

RURAL HEALTH CLINIC TECHNICAL ASSISTANCE EDUCATIONAL SERIES

MODULE 1

AN INTRODUCTION TO THE RURAL HEALTH CLINIC PROGRAM

National Organization of State Offices of Rural Health

44648 Mound Road, #114 | Sterling Heights, MI 48314-1322
Phone: 586-739-9940 | Fax: 586-739-9941 | Email: teryle@nosorh.org
www.nosorh.org



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Introduction to the Rural Health Clinic (RHC) Program

Target Audience and Objectives: This module is designed primarily for State Office of Rural Health (SORH) staff new to the Office, new to working with primary care and/or new to working with Rural Health Clinics. Objectives for this introductory module are to:

1. Review basic information about primary care and the pivotal role of primary care in rural health.
2. Introduce SORH staff to the RHC program – its history, potential benefits and unique aspects.
3. Outline issues and resources available to states, communities and providers in assuring access to primary care in rural, underserved communities.
4. Examine basic differences between RHCs and Federally Qualified Health Centers (FQHCs).

Information provided throughout this module includes definitions of primary care and how increased reimbursement helps RHCs provide access to primary health care for rural people living in rural communities.

Suggested Resource Materials and Background Reading:

[Starting a Rural Health Clinic: A How-to Manual \(Chapters 1 & 2\), 2004](#)

Requirements for Initial RHC Certification, Washington State Department of Health, Rural Health Program, Rural Health Clinics (<http://www.doh.wa.gov/hsqa/ocrh/RHC/rhcMminpg.htm#RHC cert>)

[Comparison of the RHC and FQHC Programs, HRSA Manual \(revised June 2006\)](#)

[A Comparison of Rural Health Clinics and Federally Qualified Health Centers, Colorado Rural Health Center, April 2010](#)

[CMS RHC Fact Sheet \(September 2010\)](#)

[CMS FQHC Fact Sheet \(April 2009\)](#)

Health Resources Services Administration's HPSA (<http://muafind.hrsa.gov/>) and MUA (<http://bhpr.hrsa.gov/shortage/>) Web sites

Am I Rural? Rural Assistance Center (<http://www.raonline.org/>)

What is primary care?

Primary care is defined as “basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient’s health problems, be they biological, behavioral, or social.”ⁱ

Wikipedia offers the following definition:

*Primary care is the term for the health services that play a central role in the local community. It refers to the work of healthcare professionals who act as a first point of consultation for all patients.*ⁱⁱ

In 1996, the Institute of Medicine (IOM) convened a committee to discuss the future of primary care which described primary care as:

*The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.*ⁱⁱⁱ

Further, the IOM committee stated that, “no healthcare system can be complete without primary care, indeed it is the foundation of health care delivery.”^{iv}

Because primary care is essential and because rural people need access to primary care throughout the life cycle, many SORHs consider work to assure primary care access for rural people a major, core responsibility of the Office.

RHC Program History, Purpose, Benefits

Access to primary care is essential. Primary care is the level of care everyone needs, regardless of age, income or type of insurance coverage. Primary care includes preventive services and health screenings which help diagnose problems early when treatment is less costly. Over the past four decades, state and federal governments have advanced policies and programs designed to assure beneficiaries of Medicaid and Medicare have access to primary care. A variety of programs assist selected communities with developing or maintaining primary care. Both the federal Centers for Medicaid and Medicare Services (CMS) and the Health Resources and Services Administration (HRSA) administer programs to aid underserved communities to attract and retain primary care providers.

In many rural and other medically underserved communities, basic access to primary care is difficult to maintain without public intervention and support. In many rural communities, the percentage of population insured by Medicaid and Medicare is disproportionately high and the number of people covered with adequate employer based health insurance is low. Because of the types of employment

available, too many rural people are uninsured altogether and do not have enough income to pay for needed primary care. This combination of low private insurance, low income and heavy reliance on Medicaid and Medicare as payment sources make it difficult for some rural primary care practices to be viable.

Medicaid and Medicare are essential health insurance programs providing coverage for populations for whom society, through government, has agreed to provide public financing for health care. Both Medicaid and Medicare are administered through CMS; however, Medicaid is a partnership between the federal government and states.

Medicaid and Medicare programs are especially important health care payers in rural communities. The amounts paid vary by program, location and state. Both programs provide coverage for primary care but the amounts paid do not generally cover the full expense of care provided. Some CMS programs are designed to pay a higher portion of the cost of care of their beneficiaries in an effort to help assure an adequate distribution of primary care providers and thus to assure access to care for rural people. The RHC program is one of these programs.

RHC History: For many years it has been evident that primary care practices located in rural communities and serving a large portion of Medicaid and Medicare beneficiaries are not competitive or profitable health care businesses. Most primary care is provided in private practices. Congress and the federal government learned that without subsidy or special financial support rural primary care practices are extremely vulnerable. The RHC program is one of the earliest mechanisms developed by the federal government to assist rural people and rural communities achieve or maintain primary care through reimbursement policy.

In the mid-1960's the physician shortage in rural America reached a crisis point. The supply of physicians was insufficient to meet the demands of many communities, particularly small, isolated rural areas. To alleviate the effects of this crisis, physician assistants (PA) and nurse practitioners (NPs) services were introduced to help extend primary care and physician services.

During the early days of the Medicare program, PA and NP services were not eligible for reimbursement. Many state Medicaid programs also excluded NPs and PAs from direct payment. For most PA and NPs, third-party reimbursement was dependent upon working under the immediate supervision of a physician. This lack of third-party reimbursement from public payers was considered a substantial disincentive for PAs and NPs to locate in rural areas.

With significant political energy directed toward resolving this issue, Congress passed Public Law 95-210, known as the Rural Health Clinic Services Act in December 1977. The act was intended to address some of the NP and PA reimbursement issues and increase availability and accessibility of primary care services for residents in rural underserved rural communities. Because NPs and PAs were required and thus central to the RHC program, these providers gained greater support and utility and helped assure access to primary care in rural areas.

Purpose of RHCs: RHC legislation had two main purposes: to improve access to primary health care in rural, underserved communities; and, to promote a collaborative model of health care delivery using physicians, nurse practitioners and physician assistants. Congress later added certified nurse midwives to the core set of primary care professionals and included mental health services provided by psychologists and clinical social workers as RHC benefits.

CMS uses state survey and licensure agencies to review and recommend designation of private or non-profit clinics meeting conditions for participation and certification as RHCs. Federally certified RHCs are primary care practices which use a particular practice model and are reimbursed in a special way by CMS and state Medicaid programs. RHCs are important safety net providers since the populations for whom they receive enhanced reimbursements is Medicaid and Medicare beneficiaries.

RHC Certification Benefits: The law authorizes special Medicare and Medicaid payments for certified RHCs. That means that certified primary care practices can receive higher reimbursement than traditional primary care practices in rural communities. This increased reimbursement is generally considered the primary incentive for becoming a Federally Certified Rural Health Clinic.

Medicare uses a modified cost-based method for determining the payment amount per visit for Medicare beneficiaries. For *Medicaid*, states are mandated to reimburse RHCs using a Prospective Payment System (PPS). The federal law allows states to use an alternative payment method for Medicaid services, as long as the payment amounts are not less than the clinic would have received under the PPS method.^v

RHCs receive enhanced reimbursement for care provided to Medicaid and Medicare beneficiaries only. The payment amount is based on each clinic's allowable costs of doing business. The amount paid varies by clinic since it is specific to the expenses of each clinic. An annual cost report is required, as is an annual evaluation. These requirements are in addition to the initial certification process. RHCs are required to maintain the clinic staffing model as well as to continually meet other federal participation requirements.

There is a maximum amount Medicare will pay independent RHCs for Medicare visits. As of January 1, 2010, reimbursement for Medicare is capped at \$77.76 per encounter. There is no per visit reimbursement cap for provider-based RHCs affiliated with a hospital under 50 beds.

Private primary care providers, which are not certified RHCs, are generally paid based on the Resource Based Relative Value System (RBRVS) fee schedule and/or through managed care fees negotiated with plans. Primary care practices not enrolled in the RHC program are paid based on specific services provided to each beneficiary not per encounter. This is an essential difference. Payments for primary care provided to Medicaid beneficiaries vary by state and are generally paid using a state Medicaid established fee schedule.

RHC designation is one tool to help attract and retain qualified primary care providers. Because of enhanced reimbursement for Medicaid and Medicare beneficiaries, many RHC are able to continue to operate in remote, rural or frontier communities.

There are two types of RHCs: independent/free-standing and provider-based. *Provider-based* RHCs are certified as a unit of a hospital, skilled nursing facility or home health agency.

RHCs can be for-profit, not-for profit or publicly owned.

Basic Qualifications for and Types of RHC Certification

RHCs must meet basic geographic, provider type and primary care requirements:

1. Clinic or practice must provide primary care that includes:
 - √ Commonly furnished outpatient diagnostic and therapeutic primary care services; and
 - √ Basic lab services (including chemical examinations of urine, hemoglobin/hematocrit and blood sugar; examination of stool specimens for occult blood; pregnancy tests; and primary culturing for transmittal).
2. Provider staff requirements include:
 - √ At least one Nurse Practitioner, Physician Assistant or Certified Nurse Midwife must be on site and available to see patients 50% of the time the clinic is open as an RHC (RHC hours of operation must be posted).
 - √ A physician must be in the clinic at least once every two weeks. The physician must provide medical direction and be a member of the clinic's staff or work under agreement with the RHC to fulfill responsibilities required of a physician.
3. The RHC must be located in a non-urbanized area (as defined by the U.S. Census) and in an area with one of the following current designations:
 - √ Medically Underserved Area (MUA);
 - √ Geographic or population-based Health Professional Shortage Area (HPSA); or
 - √ Governor-designated and Secretary-certified shortage area.

Current shortage designation means the location was designated within the past four calendar years.

Current HPSA and MUA designations can be found on HRSA's "Shortage Designation Branch" Web page at <http://bhpr.hrsa.gov/shortage/>. State Offices of Primary Care are directly involved in recommending

areas that meet designation requirements to HRSA; currently, 13 states have met the requirements for Governor-designated shortage areas.

An RHC's geographic definition of rural is defined by the U.S. Census Bureau, which designates areas as being urbanized or non-urbanized. The RHC rural requirement is very specific; any provider considering designation should first determine if the site qualifies by location. SORH staff should be familiar with the specifics of the geographic requirement.

The Rural Assistance Center provides a useful tool for learning about rural definitions and determining whether a specific address meets the definition as non-urbanized. Visit the RAC Web site at www.raconline.org and click on the "**Am I Rural?**" link to learn more.

Resources to Assist with Primary Care in Rural Areas

States, rural communities and providers are uniquely challenged in assuring access to primary care in rural, underserved communities. Because primary care is *essential*, state and federal governments, health organizations and economic development groups recognize the importance of ensuring access to primary care. Rural areas are distinctly challenged and it is difficult to develop or maintain access to basic, essential primary care throughout diverse rural communities. The supply of primary care providers is an issue. Additionally, the distribution of primary care providers is a substantial problem states and the federal government recognize and work to resolve. Assuring access to primary care for people living in rural and frontier areas can be especially difficult if the population does not have sufficient private health insurance resources or other funding support to attract and retain the number of primary care providers needed. While it is not true of every rural community, many rural communities have a disproportionate percent of the population which is elderly or very young.

There are several measures of primary care access. A widely used gauge is a count of primary care physicians providing care in a specified community (county, parish, region, facility or census tracts) compared with the number of people living in that geographic area. From those two counts a ratio is derived. If there are not sufficient primary care providers available to the population, that population or community is considered to have a primary care shortage. HRSA uses a specific methodology to determine areas that are designated a Health Professional Shortage Areas (HPSA).

A Medically Underserved Area (MUA) designation is another measure used by HRSA to designate communities as underserved. This definition relies on health status indicators, as well as the number of primary care providers available for the population or area. An index of medical under service is used to designate Medically Underserved Areas. The MUA designation uses four variables to determine if an area should be designated as medically underserved; these include the ratio of primary medical care physicians per 1,000 people, the infant mortality rate, the percentage of the population with incomes below the poverty level, and the percentage of the population age 65 and older. ^{vi}

Resources, programs and tools to assist rural communities vary among the states. Some resources are available through the State Office of Rural Health, some through the Primary Care Office (PCO) or Area Health Education Centers (AHEC) programs. According to the state, services to support primary care range from technical assistance (TA) or consultation to communities or providers, to assistance with recruiting and retaining primary care providers, to helping communities *grow their own* health providers, to assisting communities or practices apply for RHC designation or for a federal grant (operational subsidy) to support a Community Health Center (or Federally Qualified Health Center).

States vary in the type and amount of TA provided to rural communities and primary health providers. HRSA, the federal agency providing direct state grants for support and technical assistance, has not designated a *single* state office or organization to specifically provide technical assistance, support or resources to assist RHCs. SORH, however, are charged with five core mandates of which one is to provide technical assistance to rural health providers. Providing RHC consultation, TA and support therefore fit within the five core mandates of SORH.

Shortage Area Designations

A primary care Health Professional Shortage Area (HPSA) designation is often a gateway to other primary care resources. HPSAs are used as eligibility criterion for various federal and state programs. Every state in the country has a Primary Care Office (PCO) located in the state health department. PCOs are charged with making shortage area recommendations to the US Department of Health and Human Services, HRSA, Shortage Designation Branch. Designation *recommendations* are made by the state PCO but HPSA status is *awarded* by the federal government.

The designation process can be complicated and data collection cumbersome and time consuming. Descriptions of designations and the processes for designation are located at <http://bhpr.hrsa.gov/shortage/>. To determine if specific addresses or areas are designated check <http://muafind.hrsa.gov/>

Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (RHC, FQHC or other public facility). Counties, parishes, census tracts and health facilities can be designated as health professional shortage areas. HPSA designations are updated every three years.

Another program useful in supporting rural primary care is the Medicare 10% bonus payment. Medicare makes bonus payments to physicians who provide medical care services in geographic areas that are designated as primary medical care HPSAs and to psychiatrists who provide services in HRSA-designated mental health HPSAs.^{vii} CMS provides specific information about what practices are eligible for this payment and how payment is made. (RHCs are not eligible for this bonus as services are paid on a cost basis.)

The National Health Service Corps (NHSC) is a helpful rural primary care program, as is state or federal Loan Repayment Programs. In loan repayment programs, primary care providers agree to practice in designated HPSAs and for every year served a portion of medical loans are repaid. The NHSC, a major federal workforce support program, uses HPSA designations to target placement of physicians, nurse practitioners, physician assistants, nurse midwives, dentists and selected mental health providers in the most underserved communities in the nation. RHCs can become a NHSC approved site. SORHs could explore this benefit for RHCs with the State PCO.

Often the State PCO and the SORH work together closely and are often located within the same organizational unit. More information about designations, NHSC, loan repayment and Primary Care Offices is available through HRSA, Bureau of Health Professions, Shortage Designation Branch or the NHSC. A list of PCOs by state is located at <http://bhpr.hrsa.gov/shortage/pcos.htm>.

An orientation to the NHSC, HPSAs and other primary care retention and recruitment programs could be helpful to SORH staff working to help build primary care assets in rural communities. Contact the state PCO or NOSORH to arrange an orientation.

What is a FQHC? How is it similar to an RHC? How are they different?

Federally Qualified Health Centers (FQHCs) are also known as Community Health Centers (CHC). CHCs are authorized through Section 330 of the Public Health Services Act. CHCs are primary care practices, located in underserved communities, and supported through grants from HRSA, as well as revenue earned through patient fees.

FQHCs are paid by Medicaid and Medicare using a cost based reimbursement mechanism, adapted from the RHC program. FQHCs, in addition to receiving cost based reimbursement, receive a federal grant or an operational subsidy to assure every FQHC in the county provides care to all without regard for ability to pay. A sliding fee scale and reduced fees are required to assure people are provided care regardless of their income, insurance status or ability to pay.

FQHCs must meet specific requirements for funding, including a location criteria and governing board requirements. FQHCs are public or not-for profit organizations. The type of primary care practitioners vary based on the needs of the population. FQHCs are governed by a not-for-profit board of directors which must meet federal specifications. There are a few FQHCs which are public organizations. FQHCs are not required to be certified through the state licensing and certification agency, instead they are certified by HRSA, Bureau of Primary Health Care through grant processes.

There are several excellent documents outlining how FQHCs and RHCs compare, some of which are listed on page 1 in the Suggested Reading section. The following comparison chart, adapted from several sources, is from the Michigan Center for Rural Health's web site.^{viii}

| RHC and FQHC Program Comparison | | |
|--|---|---|
| | RHC | FQHC |
| Location | Non-urban MUA or HPSA | MUA or MUP |
| Organizational Type | For profit, nonprofit, or public entity | Nonprofit or public entity |
| Governance Requirement | None | Majority user board of directors |
| Services Provided | Basic Primary Care | Comprehensive primary care, mental, and dental health |
| Other services required | Basic lab | Pharmacy, lab, enabling services |
| Mid-level provider required | Yes, 50% | No |
| Enhancement Medicaid/Medicare reimbursements | Yes | Yes |
| Federal funds to offset uninsured costs | No | Yes |
| Application Process | Certification any time | Competitive grant cycles |
| Access to free medical malpractice coverage (FTCA) | No | Yes |

Learning more about FQHCs could help SORH staff develop more knowledge about primary care assistance for rural communities. An orientation or learning session could be scheduled with the State PCO, State Primary Care Association or by contacting NOSORH.

This module is intended to serve as a brief introduction/overview of RHCs and primary care. For more information, please review the background reading materials found on page 1 or visit the Web site suggested throughout the module.

ⁱ Academy Health, www.academyhealth.org/publications/glossary.pdf, revised January 2004, page 26.

ⁱⁱ Wikipedia, Primary Care, http://en.wikipedia.org/wiki/Primary_care, accessed April 2010

ⁱⁱⁱ Institute of Medicine. Committee on the Future of Primary Care, Division of Health Care Services, 1996

^{iv} Institute of Medicine. Committee on the Future of Primary Care, Division of Health Care Services, 1996.

^v Starting a Rural Health Clinic – A How- to Manual, 2004, Office of Rural Health Policy, page i.

^{vi} HRSA, Shortage Designation: MUA & MUP, accessed February 2010, <http://bhpr.hrsa.gov/shortage/>

^{vii} HRSA, HPSA designations web page, accessed March 10, 2010. Centers for Medicare and Medicaid Services provide information on the physician bonus. [Centers for Medicare and Medicaid Services PSA/HPSA Physician Bonuses](#)

^{viii} Michigan Center for Rural Health, <http://www.mcrh.msu.edu/>, RHC, accessed February 2010.

A Comparison of Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)

RHCs

FQHCs

Primary Care & Preventative Services

All RHCs must provide:

- Basic outpatient primary care
- Emergency care for life-threatening conditions, regardless of cost
- Basic lab services

All RHCs must have:

- Written guidelines and protocols for medical management
- Annual evaluation and planning process
- Multiple written policies and procedures, such as referral and tracking of patients, risk management, and patient grievances
- A Quality Improvement/Assurance Plan

In addition to the RHC requirements, FQHCs must provide, directly or by formal arrangement, more comprehensive services, including:

- Diagnostic lab & radiology services;
- Pharmaceutical services;
- Behavioral & oral healthcare services;
- Hospital & specialty care arrangements;
- After-hours care;
- Case management;
- Transportation; and
- Interpretive services

Population Served

- RHCs serve a significant proportion of Medicare patients due to the aging population in rural communities

- In 2007, the largest proportion of FQHC patients were uninsured

HPSA or MUA Designation

- Must be located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA); designations are assessed & updated every 3 years
- Must be located in a non-urbanized area

- Must be located in a community designated a MUA or MUP
- Receive automatic HPSA facility designations, but most also serve geographic or population HPSAs, which are updated every 3 years
- Located in urban or rural communities

Providers

- A non-physician provider (NP, PA, CNM) must be on-site at least 50% of the clinic's open hours
- A physician must be on-site once every two weeks to serve as medical director and review patient charts

- No requirement to employ non-physician providers; however, FQHCs employ physicians and non-physician providers along with clinical support staff

Status

- RHCs may be public, for-profit, or nonprofit and do not have a specific requirement for governance by a Board of Directors

- FQHCs must be nonprofit or public entities governed by a board composed of a majority of active, registered patients of the center

RHCs

FQHCs

Funding

- RHCs do not receive federal funding for start-up or to support the provision of patient care services
- Although RHCs care for Medicaid, CHP+ and the uninsured, they rely on sound business practices, with Medicare, Medicaid, private insurance, and minimal grant funding as their principle revenue sources
- RHCs must submit an annual cost report to CMS, which determines a clinic's per visit reimbursement rate each year

- FQHCs may receive federal funding for start-up and expansion; funding subsidizes some of the cost of serving the uninsured
- Must submit an annual audit, regular financial reports, and an in-depth annual report called the Uniform Data Set (UDS)
- Required to submit in-depth quarterly reports as part of receiving ARRA funds

Malpractice Insurance

- RHCs must provide their own malpractice insurance coverage, which results in a significant financial burden

- FQHCs are eligible for coverage under the Federal Tort Claims Act, which provides free coverage for most services

Cost for Services

- Most RHCs provide services to anyone and/or provide services on a sliding fee scale, though they are not required to

- FQHCs are required to serve all residents of their service area on a sliding fee scale based upon family size & income

Survey & Inspection

- RHCs are subject to on-site survey and inspection in order to maintain their RHC certification by CMS
- Some RHCs are licensed as Community Clinics, and surveyed to maintain this designation

- FQHCs are subject to a Federal Objective Review at least every five years
- All Colorado FQHCs are licensed as Community Clinics, and are surveyed by the state to maintain their designation

Reimbursement

- RHCs receive an all-inclusive, per visit Medicare reimbursement for outpatient primary care services provided
- Independent, free-standing RHCs are reimbursed by Medicare up to the federally-established cap of \$77.76 per visit in 2010; however, not all of them are reimbursed up to the cap
- There is no per visit Medicare reimbursement cap for provider-based RHCs affiliated with a hospital under 50 beds
- Medicaid reimburses all RHCs at a cost-based rate which varies between clinics

- FQHCs receive enhanced reimbursement from Medicare & Medicaid
- The Medicare Reimbursement Rate Cap for FQHCs in 2010 is \$125.72 for urban clinics and \$108.81 for rural clinics
- Medicaid rates are set for each individual FQHC and are reviewed annually