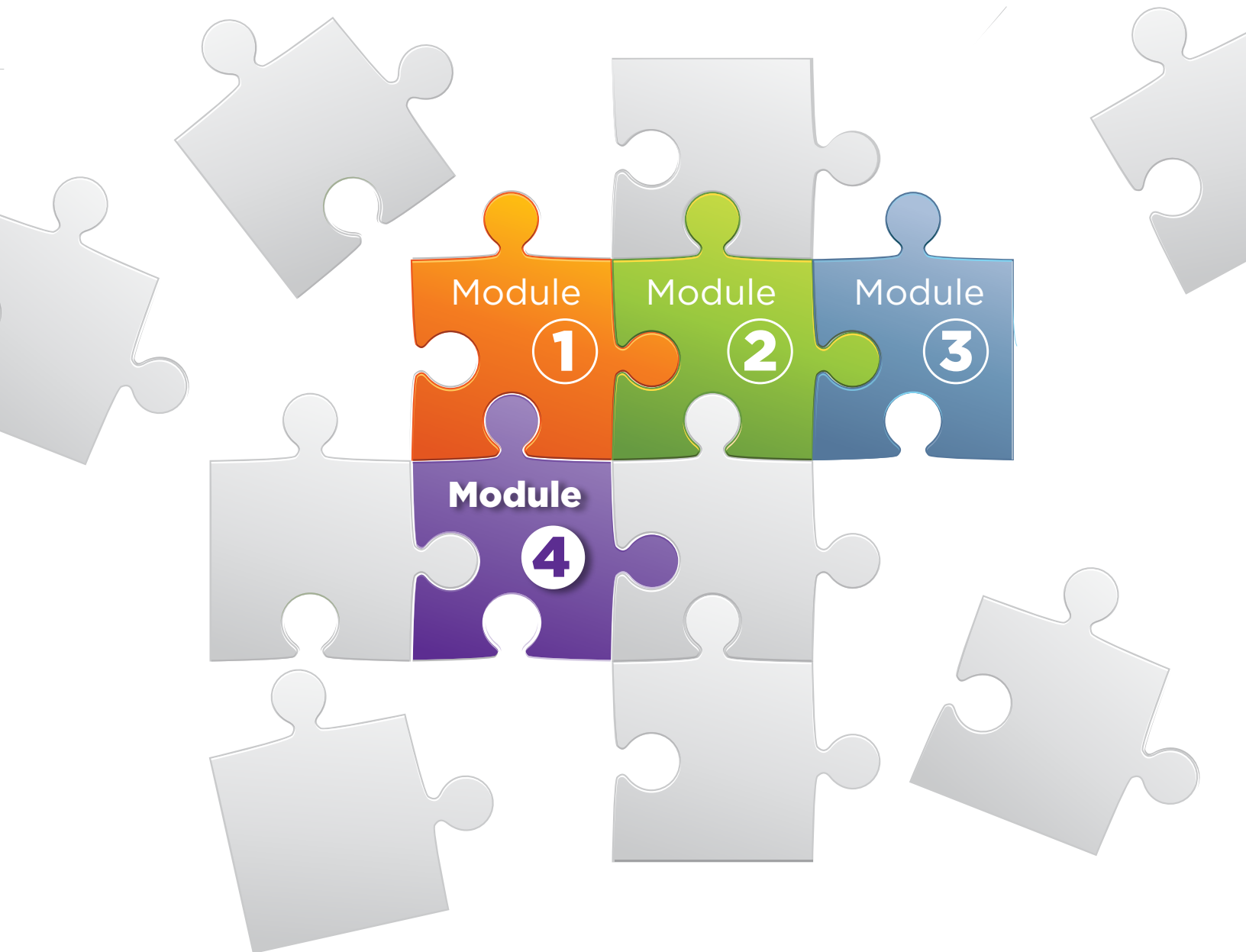




Module 4

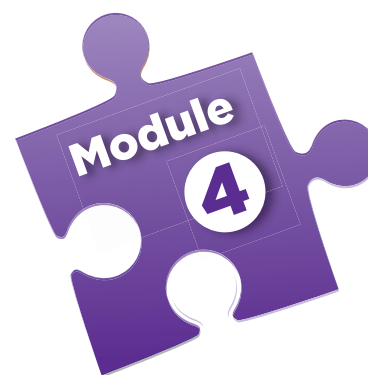
**Helping RHCs Work
Effectively with Other
Key Rural Health Providers**

**Rural Health Clinic Technical Assistance
Educational Series**



MODULE 4

Helping RHCs Work Effectively with Other Key Rural Health Providers



Target Audience and Objectives

This module is designed for State Office of Rural Health (SORH) staff with some experience working with Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), health professional shortage area (HPSA) designations, the National Health Service Corps (NHSC), the Critical Access Hospital (CAH) program, pharmacy programs, rural and referral hospitals, Emergency Medical Systems (EMS), and other rural health providers.

1. Review how RHCs can work effectively with other rural health providers.
2. Review how SORH staff can introduce RHCs to other rural safety-net providers by outlining RHC benefits and unique aspects of these primary care providers.
3. Help SORHs develop a strategy to facilitate optimizing RHC involvement with other rural safety-net providers in rural communities.
4. Help SORHs build on their own expertise and develop a greater understanding of available resources by connecting to RHC resources that benefit rural communities and other rural safety-net providers.

RHCs and CAHs

RHCs and CAHs are natural partners. Both are in rural communities; both serve rural, underserved and uninsured populations; both receive special payment provisions from the Centers for Medicare and Medicaid Services (CMS) for care provided Medicare beneficiaries and from states for Medicaid beneficiaries.

The Federal Office of Rural Health Policy (FORHP) provides direct technical assistance support and other resources to CAHs via the Medicare Rural Hospital Flexibility Program (Flex). FORHP provides indirect technical assistance to RHCs through funds provided to the National Association of Rural Health Clinics (NARHC) for conference calls and a listserv as well as availability of some financial support through the Flex Program. FORHP also provides funds to the National Organization of State Offices of Rural Health (NOSORH) for the development of the RHC TA Project learning modules — including this module, which is designed to help SORH increase the technical assistance they provide to RHCs and the communities they serve. Each SORH selects the types and levels of technical assistance offered in their state. SORH also provide support to CAHs, and many of them provide support to RHCs.

RHCs and CAHs work closely in some rural communities; in fact, in some instances, CAHs own RHCs in their communities. Some CAHs are developing RHCs as provider-based RHCs, while others are deciding not to manage RHCs as provider-based RHCs if it no longer makes business sense. In those instances where the latter is true, CAHs are either helping the RHCs transition to independent status or closing the practice.

Specific financial and community situations and other legitimate differences influence a CAHs' decision to own provider-based RHCs or support them as independent RHCs. Therefore, it is beneficial for SORHs to consider why, when, and how these issues arose if asked to offer support to CAHs and RHCs. There may be financial imperatives driving decisions, for example, or other community primary care practice issues involved. For the most part, CAHs are — and must be — engaged in supporting primary care



practices in their community; how that assistance is structured, however, varies by community, over time, and also as leadership changes.

To help gain some perspective on such a fluid situation, a former FORHP coordinator for the Medicare Flexibility Program asked several consultants with whom he worked why and when CAHs own RHCs and operate them as provider-based RHCs and when they do not. He provided the following insights.

According to one expert's opinion regarding the question why CAHs support RHCs and own RHCs the following was provided:

“CAHs generally get into RHCs in order to stabilize or grow their community’s medical staff (or to protect market share) and not because they think they can profit on the RHC itself. For the most part, and to the extent the RHC can meet productivity targets and recruit a mid-level provider, RHCs are often the best option for reducing the losses associated with a maintaining a primary care medical staff.”¹

Another CAH expert responded as follows:

“In comparison to CAHs that did not operate a RHC, we found that CAHs that operated a RHC had:

- *a lower median cash flow margin; lower patient deductions;*
- *a higher proportion of Medicare/total patient days; lower Medicare outpatient charges/total charges; higher salaries/total expenses; and*
- *lower average daily census for acute patients.*

So it is a mixed bag, slightly tending towards a negative impact.”²

A third expert said CAHs owning provider-based RHCs is conditional on a variety of factors, described as follows:

“It all depends; payer mix and practice productivity are key to answering this question along with how Medicaid handles CAH reimbursement and how Medicaid pays RHCs. I would say that, from a Medicare-only point of view, there is often very little difference between CAH Medicare split billing payments using the Method II option and provider-based RHC reimbursement. When you factor in the shift in overhead, there could be a balance in favor of CAH reimbursement vs. PB RHC.”³

CAH Ownership Scenarios: A CAH administrator recently said he was buying three primary care practices to protect the hospital's market share, adding that a larger regional hospital would buy them if his hospital did not. This administrator questioned if it would be more advantageous to the hospital's bottom line to set up provider-based RHCs or independent RHCs. He hired consultants to run the numbers and advise him on which to pursue.

In another situation, a provider-based RHC contacted the Georgia Rural Health Association in early January 2011 to ask for help. The CAH administrator told the RHC nurse practitioner (who also serves as the practice administrator and leader) that they would be “spun off” as an independent RHC within two weeks — a decision based on advice from the hospital's auditors. RHC staff were concerned that it was not possible to have the split occur that quickly. A more realistic spin-off timeline was arranged, but the CAH did not change its position to maintain the RHC as provider-based.

In a third scenario, a CAH administrator announced during a mid-May RHC workshop in Georgia that the hospital is building two new provider-based RHCs. The sites have been approved and the plan is for the clinics to open in September 2011.



The hospitals in the Georgia examples are located within 100 miles of each other. The difference in how these separate situations were resolved is most likely the result of the existing clinical communities and reaction to advice received from their accountants, consultants, and advisors.

It is important for SORH staff to be aware that varying community and clinical situations lead to different advice and outcomes. It is not always true that it makes good, savvy business sense for CAHs to own provider-based RHCs. What is true, however, is that CAHs need to have strong relationships with primary care providers and support primary care access for Medicare, Medicaid, insured and uninsured people living in the communities they serve. CAH clinical and administrative leaders must have relationships with primary care providers who will refer patients and clients to their hospital; use the CAH for care that can be appropriately managed in the hospital; and use the CAH for laboratory and other clinical services needed by patients.

A December 2010 report by Stroudwater Associates titled *Clinic Considerations For: Provider Based (PB) Clinics; Rural Health Clinics (RHC), Federally Qualified Health Clinics (FQHC)* outlines the fiscal, governance and eligibility issues that rural hospitals and other rural providers should consider when trying to determine what types of primary care practices communities and providers should choose.

The report also provides an overview of the intricacies, considerations and options of various types of rural primary care practices. It might be a helpful resource to SORH staff interested in learning more about the decisions that CAHs and other rural hospitals make when considering the primary care providers they will support.

It is important for the CAH and the RHCs in a particular service area to understand each other's

clinical capacity, recognize that both receive assistance from SORHs and the FORHP, and remember both serve Medicaid and Medicare beneficiaries and other medically underserved populations. CAHs and RHCs should work together on important issues such as creating compatible electronic health records, utilizing health information technology to transfer information, working together to recruit and retain primary care providers and other key personnel, improving the quality of care, preventing hospital re-admissions, and performing other work that improve healthcare quality and build the infrastructure in the rural community in which they work.

RHCs have specific emergency care responsibilities important for the CAH to understand (see page 10), as well as unique staffing requirements.

SORHs are in a pivotal position to ensure that gaps are identified and bridged between RHCs and CAHs. If there are gaps in understanding

what each provider contributes, SORHs could bring RHCs and CAHs together to discuss partnership opportunities and help ensure there is a strong relationship between these important safety net providers. Both CAHs and RHCs are assets in ensuring access to high-quality health services for rural people.

SORH can help facilitate RHCs and CAHs “by being at the table” together representing rural communities, other rural providers and rural Medicare and Medicaid beneficiaries when resources or plans are being made. All SORHs are concerned to some extent with the quality improvement work taking place in CAHs in their respective states. RHC providers often admit patients to a CAH and continue to provide care for the patient upon discharge. RHC providers might be a part of quality initiatives directed by the CAH or small rural hospital, but some RHC providers are not involved. SORH staff could decide whether it is an important priority for rural health to ensure RHCs are

Both CAHs and RHCs are assets in ensuring access to high-quality health services for rural people.



included in quality improvement projects, programs to reduce hospital re-admissions, plans to develop products for Accountable Care Organizations and other quality initiatives.

Ensuring RHC involvement in quality improvement activities will be enhanced by having SORH staff continuously asking how RHCs are included, and by continuing to have them question/remind the state Flex coordinator to think of RHCs as key primary care providers. SORH should not assume provider-based or independent RHCs are at the “quality table”; it will be helpful for the SORH to continue urging inclusion and continue inviting RHCs to participate in quality improvement work.

RHCs and Small Rural Hospitals

Small rural hospitals not certified CAHs also work closely with and can own RHCs. Many of the previous comments apply to the working relationships between other rural hospitals and RHCs.

RHCs and Federally Qualified Health Centers (FQHCs)

Both RHCs and FQHCs are primary care providers; they are also safety net providers with special payment provisions available through CMS. RHCs and FQHCs share a lot of similarities, but they have significant differences as well (as outlined in the following chart). For example, while both receive special payment provisions through CMS, the way those payments are calculated, and the amount paid

varies. RHC and FQHC payment methodologies and payment nuances are beyond the scope of this document; however, the following information from the Colorado Rural Health Center might be useful.

Comparison of Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs) Reimbursement	
RHCs	FQHCs
The Medicare upper payment limit for independent RHCs is \$113.00 per visit per visit in 2022.⁴	The Medicare PPS rate per visit for FQHCs is \$180.16 for 2022. This rate is updated annually by the FQHC market basket.⁵

(Note: Rural primary care sites can also apply to be designated as an FQHC Look-Alike by the U.S. Health Resources and Services Administration (HRSA). FQHC Look-Alike providers are not discussed in this document. For more information, please visit the HRSA Bureau of Primary Care website at <https://bphc.hrsa.gov/programopportunities/lookalike/index.html>.

RHCs and FQHCs can be in the same community; in the same county or parish; and/or within the same Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA). RHCs and FQHCs sometimes have good working relationships, however these primary care providers all too often have either a strained relationship or no working relationship whatsoever.

It is helpful for SORHs to understand some of these nuances — especially if they also serve as their state’s respective Primary Care Office. In that role, SORHs work with a full range of rural primary care providers — from private practices to practices operating in HPSAs eligible for the 10% Medicare Geographic HPSA bonus, to practices certified as RHCs, to RHCs using a sliding fee scales (SFS) and using NHSC loan repayment resources or scholars, to FQHCs receiving a federal operational subsidy for providing primary care to the uninsured.

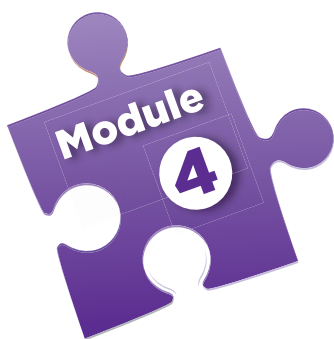


Figure 1: Rural Primary Care Practices

Continuum of State and Federal Resource Intervention					
practice accepts cash and private insurance only	practice accepts all insured patients, including Medicaid and Medicare	practice located in rural geographic primary care HPSA – receives 10% bonus for Medicare beneficiaries	practice certified as independent or provider-based RHC, no SFS – receives enhanced reimbursement	practice certified as independent or provider-based RHC, uses SFS – receives enhanced reimbursement and NHSC resources	FQHC – receives HRSA operational grant subsidy; enhanced reimbursement and other HRSA benefits

SORHs should be aware of the continuum of primary care available in rural communities and how each type serves rural people. As noted in Figure 1 (above), primary care providers that only accept private payers/private insurers are the only ones that do not benefit from state or federal government investments in primary care. As the table moves to the right, the federal and state investment increases. It is helpful to understand how the state and the federal government invests in primary care and how these investments help retain primary care providers to serve rural people; in so doing, SORH staff can help bridge gaps and strengthen the technical assistance provided.

Primary care is an essential part of the rural safety net; it is the platform upon which all other parts of the healthcare system are built. Therefore, community-based primary care must be strong; it should help ensure access and improve the quality of care for rural people.

Because RHCs and FQHCs can be located in the same geographic community, there is opportunity for friction and misunderstanding. However, there are also outstanding opportunities to develop a working relationship. As mentioned above and in some of the suggested reading documents, FQHCs receive a direct federal grant to provide care to clients that do not have health insurance. They also receive other benefits, such as malpractice protection, direct technical assistance, access to discount pharmacy pricing through the 340B drug pricing program, support for retention and recruitment of primary care providers, and support for building the practice

itself and start-up support (visit the [HRSA Bureau of Primary Health Care website](#) to learn more).

Although RHCs are also significant assets, for many rural communities, especially those in which a high percentage of the population is poor and uninsured/underinsured, an FQHC could be the primary care practice that provides the essential support that community requires. Generally, if there is a heavy concentration of uninsured and underinsured people, an RHC would not be able to provide the same level and amount of primary care since it does not receive federal operational subsidies. The FQHC by design is required to see all patients regardless of ability to pay and is required to use a sliding fee scale (discussed in Module 3) to ensure a patient’s inability to pay does not create a barrier to care.

Even though some RHCs are not able to provide access to care to all people regardless of ability to pay, many do. Although RHCs are not required to publish and use a sliding fee scale (SFS), many use one anyway and charge patients for care based on income. RHCs that do use a SFS can apply for retention and recruitment assistance through the NHSC.

For RHCs and FQHCs to be successful, both must have a good balance between private-pay patients and Medicaid and Medicare beneficiaries. When a new provider moves into a market or community, there is often concern that existing practices will lose paying patients. Because RHCs benefit mostly from enhanced Medicaid and Medicare reimbursements,

RHCs should be concerned that a new FQHC in the community will damage the business of the practices already there — a concern often shared by other private primary care providers as well. The concern is generally that the other practices will lose Medicaid and Medicare patients to the new FQHC practice.

How often this happens is unclear, however.

The evidence of the amount of work RHCs perform as safety net providers in rural America and the amount of care provided to rural Medicaid and Medicare beneficiaries is clear and impressive.

SORHs can help work through concerns between RHCs and FQHCs. Several are already doing that, including the Iowa Office of Rural Health. The Iowa ORH has created the Iowa Collaborative Safety Net Provider Network, an approach that supports and promotes RHCs and FQHCs working and learning together. The network provides a forum for safety net health care providers from across the state to identify common unmet needs that can be addressed cooperatively. Network participants include Community Health Centers, Free Clinics, RHCs, Family Planning Agencies, Maternal and Child Health Centers, Local Boards of Health, and other safety net providers.”⁶ The Network is administered by the Iowa Primary Care Association and funded by the Iowa legislature.

The director of the Iowa ORH lists the following benefits of RHCs participating in the network:

- Brings RHCs together for networking opportunities;
- Helps RHCs participate in a regional and state initiative;
- Helps RHCs understand the value of data collection;
- Educates RHCs about funding, grant and training opportunities;

- Builds RHC leaders and promotes leadership; and
- Helps RHCs feel included in the world of “safety-net” providers.

Iowa ORH staff work on strengthening partnerships between RHCs and FQHCs, thereby making the safety net stronger for rural Iowans.

The North Carolina Office of Rural Health (NC ORH) also has a long history of working with FQHCs, RHCs and other primary care providers to improve quality and help clinics improve their practice management efficiencies and resolve clinical/management issues. The NC ORH continues to improve the rural health infrastructure by supporting collaborative FQHC and RHC efforts at the community level. Examples of these partnerships can be found in Gaston County, Henderson County and Saluda, where FQHCs work with RHCs interested in learning more about FQHC funding, support, regulations and requirements. In another North Carolina community where the RHC has been very

clear about wanting to remain independent as long as possible, the RHC is exploring scenarios with a local FQHC in case it would become necessary for the RHC to convert to an FQHC or other service model. A few North Carolina FQHCs have reached out to receptive RHCs to explore how they also could work together more effectively.

The North Carolina Community Health Center Association also extends invitations to RHCs and state-supported Rural Health Centers to participate in their annual meeting. The NC ORH has paid for RHCs to participate in that meeting as it is considered another strategy to promote collaboration and synergy.

For RHCs and FQHCs to be successful, both must have a good balance between private-pay patients and Medicaid and Medicare beneficiaries.



The Colorado Rural Health Center is another SORH assisting RHCs and FQHCs. CRHC is working directly with the Colorado Community Health Network (the state's primary care association) and ClinicNet (a group that supports safety net clinics) to create an environment where RHCs, FQHCs and other safety net clinics can collaborate more effectively. Working with these organizations, CRHC sponsors Safety-Net Clinic Week each year to promote RHCs, free health clinics and faith-based clinics as part of the overall primary care safety net in rural Colorado. According to the center's web site, Safety-Net Clinic Week "is devoted to educating the public and policy makers about often overlooked providers, community-funded safety net clinics and federally certified RHCs that care for uninsured and underinsured Coloradans."⁷

The idea is that through working together at the state level, these very crucial primary care providers can increase their effectiveness, deepen their understanding, and build awareness that will lead to more effective, collaborative and non-duplicative work in underserved communities. The next step in this strategy is for clinical and administrative providers (three from each group) to work together on finding opportunities for synergy and improvements. The state-level participants will help facilitate those exchanges and discussions. Competition and non-communication are costly and the hope is that through this effort, RHCs, FQHCs and free clinics will learn about each other, build bridges and offer a stronger safety-net for the many in Colorado who depend on access to the essential primary care services.

Colorado also encourages and supports RHCs' involvement in medical home initiatives, as well as participating in quality improvement activities.

SORHs are in a very good position to work within the state to help ensure primary care assets are recognized, deployed, and used most effectively. This important work will be done best when SORHs are clearly aware of what the issues are from all parties involved. States are major players and have a real reason to want to attract and retain resources needed to ensure their citizens benefit from the best care available. That is yet another reason why SORHs need

to be engaged with RHCs and help provide visibility and support to the RHCs in the state. Here are some other potential steps:

- Recognize and understand why there is concern on the part of some RHCs about FQHC expansion, and vice versa.
- Consider what Iowa, North Carolina and Colorado are doing to work with RHCs and FQHCs. Ask questions or ask for more information.
- Review the HRSA-supported conference call on November 23, 2010 (archived on the ORHP website) and re-read the HRSA, BPHC Program Assistance Letter (Document # 2011-02) titled Health Center Collaboration.
- Convene a meeting with the state Primary Care Office and the Primary Care Association to discuss the strategic direction of the state in developing and expanding FQHCs.
- Convene a discussion meeting with a few RHCs to gain insight or review the notes from the NRHA RHC Constituency Group meeting from January and May 2011 (if available for sharing).
- Participate in a NOSORH discussion session about engaging and assisting RHCs and FQHCs with managing primary care growth in rural communities in your state.

RHCs and Emergency Medical Systems (EMS)

As part of certification, RHCs must be able to provide emergency services. When an initial RHC site survey is conducted, the surveyor looks to see if the RHC meets many standards, one of which is the emergency standard:

"(3) Emergency: The clinic provides medical emergency procedures as a first response to common life-threatening injuries and acute illness, and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids."¹⁸

RHCs are required to perform a program evaluation biennially, reviewed annually to ensure they have the correct necessary medicines noted above; and that they, in fact, can treat and have policies and procedures in place and are prepared for emergencies. As with all medications in the clinic, the emergency supply should never contain expired medications. The emergency requirement to provide lifesaving treatment is not a specific requirement for other primary care practices.

In some rural and frontier communities, the primary care providers working in the RHC are also members of the EMS squad; as a result, they could be out of the clinic during emergency calls. RHC providers are often the only health providers in small, rural places — meaning they not only provide all the primary care, but also stabilize patients, prepare them for transport and, in some cases, serve on the transport team.

Because RHC providers have many roles in a community, it is important to at least consider them when EMS training is offered. Some SORHs assist RHCs with purchasing automated external defibrillators.

Often the EMS medical director is an RHC provider. SORHs could improve the rural health system of care and assist RHCs, as well as enhance coordination and collaboration, by considering RHCs as part of

the rural emergency medical system. Patient hand-off instructions are an area where there is major opportunity for improvement and several states work on this by using Flex resources.

So, when there is occasion to include RHCs in training, purchase of equipment or materials, or when considering especially Health Information Technology (HIT) or Electronic Health Records (EHRs), remembering that RHCs are part of the emergency medical system (as well as part of the primary care system) is a positive step. Helping and investing in RHCs could be considered a direct investment in enhancing rural community health and individual health.

Conclusion

Many SORHs are in an excellent position to help strengthen RHCs and build bridges between RHCs and other providers. This can be done in a variety of ways. SORHs can purposefully create opportunities to facilitate understanding, provide technical assistance and other support for RHCs. SORHs can clarify what RHCs are, what they contribute to primary care, and the important role of RHCs as safety net providers that ensure access to primary care for Medicare and Medicaid beneficiaries.

¹ E-mail from S. Hirsch to R. Salain regarding why CAHs support RHCs, March 2, 2011.

² Ibid.

³ Ibid

⁴ CMS MLN Booklet: Rural Health Clinic: MLN006398 December 2021.

⁵ Ibid. CMS Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2022 <https://www.cms.gov/files/document/r11057cp.pdf>

⁶ Iowa Collaborative Safety Net Provider Network, Network Newsletter, Issue 5, June 2010, page 1.

⁷ Colorado Rural Health Center, Safety Net Clinic Week, <http://www.coruralhealth.org>, accessed August 1, 2011.

⁸ Rural Health Clinic Survey Report, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Form CMS-30, (5/78), page 12.