RHCs at the Crossroad

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RHRC
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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

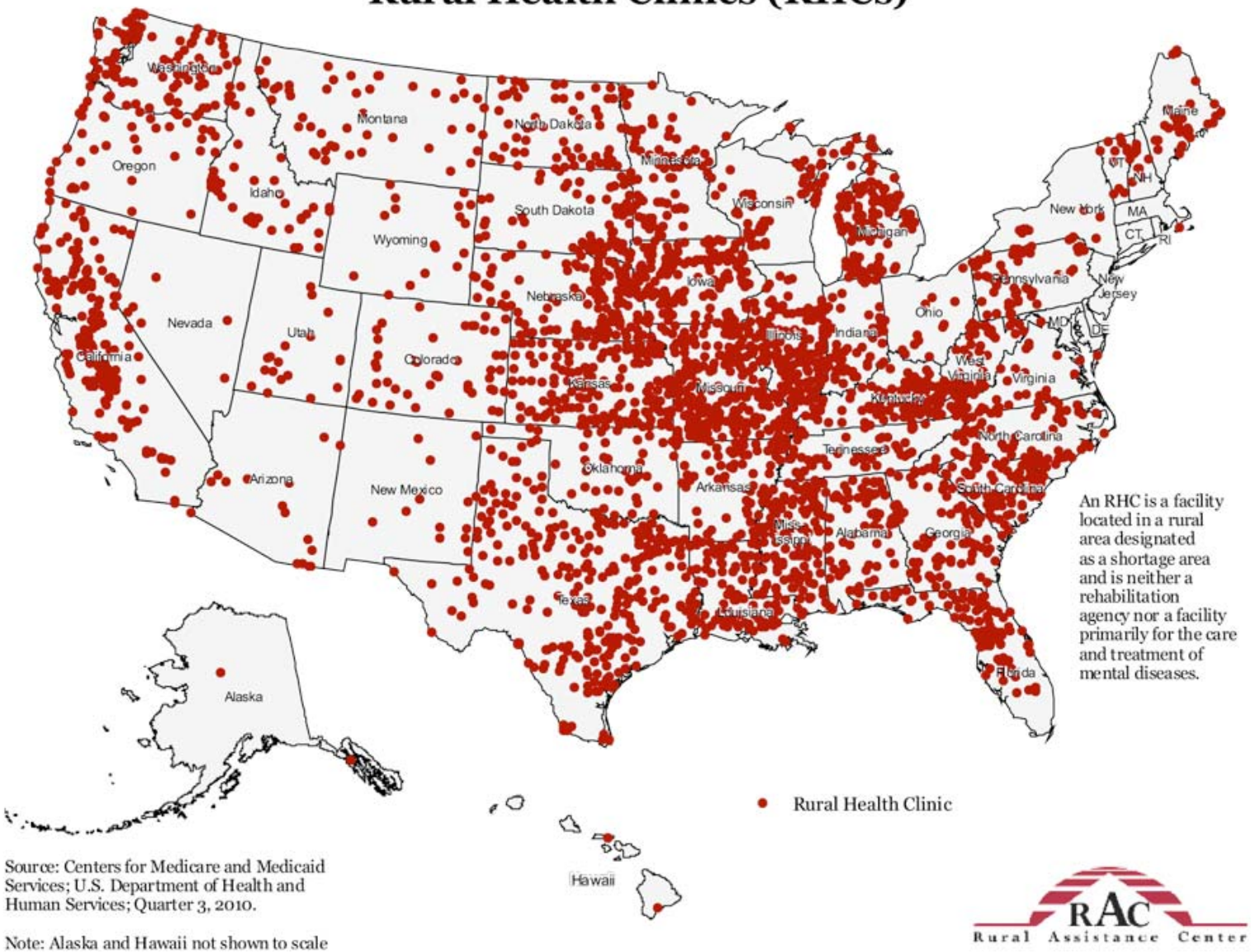
RHC Certification Requirements

- 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

Rural Health Clinics (RHCs)



Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 3, 2010.

Note: Alaska and Hawaii not shown to scale

RAC
Rural Assistance Center

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 920,00 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

Payer Type	% of Revenues	% of Visits
Medicare	29.9%	30.8%
Medicaid-SCHIP	24.4%	25.0%
Uninsured, Private Pay, and Free/Reduced Cost Care	14.7%	14.6%
Commercial/Private Insurance	29.5%	28.4%
Other	4.2%	3.9%
Gale & Coburn 2003		

% of Monthly Visits Receiving Charity Care

	%	N
All RHCs	7.8%	292
Independent RHCs	8.7%	148
Provider-Based RHCs	7%	144
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 starting 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

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