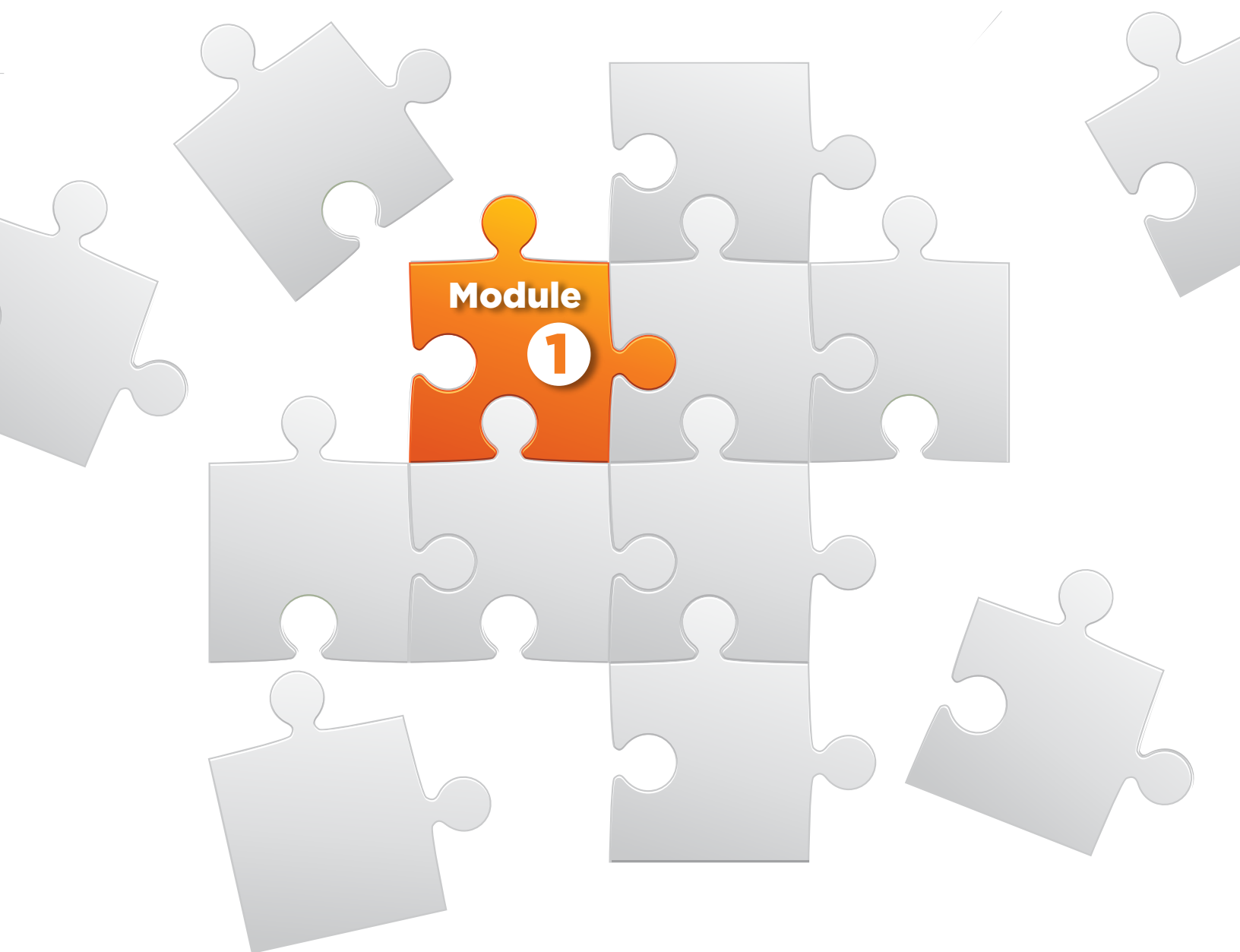




Module 1

An Introduction to the Rural Health Clinic Program

Rural Health Clinic Technical Assistance
Educational Series





MODULE 1

An Introduction to the Rural Health Clinic Program

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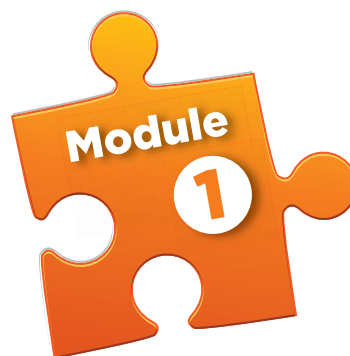
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MODULE 1

An Introduction to the Rural Health Clinic 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 these services for people living in rural communities.

Suggested Resource Materials and Background Reading:

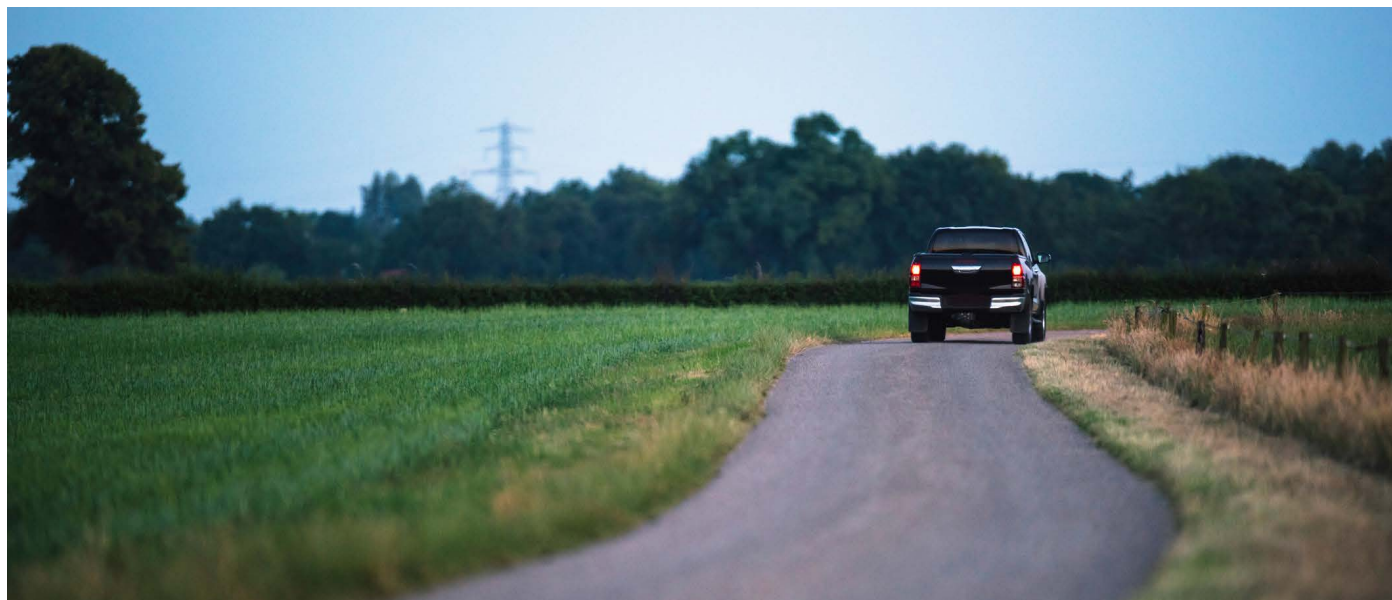
[CMS RHC Fact Sheet \(January 2018\)](#)

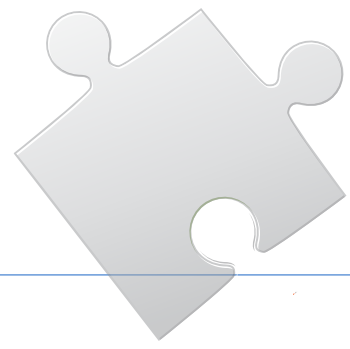
[CMS FQHC Fact Sheet \(January 2018\)](#)

[HRSA Health Center Program \(CHC\) — Chapter 1: Health Center Program Eligibility](#)

Health Resources Services Administration's [HPSA Find](#) and [MUA Find](#) sites

Rural Health Information Hub (RHI – Hub)
[Am I Rural?](#)





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

The Institute of Medicine, now the National Academy of Medicine, has defined [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.”ⁱⁱ

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

The American Academy of Family Physicians (AAFP) has a much more focused group of five (5) definitions ([found here](#)) to adequately define Primary Care services and the providers that provide these services. AAFP’s website states:

Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the “undifferentiated” patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).



Primary care is performed and managed by a personal physician often collaborating with other health professionals and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.”^{iv}

Because primary care is essential and because rural people need access to primary care throughout the life cycle, many State Offices of Rural Health (SORHs) consider work to ensure 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 challenges early when treatment is less costly. Over the past four decades, state and federal governments have advanced policies and programs designed to ensure beneficiaries of Medicare and Medicaid 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 Medicare and Medicaid 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 and do not have enough income to pay for needed primary care. This combination of low private insurance, low overall income and heavy reliance on Medicare and Medicaid as payment sources make it difficult for some rural primary care practices to be sustainable.

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

Medicare and Medicaid 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 cost of care provided. The Rural Health Clinic (RHC) program is one approach taken by Congress and CMS to support access to primary care for rural people.

RHC History:

For many years, primary care practices located in rural communities and serving a large portion of Medicare and Medicaid beneficiaries have struggled to be financially competitive or profitable health care businesses. Most primary care is provided in private practices. Congress and federal government agencies 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 to 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 assistant (PA) and nurse practitioner (NP) 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 NPs and PAs, third-party reimbursement was dependent upon working under the direct supervision of a physician. This lack of third-party reimbursement from public payers along with the shortage of physicians was considered a substantial disincentive for NPs and PAs 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 underserved rural communities. Since NPs and PAs were required and central to the RHC program, these providers gained greater support and utility helping ensure 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, NPs and PAs. Congress later added certified nurse midwives (CNMs) 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 and vets deeming entities to review and recommend designation of private or non-profit clinics meeting conditions for participation and certification as RHCs. Certified RHCs are primary care practices that 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 are Medicare and Medicaid beneficiaries.

RHC Certification Benefits:

The law authorizes special Medicare and Medicaid reimbursement for certified RHCs. That means that certified primary care practices can generally receive higher reimbursement than traditional primary care practices in rural communities. This increased reimbursement is an incentive for becoming a Rural Health Clinic. This reimbursement is an All-Inclusive Rate (AIR) that bundles all RHC services into one reimbursement amount.

Medicare uses an annual modified cost-based method for determining this reimbursement amount per visit for Medicare beneficiaries.

Difference Between Independent & Provider Based RHCs:

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

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

Basic Qualifications for and Types of RHC Certification

Rural Health Clinic regulations can be found at 42 CFR Parts 405 and 491.

Visit [Appendix G – Guidance for Surveyors](#) and visit [Ch. 13 of Medicare Benefit Policy Manual](#) for additional information.

RHCs must meet basic geographic, provider type and primary care requirements to be certified by CMS, including but not limited to:

■ Clinic or practice must provide primary care that includes:

- Commonly furnished outpatient diagnostic and therapeutic primary care services
- 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)

■ RHC Provider staff requirements include:

- At least one employed NP, PA or CNM 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). Physician on-site requirements per state regulations

Physician responsibilities.

The [physician](#) performs the following:

1. provides medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff.
2. In conjunction with the [physician assistant](#) and/or [nurse practitioner](#) member(s), participates in developing, executing, and periodically reviewing the clinic's or center's written policies and the services provided to Federal program patients.
3. Periodically reviews the clinic's [patient](#) records, provides medical orders, and provides medical care services to the [patients](#) of the clinic or center.

■ 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)
- 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" webpage at <https://bhwh.hrsa.gov/shortage-designation>. State Primary Care Offices (PCOs) 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 Health Information Hub provides a useful tool for learning about rural definitions and determining whether a specific address meets the definition of rural for the CMS Rural Health Clinic Program. Visit the RHHub website at <https://www.ruralhealthinfo.org/> and click on the "Am I Rural?" link to learn more. Additional information on location requirements for RHCs may also be found on the [RHHub website](#).

Reimbursement:

RHCs receive enhanced reimbursement for care provided to Medicare and Medicaid 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 called an All-Inclusive-Rate or AIR. As of January 1, 2019, reimbursement for Medicare is capped at \$84.70 per provider face-to-face encounter ([CMS MLM Rate Notification](#)). There is no per visit reimbursement cap for provider-based RHCs affiliated with a hospital under 50 beds but is based on cost (i.e., the \$84.70 cap does not apply to these specific RHC types).

For *Medicaid*, states are mandated to reimburse RHCs using a Prospective Payment System (PPS). 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

Primary care providers not part of certified RHCs are generally paid on a fee for service (FFS) basis and/or through managed care fees negotiated with individual plans. Primary care practices not enrolled in the RHC program are paid based on specific



services provided to each beneficiary not per visit. This is an essential difference. Payments for primary care provided to Medicaid beneficiaries by non-RHC providers vary by state and are generally paid using a state Medicaid established fee schedule or negotiated managed care rates.

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

Resources to Assist with Primary Care in Rural Areas

States, local municipalities and providers are uniquely challenged in ensuring access to primary care in rural, underserved communities. Since primary care is essential, state and federal governments, health organizations and economic development groups recognize the importance of ensuring access to primary care. 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 tirelessly to resolve. Ensuring 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 tend to be older, sicker, and poorer than urban communities.

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 same 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 these areas that are designated as Health Professional Shortage Areas (HPSAs).

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. 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} See the section on shortage area designations for further information.

Resources, programs and tools to assist rural communities vary among the states. Some resources are available through the State Office of Rural Health (SORH), the Primary Care Office (PCO), or Area Health Education Centers (AHEC) programs. Depending on the state, services to support primary care cover a range of technical assistance (TA) offerings or consultations to communities or providers, including assistance with recruiting and retaining primary care providers, helping communities *grow their own* health providers, or assisting communities or practices in application for RHC designation or Community Health Center (CHC) and/or Federally Qualified Health Center (FQHC) designation.

States vary in the type and amount of TA provided to rural communities and primary care providers. HRSA, the federal agency providing direct state grants for support and technical assistance, has not designated a *single* state office to specifically provide technical assistance, support or resources to assist RHCs. However, the National Association of Rural Health Clinics (NARHC) provides TA webinars and a membership listserv. Also, State Offices of Rural Health (SORH) are charged with three core mandates one of which is to provide technical assistance to rural health providers. Providing RHC consultation, TA and support; therefore, fit within these core SORH mandates.



Shortage Area Designations

A primary care HPSA designation is often a gateway to other primary care resources. HPSAs are used to determine eligibility for various federal and state programs. Every state in the country has a PCO located in the state department of health. 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 <https://bhw.hrsa.gov/shortage-designation>. To determine if specific addresses or areas are designated check <http://muafind.hrsa.gov/>.

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 HPSAs. HPSA designations are updated every three years.

Another program useful in supporting rural primary care is the [Medicare 10% bonus payment](#).^{vi} 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. CMS provides specific information about what practices are eligible for this payment and how payment is made.

CLARIFICATION NOTE: *RHCs are not eligible for this bonus as services are paid under a different system than other physicians and clinicians.*

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 education loans are repaid. The NHSC, a major federal workforce support program, uses HPSA designations to target placement of physicians, NPs, PAs, CNMs, dentists and select mental health providers in the most underserved communities in the nation. RHCs may become a NHSC approved site. SORHs might explore this benefit for RHCs with the State PCO.

Often the State PCO and the SORH work together closely and are often co-located within the same organizational unit. More information about designations, NHSC, loan repayment and PCOs is available through HRSA, Bureau of Health Professions, Shortage Designation Branch or the NHSC. A list of PCOs by state is located at <https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices>.

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) and Rural Health Clinics (RHCs) both provide essential health services in underserved areas and are important contributors to rural communities. Both offer services that are typically provided in outpatient clinics, and both are certified to receive reimbursement from the Centers for Medicare & Medicaid Services (CMS). RHCs and FQHCs are often thought to be interchangeable. However, they are distinct provider types with unique certification requirements and payment policies.

As previously mentioned, RHCs are certified by CMS, so they can receive Medicare and Medicaid reimbursement, and they required to use PAs and NPs to qualify for the designation.

FQHCs are also certified by CMS to receive Medicare and Medicaid payment; however, they must first apply to the HRSA Health Center program. Many in the rural health environment use the terms Community Health Center (CHC) and Federally Qualified Health Center (FQHC) interchangeably, but there is a technical difference between the two. The Health Center Program was authorized in 1975 under Section 330 of the Public Health Service (PHS) Act, and the Omnibus Budget Reconciliation Act of 1990 created the Federally Qualified Health Center (FQHC) provider type to allow Health Center Program entities to receive Medicare and Medicaid reimbursement. HRSA determines the requirements for Health Center Program grantees and look-alikes based on statute and approves organizations for participation. CMS then approves FQHC certification.

Organizations eligible to FQHCs include: the [CMS FQHC fact sheet](#):

- HRSA Health Center Program grantees who receive grant funding.
- HRSA Health Center Program look-alikes (LAL) that meet the requirements of the Health Center Program but do not receive grant funding.
- Tribal entities that operate as an outpatient health program or facility of a tribe or tribal organization

under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991. Tribal entities apply directly to CMS for certification.

Health center grantees and look-alikes are public or not-for profit organizations, and they may be located in urban or rural areas. The type of primary care practitioners varies based on the needs of the population. Health center grantees and look-alikes are governed by a not-for-profit board of directors which must meet federal specifications, though some may be public organizations. As required by the Health Center program, they must charge patients a sliding fee scale and reduced fees are required to ensure health care services are provided regardless of patient income, insurance status, or ability to pay.

Health Center Program grantees and look-alikes that have received FQHC certification from CMS are paid using a Prospective Payment System (PPS) for services provided to Medicare and Medicaid beneficiaries.

For information regarding the HRSA Health Center Program [click here](#) for the link to the program Compliance Manual.

For information regarding the CMS Federally Qualified Health Program [click here](#) for the link to the Federally Qualified Health Centers (FQHC) Center.

The following comparison chart identifies similarities and differences of several provider types, is adapted from several sources.

RHC and FQHC Covered Services

Service Type	RHC		FQHC	
	Medicare	Medicaid	Medicare	Medicaid
Preventive Services				
Preventive Services	Specified Medicare-Covered Preventive Services Only	If covered in State Plan	✓	If covered in State Plan
Core Services				
Physician Services	✓	✓	✓	✓
Nurse Practitioner, Physician Assistant, and Certified Nurse Midwife Services	✓	✓	✓	✓
Clinical Psychologist Services	✓	✓	✓	✓
Clinical Social Worker Services	✓	✓	✓	✓
Services and Supplies “Incident to” Covered Services	✓	✓	✓	✓
Nurse Home Health Services (in designated areas)	✓	✓	✓	✓
Other Services				
Hospital Care	✗	If covered in State Plan	✗	If covered in State Plan
RHC or FQHC Services Provided in Skilled Nursing Facility	✓	If covered in State Plan	✓	If covered in State Plan
Other Ambulatory Services Included in the State Medicaid Plan	✗	If covered in State Plan	✗	✗
Diabetes Self-Management Training Services and Medical Nutrition Therapy Services	✓	If covered in State Plan	✓	If covered in State Plan
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	✗	✓	✗	✓
Chronic Care Management (CCM)	✓	✗	✓	✗
Transitional Care Management (TCM)	✓	✗	✓	✗

Learning more about the Rural Health Clinic Program, the Health Center Program and Federally Qualified Health Centers 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 (PCA), 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 sites suggested throughout the module.

Endnotes

- ⁱ Academy Health, www.academyhealth.org/publications/glossary.pdf, revised January 2004, page 26
- ⁱⁱ Institute of Medicine. <https://www.ncbi.nlm.nih.gov/books/NBK232631/>.
- ⁱⁱⁱ Institute of Medicine. Committee on the Future of Primary Care, Division of Health Care Services, 1996.
- ^{iv} American Academy of Family Physicians (AAFP) — Definitions of Primary Care and related services — <https://www.aafp.org/about/policies/all/primary-care.html>
- ^v *Starting a Rural Health Clinic — A How-to Manual*, 2004, Office of Rural Health Policy, page i.
- ^{vi} HRSA, HPSA designations web page, accessed February 2019. Centers for Medicare and Medicaid Services provide information on the physician bonus. [Centers for Medicare and Medicaid Services PSA/HPSA Physician Bonuses](#)

