

- EHR in use 42%
- EHR purchased/implementation begun 12%
- RHC does not have an EHR 46%

- Most commonly used EHR brands: Allscripts (6), GE Centricity (5), Lake Superior Data Systems (4), McKesson (3)

* Based on preliminary results – early adopters may be over-represented (n=65)
Implementation Plans for RHCs Without an EHR

- Planning to purchase and implement within next year 25%
- Planning/exploring vendors with plans to implement within 1-3 years 46%
- Would like to implement but have not started planning/exploring vendors 11%
- No plans to implement an EHR/Not sure of plans 18%
What Does It All Mean?

- **Caution:** Results are based on a small set (65) preliminary respondents and should be interpreted with caution.
- Slightly over 50% of early respondents have implemented an EHR.
- A substantial number of RHCs will need support in acquiring/implementing an EHR to achieve meaningful use.
Need for a National RHC Data Strategy

- Lack of data is a big challenge to the RHC Program
  - Difficult to create a national advocacy and support strategy
  - Hard to garner support for legislative change (e.g., RHC Patient Access Improvement Act or exceptions to designation criteria under BBA 97)
- May be left out of health reform/transformation activities
- Safety net role of RHCs is under appreciated in the absence of evidence documenting their contribution
- Current database of RHC addresses and owners does not exist
- Need for a consistent advocacy voice
Options to Create a National RHC Database

• Make independent RHC costs reports available in a database format similar to hospital cost reports
• Engage state licensing agencies in collecting and reporting a core set of RHC data
• Support CMS in collecting core RHC data (similar to UDS)
• Engage SORHs, state RHC associations, and National Association of Rural Health Clinics in encouraging RHCs to participate in data collection efforts
Contact Information

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