REPORT BY THE U.S.

General Accounting Office

Rural Health Clinic Services Act Has Not Met Expectations

The act authorized Medicare and Medicaid reimbursement for the services of physician extenders in participating rural health clinics in medically underserved areas. The services provided under the act have been much lower than anticipated. GAO found that Medicare beneficiaries in the clinic service areas principally use local physicians, instead of the clinics, to provide their primary health care. Also, many clinics have declined to participate or have withdrawn from the program because the reimbursement rates under the Federal guidelines are perceived to be too low. Federal grant funds are a more significant source of clinic revenue than Medicare and Medicaid. Under legislation enacted in August 1981, these grant funds are to be included in block grants to be distributed by the States.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-207118

The Honorable Patrick J. Leahy
United States Senate

The Honorable Max S. Baucus
United States Senate

In accordance with your request, we reviewed the progress made by the Department of Health and Human Services (HHS) to implement the Rural Health Clinic Services Act, the extent to which Medicare beneficiaries use the clinics, and any obstacles preventing broader implementation of the act.

The act has not fulfilled congressional expectations. Medicare beneficiaries in the clinics' service areas principally use local physicians instead of the clinics to provide their primary health care. Also, many clinics have chosen not to participate under the act or have withdrawn because of reimbursement limitations and administrative requirements. Likewise, the act has not significantly increased clinic financial stability and many will continue to require other Federal assistance in order to survive.

The report contains recommendations to the Secretary of HHS. As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time, we will send copies to the Secretary of HHS; the Director, Office of Management and Budget; and other interested parties. Also, copies will be made available to others upon request.

Gregory J. Ahart
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE HONORABLE
PATRICK J. LEAHY AND
MAX S. BAUCUS
UNITED STATES SENATE

RURAL HEALTH CLINICS SERVICES ACT HAS NOT MET EXPECTATIONS

D I G E S T

Public Law 95-210 (approved Dec. 13, 1977) amended titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. The purpose of the law, commonly referred to as the Rural Health Clinic Services Act, was to increase medical care to rural residents by improving health care access.

The act, for the first time, provided Medicare and, to a lesser extent, Medicaid reimbursement for the services of physician extenders (nurse practitioners and physician assistants) working in certified clinics located in rural, medically underserved areas. Previously, these services were generally reimbursable only when a licensed physician was present and such payments were made to the supervising doctor.

GAO was asked to determine the progress made by the Department of Health and Human Services (HHS) to implement the act, the extent to which beneficiaries use the clinics, and any obstacles preventing broader implementation. To respond, GAO examined the activities of 40 clinics in five States (Maine, North Carolina, South Dakota, Tennessee, and Vermont), but was able to obtain cost information from only 35 clinics. As of September 30, 1981, these five States contained 129 clinics (or 31 percent) of the 422 clinics nationwide.

Medicare reimbursement to rural health clinics was expected to be $71.7 million for 1980. Actual payments for that year, however, were $3.2 million. Likewise, Medicaid reimbursement for 1980 was expected to be $18.7 million but amounted to $2.1 million. (See p. 9.)

The act has not fulfilled expectations. Many clinics have chosen not to become certified or have relinquished their certification because of reimbursement limitations and administrative

requirements. Likewise, the act has not significantly increased clinic financial stability and many will continue to require Federal grant assistance in order to survive. Although the impact of the following factors varies among individual clinics, they represent the principal obstacles to broader implementation of the act.

--Few clinics attract the majority of Medicare beneficiaries in their service areas because the beneficiaries are choosing private physicians who are close by.

--Federal reimbursement guidelines prevent many certified clinics from fully recovering incurred and otherwise allowable costs.

--Federal administrative requirements are costly and time consuming and reduce further the financial benefits of participation.

--Certain States refuse to allow physician extenders to practice independently and thus nullify a principal objective of the act.

MEDICARE BENEFICIARIES USE OTHER PROVIDERS

Medicare beneficiaries living within clinic service areas generally went to private physicians for their primary health care. Of the 4,575 Medicare beneficiaries GAO sampled who resided in areas serviced by the clinics and who received primary health care during a 2-year period, 3,290 (or 72 percent) principally used physicians rather than the clinics. (See pp. 11 and 12.)

Although rural health clinics are located in areas designated as medically underserved, in most instances other providers are close by, which raises the question as to whether many clinics are needed. GAO found that 63 percent of the beneficiaries using other providers lived in locations which were less than 20 miles from where their provider practiced. Furthermore, 24 percent of these beneficiaries lived closer to private physicians than to the clinic.

For example:

--A North Carolina clinic with a Medicare beneficiary usage rate of 4 percent was located in a town 10 miles from a city having several private physicians and a hospital. GAO found that 45 percent of the Medicare beneficiaries in the clinic's service area went to doctors in this city, which was closer to their homes than the clinic.

Although most clinics reviewed were not used as the principal source of primary health care for Medicare beneficiaries in their service areas, GAO identified at least five clinics in South Dakota, Maine, Vermont, and North Carolina where from 50 to 75 percent of the Medicare beneficiaries receiving primary care during a 2-year period principally used the clinics for such care. Generally, those clinics were in isolated areas with no alternate providers nearby. (See pp. 14 and 15.)

MEDICARE AND MEDICAID REPRESENT A SMALL PERCENTAGE OF CLINIC REVENUE

Medicare and Medicaid revenues represented a relatively small percentage of total revenue for the clinics GAO reviewed (8 percent for Medicare and 6 percent for Medicaid). Besides low usage, there are other reasons why Medicare and Medicaid revenues are a minor source of funds:

--Productivity standards and administrative cost limits reduced revenues at practically all of the 35 clinics GAO reviewed, accounting for an average reduction of 26 percent in Medicare and Medicaid revenues.

--A $27.30 per encounter limit on reimbursement rates, accounting for an average reduction of 6 percent in Medicare revenues at the 35 clinics. (See pp. 16 and 17.)

Public Health Service grants and National Health Service Corps personnel represent a more significant contribution to clinic financial stability than do Medicare and Medicaid revenues. For example, for 27 of the clinics

GAO examined, they averaged about 53 percent of total revenue. (See pp. 18 and 19.)

RESTRICTIVE STATE LAWS IMPEDE CLINIC PARTICIPATION

States with restrictive laws governing the use of physician extenders have all but prevented their independent practice in a clinical setting. Four States--Delaware, Missouri, New Jersey, and North Dakota--prohibit physician extenders from providing primary health care. Another six States recognize nurse practitioners and/or physician assistants but require direct physician supervision. Although this does not prevent certification, it nullifies one of the act's principal purposes by prohibiting physician extenders from independent practice and, accordingly, from receiving Medicare reimbursement. (See pp. 29 and 30.)

HCFA SLOW TO ADDRESS PROBLEMS IMPEDING IMPLEMENTATION

Although the Health Care Financing Administration (HCFA) has established goals which address many of the obstacles preventing the act from fulfilling its expectations, HCFA has failed to meet them. There has been

--a lack of effort devoted to encouraging certain States to permit physician extenders to practice in accordance with the objectives of the act and

--a failure to implement a reimbursement system which covers the costs clinics incur for providing care to Medicare and Medicaid patients.

HCFA is currently developing a cost-based fee-for-service reimbursement system based on the ratio of clinic costs to charges. Under this system, HCFA plans to eliminate the administrative costs and productivity standards and replace the national reimbursement limitations with upper limits based on prevailing rates for general practitioners in each clinic service area. (See pp. 33 to 34.)

CONCLUSIONS AND RECOMMENDATIONS TO THE SECRETARY OF HHS

GAO believes that the act has the potential to bring health care to the poor and elderly living

in rural areas needing supplemental health facilities. However, since many clinics GAO visited were located near physicians or other providers, the implementation of the act in this setting will never fully meet its expectations.

Since HCFA has established goals which address some of the obstacles preventing broader implementation, GAO's recommendations concern the reimbursement system which is the principal reason most clinics relinquished their certification. GAO recommends that the Secretary require HCFA to:

--Eliminate the administrative expense limit, adopt more realistic and flexible productivity standards, and replace the current rate ceiling with the planned $32.10.

--Replace the existing system as soon as feasible with a prospective reimbursement system similar to the one currently being discussed, i.e., with rates based upon the ratio of cost to charges, and with rates limited to the prevailing rate for similar services performed by physicians within the same geographical area.

AGENCY COMMENTS

In the near future, HHS plans to publish regulations addressing the administrative expense limit, productivity standards, and the current rate ceiling. Regarding a prospective reimbursement system, HHS is preparing a notice of proposed rulemaking which it told GAO will be published shortly.

Tear Sheet

Contents

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
NHSC	National Health Service Corps
PHS	Public Health Service
RHI	Rural Health Initiative

CHAPTER 1

INTRODUCTION

On December 13, 1977, the Congress passed Public Law 95-210, the Rural Health Clinic Services Act, which amended titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. The act allowed certified clinics in rural areas designated as medically underserved 1/ to receive Medicare and Medicaid reimbursement for medical services performed by physician extenders (commonly referred to as nurse practitioners and physician assistants).

Rural America contains almost one-third of the country's population, but it is served by only 12 percent of the Nation's physicians and 18 percent of its nurses. On a per capita basis, rural areas have 58 percent fewer physicians and 29 percent fewer nurses. Yet residents of such areas suffer from a higher incidence of chronic disease and lose more workdays due to illness or incapacity than urban residents. In addition, a disproportionate share of the Nation's poor live in rural areas--about 40 percent of the total.

The Congress anticipated that the act, by allowing reimbursement for physician extender services, would expand health care access for Medicare and Medicaid recipients, increase the number of rural health clinics, and promote the financial stability of existing ones. The act also represented the first attempt to combine Medicare and Medicaid reimbursement under a single regulatory and rate setting structure.

Before the act, the services of about 3,100 physician extenders working in rural areas were reimbursed by Medicare only when their services were provided under the direct supervision of a physician. However, physician extenders often rendered services in clinics with no physician present and thus were not eligible for Medicare reimbursement. As of March 31, 1981, there were 413 rural health clinics certified for participation under the act of which two-thirds did not have a full-time physician. (See app. I for a list of the number of certified rural health clinics by State as of Sept. 1981.)

Regarding Medicaid, before the act each State had the option to reimburse physician extenders when they provided services independent of a physician. In 1977, however, only 27 States provided

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1/A medically underserved area is one designated by the Secretary of the Department of Health and Human Services (HHS) to have a shortage of personal health services or a shortage of primary health care personnel. Factors considered include primary care physician-to-population ratio, infant mortality rate, percentage of population over 65, and percentage of population below the poverty level.

reimbursement for such services under their State Medicaid plans. The act required States to include rural health clinic services in their State plans if State law or regulation authorized independent practice by physician extenders.

On March 18, 1980, the then Chairman, Rural Development Subcommittee, Senate Committee on Agriculture, Nutrition and Forestry, and a member of the Senate Committee on Finance requested us to review the progress made by HHS toward implementing the act. They also requested us to (1) determine the extent to which Medicare beneficiaries use rural health clinics, (2) identify obstacles limiting the act's success, and (3) assess the act's impact on clinic financial stability.

CERTIFIED RURAL HEALTH CLINIC CHARACTERISTICS

The term "rural health clinic" does not describe a specific type of facility providing health care. A clinic can be provider-based (i.e., part of a hospital, skilled nursing facility, or home health agency) or independent. Of the 413 certified clinics, as of March 31, 1981, 394 (or 95 percent) are independent facilities. Clinics can be privately or publicly owned and operated on a profit or not-for-profit basis. Clinics also vary in size, staffing, and services offered. For example, a clinic could be staffed by a nurse practitioner with an unpaid volunteer working as receptionist, clerk, and bookkeeper. Another clinic, however, may have many physicians, numerous nurse practitioners and physician assistants, and provide primary, secondary, and tertiary care for a wide geographic area. (See app. II for a definition of tertiary, secondary, and primary medical care.)

For a rural health clinic to be certified under Medicare and Medicaid it must:

--Be located in a rural area as defined by the Bureau of the Census which had been designated by the Secretary of HHS as medically underserved.

--Employ at least one nurse practitioner or physician assistant.

--Be under the general direction of a physician who must be present at least once every 2 weeks.

--Maintain medical records on all patients.

In addition, clinic staff must furnish diagnostic and therapeutic services and supplies commonly furnished in a physician's office, such as performing physical examinations, assessing health status, treating a variety of medical conditions, and providing basic laboratory services.

ADMINISTRATION OF THE ACT

The Health Care Financing Administration (HCFA) within HHS has primary responsibility for implementing the Rural Health Clinic Services Act because it administers and coordinates the Medicare and Medicaid programs. Within HCFA, four groups share responsibility for implementing the act: the Bureau of Program Operations coordinates the act's overall administration; the Bureau of Program Policy develops and implements reimbursement policy; the Health Standards and Quality Bureau develops, interprets, and implements policies for the certification for participation in the program; and the Office of Research, Demonstration and Statistics evaluates the act's impact. (A more detailed description of each group's duties and responsibilities is given in app. III.)

Designated State health agencies recommend clinic certification to HCFA. During the certification process, State officials review facilities, personnel credentials, staffing, governing policies, medical services, and referral arrangements.

Initially, HCFA contracted with five regional intermediaries to process Medicare rural health clinic claims. An intermediary is a national, State, or other public entity or private insurance company which has a contract with HCFA to pay Medicare claims for institutional providers, such as hospitals and nursing homes. As of March 1981, eight intermediaries processed claims from clinics. During fiscal years 1979 and 1980, the intermediaries paid benefits totaling about $1.7 million and $3.2 million, respectively. (App. IV lists the eight intermediaries and their service areas.)

For such noninstitutional providers as physicians and nonparticipating clinics, one carrier (usually an insurance company) processes claims for a geographic area, generally a single State. However, HCFA elected to use regional intermediaries to process rural health clinic claims because of the intermediaries familiarity with cost-based reimbursement and because HCFA believed regionalization would

--be more cost effective because it offers economy of scale,

--allow centralized administration from HCFA headquarters during the initial years,

--develop a higher level of claim-processing expertise, and

--provide a structure which could later be used to reimburse other providers, such as home health agencies.

Medicaid claims are processed by the State Medicaid agency or a private contractor which could also be a Medicare intermediary or carrier. During fiscal year 1980, Medicaid paid $2.1 million to certified rural health clinics.

OBJECTIVES, SCOPE, AND METHODOLOGY

Because the Rural Health Clinic Services Act has fallen short of expectations in terms of the number of certified clinics and the amount of Medicare and Medicaid revenues paid to them, we were asked to respond to a series of questions aimed at identifying and correcting the barriers to the act's broader implementation. Generally, the questions could be grouped into four categories or areas of concern.

One group of questions focused on the reasons for the suspected low clinic utilization by Medicare beneficiaries and the probability of the clinics' becoming financially self-sufficient. These issues are discussed in chapter 2. The second group of questions focused on the effect of HCFA's administrative and reimbursement requirements on the implementation of the act which is discussed in chapter 3.

The third group principally involved the effect that State laws pertaining to the independent practice of physician extenders and nurse practitioners have had on the program. This and other issues involving the States' role are discussed in chapter 4. The fourth group dealt with HCFA goals or objectives for implementing the act and the extent that they have been met. These questions are answered in chapter 5.

The following table presents information regarding the States, HHS regions, and other matters related to the scope of our review.

States included in review (note a)	HHS regional office visited by State (note b)	Number of clinics in each State (note c) Total	Reviewed	Clinic intermediaries by State (note d)	Medicare carriers by State
Maine	Region I	20	7	Blue Cross of Maine	Blue Shield of Massachusetts
Vermont	Region I	7	7	Blue Cross of New Hampshire-Vermont	Blue Shield of New Hampshire-Vermont
North Carolina	Region IV	50	8	Blue Cross of Tennessee	Prudential Life Insurance Company of America
Tennessee	Region IV	36	9	Blue Cross of Tennessee	Equitable Life Assurance Society
South Dakota	Region VIII	16	9	Blue Cross of Colorado	Blue Shield of North Dakota
Total		e/129	40		

a/The congressional requestors specified HHS regions to be included in the review, and we selected the State(s) which had the largest number of certified clinics in each specified HHS region. We visited the States' clinics certifying agencies in all these States except South Dakota.

b/Region I consists of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; Region IV consists of Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennesse; and Region VIII consists of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.

c/We met with clinic officials in each State except South Dakota to evaluate the impact of HCFA administrative and reimbursement regulations. In that State, financial and utilization data were obtained from the paying agents.

d/In addition to these four intermediaries we visited Blue Cross of Western Pennsylvania which at one time served all clinics in Region I. In fiscal year 1980, these five intermediaries out of the total of eight intermediaries paid $2.73 million in Medicare reimbursement to clinics or 85 percent of the $3.2 million total.

e/The 129 certified clinics in these States represented 31 percent of the 422 nationwide total as of September 1981.

The clinics were selected to obtain a statewide mix of clinics with varying staffing profiles (i.e., full-time physician, part-time physician, one physician extender, and multiple physician extenders). In our selection of clinics, we focused on those that had been certified for at least 2 years to enable us to determine the extent to which Medicare beneficiaries used the clinics over a 2-year period.

To determine the extent to which Medicare beneficiaries in a clinic's service area used the clinic, we contacted officials at each selected clinic and obtained the ZIP codes for the towns located in what they considered the clinic's service area. We then contacted each State's Medicare carrier and obtained the Medicare populations for the towns. From the Medicare population figures, we determined a statistically valid sample size for the universe of Medicare beneficiaries living within each clinic's stated service area. (See app. VI for the precision limits of our sampling plan and other data regarding the sample.) Then each carrier provided a random listing for the number of Medicare beneficiaries we requested. However, the method used to select the beneficiary sample for Vermont clinics was different. For Vermont clinics, we selected every third beneficiary to determine whether they principally used the clinic or not.

After the sample beneficiaries were identified, we obtained their medical Part B claims histories 1/ from the carriers for each beneficiary. We reviewed the histories to determine the medical services (if any) they received from October 1, 1978, to September 30, 1980. For the Vermont analysis, we used the period of March 1, 1978, to February 29, 1980.

To determine whether and to what extent Medicare beneficiaries visited the selected clinics, as opposed to other providers, we obtained their Medicare records from the intermediaries for North Carolina, Tennessee, and South Dakota and reviewed rural health clinic records for the Vermont and Maine beneficiaries.

We analyzed these records to determine the number of times each sample Medicare beneficiary visited the clinics during a 2-year period. We then compared the results of this analysis with the beneficiary's claims history to determine whether the beneficiary principally used the clinic or another provider for their primary health care needs. Generally, the services rendered by

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1/Medicare consists of two parts. Part A is designated as Hospital Insurance Benefits for the Aged and Disabled and covers inpatient hospital care and certain posthospital benefits in a skilled nursing facility or in the patient's home. Part B called Supplementary Medical Insurance Benefits for the Aged and Disabled covers physician services, outpatient hospital services, and certain other medical services.

general practitioners, family practitioners, internists, and general surgeons were comparable to the services available at a rural health clinic, such as performing examinations, treating illnesses, suturing, and providing emergency care.

To determine why Medicare beneficiaries did not use the clinics, we telephoned 562 of the 2,515 sampled beneficiaries (about 22 percent) who principally used physicians. We also telephoned 152 of 909 Medicare beneficiaries (about 17 percent) who principally used the rural health clinics for their primary health needs to ascertain why they did so. South Dakota Medicare beneficiaries were not included in this analysis.

To evaluate the impact of HCFA reimbursement and administrative regulations, we met with officials representing the 31 clinics selected for review in Maine, Vermont, North Carolina, and Tennessee and analyzed available financial data. Since we did not visit the nine South Dakota clinics, these problems were not discussed with clinic officials. We reviewed cost information from 35 of the 40 clinics where it was available and met with officials representing private groups concerned with rural problems.

To determine the extent that State laws inhibit clinic certification, we met with officials from HCFA's Health Standards and Quality Bureau in Woodlawn, Maryland; the HHS Regional Counsel in Denver, Colorado; State assistant attorneys general in Montana and North Dakota; and State health departments in Maine, Vermont, North Carolina, Tennessee, Montana, and North Dakota.

To assess HCFA's administration of the act we interviewed officials at HCFA offices in Woodlawn, Maryland, and HCFA regional offices in Boston, Atlanta, and Denver. We also did work at the Public Health Service (PHS) headquarters in Rockville, Maryland.

Our review was made in accordance with standards prescribed by the Comptroller General for audits of Federal organization programs, activities, functions, and funds received by contracts, nonprofit organizations, and other external organizations.

CHAPTER 2

LOW MEDICARE BENEFICIARIES' USE OF CLINICS LIMITS ACT'S FINANCIAL IMPACT

Medicare beneficiaries in clinic service areas generally received most of their medical care from private physicians rather than clinics. Beneficiary use of many clinics was low because of the nearby availability of physicians and/or the beneficiary's long time association with a particular physician. The beneficiaries who principally used the clinics did so primarily because of the clinics' proximity to their homes.

The act has not significantly improved the clinics' financial stability because of the small amount of Medicare and Medicaid revenues they received caused partly by the small percentage of Medicare beneficiary use and low Medicare and Medicaid reimbursement rates.

CLINICS EXPECTED TO FILL A GAP IN THE AVAILABILITY OF PRIMARY CARE

Rural communities, unable to attract or retain a physician, often rely on clinics staffed by physician extenders to provide primary medical care normally offered by physicians. Primary care represents 80 percent of the medical care people receive and it includes

--diagnosis and treatment of uncomplicated illnesses and disease,

--preventive services,

--home care services,

--minor surgery,

--emergency care for problems not requiring specialized personnel and equipment, and

--preventive dentistry.

When the Congress passed the Rural Health Clinic Services Act, it expected the act to expand health care access for rural residents especially Medicare beneficiaries and Medicaid recipients. In 1977, the Congressional Budget Office estimated that Medicare payments under the act would total $47.8 million in 1979 and $71.7 million in 1980. However, actual Medicare payments during those years were only $1.7 million and $3.2 million, respectively--falling far short of expectations. The Congressional Budget Office also estimated that Medicaid payments would total $18.7 million in 1980, but actual payments during that year were only $2.1 million.

Given the difference between the estimated and actual Medicare payments, we examined Medicare beneficiaries' claims histories to determine whether they sought or obtained primary health care during a 2-year period and who provided the care. We did not perform a similar analysis for Medicaid beneficiaries because of difficulties in: (1) identifying the Medicaid population within a clinic's service area and (2) obtaining accurate medical claims histories over a 2-year period. 1/

MEDICARE BENEFICIARIES USE PRIVATE PHYSICIANS

Medicare beneficiaries do not generally use the clinics as their principal primary health care provider. Although clinics are located in areas designated as medically underserved, private physicians, whom beneficiaries have used in the past and evidently prefer, are generally located within a reasonable distance.

Conversely, a few clinics had a relatively high percentage of beneficiary use. Certain common characteristics found at these clinics seem to account for the higher usage. Two of the characteristics were clinic size and the proximity to other providers.

Medicare beneficiaries seldom use clinics

We obtained medical claims histories for 7,335 Medicare beneficiaries living in 35 2/ clinic service areas in five States to determine the nature (i.e., primary or specialized) and extent of health care Medicare beneficiaries received over a 2-year period, including visits to hospital outpatient facilities. Our analysis

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1/In commenting on our report (see app. VIII), HHS pointed out that preliminary findings from a HCFA-sponsored study conducted by the University of Washington (see app. III) showed that on the average only 16 percent of Medicaid outpatient visit claims for nonaged Medicaid recipients were for clinic visits. The study covers Medicaid recipients living in the service areas of 12 certified rural health clinics in Washington and indicates that most Medicaid recipients do not use rural health clinics as the principal source of their primary care.

2/Not included in this anlaysis are (1) two clinics (one from Vermont and one from Tennessee) which had not been certified for 2 years, (2) one Maine clinic whose service area included two towns in New Hampshire, and (3) two satellite Tennessee clinics where the services provided by these facilities could not be separately identified.

showed that, for our sample of 7,335 Medicare beneficiaries, 4,576 or 62 percent received primary health care (i.e., health care which could have been provided by a rural health clinic). The following table summarizes by State the results of this analysis:

State	Sample size	Number of beneficiaries: Receiving primary medical care	(percent)	Receiving specialized medical care only	(percent)	No medical claims history	(percent)
Maine	1,612	938	58	159	10	515	32
Vermont	884	628	71	72	8	184	21
North Carolina	1,544	1,205	78	201	13	138	9
Tennessee	1,211	653	54	59	5	499	41
South Dakota	2,084	1,152	55	101	5	831	40
Total	7,335	4,576	62	592	8	2,167	30

During our review of Medicare beneficiaries' claims histories, we determined where each beneficiary principally received their primary medical care. That is, whether beneficaries used the rural health clinics or used other providers, such as general or family practitioners, internists or general surgeons (other than for the services relating to in-hospital surgery, including pre- and post-surgical visits), or outpatient hospital services.

As shown on the following page, of the 4,576 Medicare beneficiaries receiving primary health care, 1,286 (or 28 percent) principally 1/ used rural health clinics:

1/We defined "principally" as the provider the beneficiary visited most often during a 2-year period or, in the case of an equal number of visits, where the beneficiary has principally gone during the recent past.

State	Number of beneficiaries				
	Receiving primary medical care	Principally using rural health clinics (note a)	(percent)	Principally using physicians	(percent)
Maine	938	333	36	605	64
Vermont	628	257	41	371	59
North Carolina	1,205	212	18	993	82
Tennessee	653	107	16	546	84
South Dakota	1,152	377	33	775	67
Total	4,576	1,286	28	3,290	72

a/An additional 344 of the 4,576 Medicare beneficiaries receiving primary medical care during the 2 years visited their rural health clinics one or more times although they did not use it as their principal source of care.

The Medicare beneficiary usage rate varied widely among the clinics within each State. For example, in Maine, the usage rate ranged from 23 to 73 percent; in Vermont, from 29 to 58 percent; in North Carolina, from 4 to 52 percent; in Tennessee, from 1 to 28 percent; and in South Dakota, from 16 to 76 percent.

Although Medicare beneficiary usage rates for most clinics were not particularly high, another analysis showed that the number of Medicare visits to rural health clinics among 4,576 beneficiaries increased an average of 23 percent between the first and second year. For instance, our sample beneficiaries for the six Maine clinics made 1,024 clinic visits from October 1, 1978, to September 30, 1979. During the next 12 months, the number of visits for sampled beneficiaries increased to 1,289 or by 26 percent. During that same 2-year period, beneficiary visits made to the eight North Carolina clinics increased from 1,103 to 1,174 (or by 6 percent), while visits made to the six Vermont clinics from March 1, 1978, to February 29, 1980, increased from 940 in the first 12 months to 1,126 in the second, or by 20 percent.

Beneficiaries prefer private physicians

Many of the sample Medicare beneficiaries who received most of their primary health care from other than a rural health clinic went to general practitioners or internists. A few beneficiaries also used general surgeons or hospital outpatient units.

We telephoned 562 of the 2,515 Medicare beneficiaries 1/ principally using other providers to determine their reasons for selecting another provider and found that two reasons predominated: (1) the proximity of physicians, principally general practitioners and internists, and (2) a long time association with a particular physician.

Although rural health clinics are located in medically underserved areas, we have previously reported 2/ that criteria for designating medically underserved areas were not appropriate for assessing the adequacy of medical service in the area. The report noted that some of the health centers reviewed

--served areas that may no longer qualify as medically underserved,

--served areas already served by other health centers in the same Federal program, and

--used unsupported or inaccurate information concerning the availability and accessibility of health care.

In this review, we found that physicians are generally close enough to treat Medicare beneficiaries living within the clinics' service areas. Using State highway maps, we computed the distances between the indicated locations where the beneficiaries lived based on their addresses and where their physicians practiced to determine how far the beneficiaries who used these physicians traveled to obtain primary health care. The analysis showed that 63 percent of the beneficiaries traveled less than 20 miles to visit their physician. In addition, we compared the distances these beneficiaries lived from the clinics and found that 24 percent of the beneficiaries lived in locations which were closer to their physicians than to the clinics.

One North Carolina clinic, for example, had a Medicare beneficiary usage rate of 4 percent. Forty-five percent of the Medicare beneficiaries living within the clinic's service area went to physicians who practiced in a city which was closer to their towns than to the town where the clinic was located. The clinic is located in a town only 10 miles from North Wilkesboro, which has several private physicians and a hospital. A second clinic, located in Maine, had a Medicare beneficiary usage rate of 30 percent. Our mileage analysis showed that 67 percent of the beneficiaries in the clinic's service area who used physicians lived closer to their physicians than to the clinic. The clinic is

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1/Excluding South Dakota beneficiaries.

2/"Health Service Program Needs Assessments Found Inadequate" HRD-81-63, June 15, 1981.

located about 23 miles from Augusta, the State capital, and about 18 miles from Lewiston, Maine's second largest city. Over 60 percent of the beneficiaries sampled who principally used private physicians visited physicians in these two cities.

Two Tennessee clinics had Medicare beneficiary usage rates of 1 and 14 percent. The first clinic is located three blocks from a county hospital and is close to several private physicians. The second clinic is located 14 miles from Lebanon which has at least 20 primary health care physicians and two hospitals. Our mileage analysis showed that 78 percent of the beneficiaries using other providers traveled to this city for their primary health care.

Another factor contributing to low clinic usage by Medicare beneficiaries was their long time association with a particular physician. Our telephone contacts showed that of 562 beneficiaries who principally used other providers, 347 (or 62 percent) said that their long association with a particular physician was the principal reason for not using the clinic.

Although the majority of the Medicare beneficiaries who used private physicians had to travel less than 20 miles to their physician, we also found that some beneficiaries were willing to travel long distances to visit a physician rather than a clinic. Of 2,515 Medicare beneficiaries, 330 (or 13 percent) traveled more than 30 miles beyond the clinic to visit a private physician. For example, one Medicare beneficiary lived 5 miles from a Vermont clinic, but on seven occasions over a 2-year period traveled about 60 miles each way to visit an internist. This beneficiary did not use the clinic once during the 2-year period. Similarly, another Medicare beneficiary lived in the same North Carolina town where the clinic was located, but visited a general practitioner who was 74 miles away. The beneficiary visited this physician seven times in 2 years without ever visiting the clinic.

Beneficiaries that use clinics do so because of convenience

We telephoned 152 of the 909 Medicare beneficiaries who used the clinics as their principal primary health care provider. Of these beneficiaries, 117 (or 77 percent) cited the clinics' proximity to their homes as being the major reason for using them. Other beneficiaries said they used a clinic because (1) of its good reputation, (2) they liked the staff, or (3) their previous physician was no longer practicing. Of the 152 beneficiaries contacted, 144 (or 95 percent) were satisfied with the quality of care received at the clinic.

Clinic characteristics which affect usage

In order to identify reasons for the differences between utilization rates, we performed a statistical analysis of the correlation between seven clinic characteristics 1/ and the clinic usage rates for Medicare beneficiaries. We also examined in detail five clinics with high utilization to determine if there were common elements among them.

In our statistical analysis (the Pearson product-moment correlation), 2/ we arbitrarily excluded all characteristics with a correlation coefficient 3/ of less than 0.45 and which had a 10 percent or greater likelihood of occurring due to chance. Based upon these criteria, we found three characteristics which correlated with the usage rates for the clinics included in our review. They were: clinic size as determined by total patient revenue, the proximity of the closest provider to the clinic as determined by the distance between the town where the clinic is located and the town where the closest alternative provider practices, and the percentage of total revenues derived from services to patients including Medicare and Medicaid.

In addition to our statistical analysis, we performed a judgmental analysis of the following five clinics having high usage rates:

1/The clinic characteristics that we compared to utilization rates were: months in operation; months certified; patient revenue; distance between the town where the clinic is located and the closest, second closest, and third closest alternative providers; and patient revenue as a percent of total revenue.

2/See appendix VII for a description and definition of the statistical method used.

3/A correlation coefficient shows the strengths of association between a pair of variables, in this instance between utilization rates and the clinic characteristics.

	Number of sample beneficiaries	
	Receiving primary medical care	Principally using clinics
Mellette County Ambulatory Care Clinic, South Dakota	95	72 (76 percent)
Mission Satellite Clinic, South Dakota	51	38 (75 percent)
Aroostook Valley Health Center, Maine	149	109 (73 percent)
Mountain Valley Health Center, Vermont	147	85 (58 percent)
Hot Springs Health Program, North Carolina	116	60 (52 percent)

Our analysis showed that all five clinics are fairly isolated. Mellette County is located on an Indian reservation and the nearest doctor is 60 miles away. The closest alternate provider to Mission Clinic is 40 miles away. Mountain Valley and Hot Springs are located in mountainous areas with narrow, winding roads making winter travel slow and difficult. Aroostook Valley is located in northern Maine (30 miles from the Canadian border) where extreme winters make travel treacherous. The nearest physicians to the Aroostook Valley and Hot Springs clinics are about 25 miles away. Although Mountain Valley has two private physicians (one semiretired) only 5 miles from the clinic, the next closest providers were 25 miles from the clinic. Other factors which may contribute to the relative success of the latter three clinics include:

--Community support to establish the clinics. Aroostook Valley area residents contributed about $80,000 toward the construction costs for their clinic and Mountain Valley residents contributed about $49,000 for an extension to their clinic.

--Medical personnel that are respected by the community. For example, Aroostook Valley's physician assistant is widely accepted by the community and received an award from the National Health Service Corps (NHSC) for outstanding service. Also, many of the Medicare beneficiaries who used the Mountain Valley clinic praised that clinic's physician.

--Additional services offered. For example, Mountain Valley offered X-ray services, Aroostook Valley provided dental care, and Hot Springs offered both of these services as well as free transportation for area residents.

MEDICARE AND MEDICAID REVENUES ALONE WILL NOT ENSURE FINANCIAL STABILITY

Although the act has provided additional revenues to clinics, it has not substantially improved clinic financial stability. Many clinics receive Medicare and Medicaid reimbursement without being certified. Even for clinics receiving reimbursement under the act, the additional revenue does not constitute a significant percentage of total revenue. The principal reasons for its lack of significance are the reimbursement limits or screens--which reduce reimbursement rates--and the small percentage of Medicare beneficiaries who principally use the clinic.

Of greater importance to the financial stability of many clinics is the continuation of PHS assistance either in the form of grants or medical personnel.

Medicare/and Medicaid revenues represent small portion of total

The Congress anticipated that the act would foster the growth and stability of clinics in rural, medically underserved areas by allowing such clinics to receive Medicare/and Medicaid reimbursement for physician extender services. Many clinics, however, received Medicare and Medicaid reimbursement without being certified because they had a practicing physician or, in the case of 27 States, the State had included physician extender services in its Medicaid plan.

The act does provide additional revenue to clinics that provide services previously ineligible for Medicare and Medicaid reimbursement. The amount, however, is often less than 20 percent of the total revenue. (Total revenue includes PHS grants and the imputed value of NHSC support.) For the 25 participating clinics 1/ which provided us with Medicare and Medicaid financial information, Medicare and Medicaid revenues represented an average of 14 percent (8 percent Medicare and 6 percent Medicaid) of the total revenue. Seven of the 25 clinics had Medicare and Medicaid revenue which represented less than 10 percent of their total revenues.

Total patient revenue (Medicare, Medicaid, self-pays, and private insurance) is the key to financial self-sufficiency. Our comparison of patient revenue to total revenue at 33 clinics 2/

1/Five Vermont clinics, three North Carolina clinics, six Tennessee clinics, and one South Dakota clinic were unable to separate Medicare and Medicaid revenues.

2/Four Vermont clinics, one Tennessee clinic, one North Carolina clinic, and one South Dakota clinic were unable to provide total revenue data.

showed that six clinics received more than three-fourths of their income from patients. Conversely, 19 of the 33 clinics derived less than 50 percent of their income from patients. These clinics depended primarily upon Federal grant assistance as their principal source of revenues.

In addition to low utilization and the Federal assistance, the other principal reasons that Medicare and Medicaid revenues represented a small percentage of the total revenue was the application of HCFA reimbursement limits. HCFA places a $27.30 ceiling on the reimbursement rate for Medicare and Medicaid visits and applies productivity and administrative expense guidelines (screens) which can further reduce reimbursement. The following table shows by State the impact of the ceiling and screens on clinic revenues.

State	Medicare reimbursement				
	Number of clinics	Before ceiling and screens	After ceiling and screens	Difference	Percent reduction
Maine	6	$54,584	$ 36,897	$17,687	32
Vermont	6	95,423	54,341	41,082	43
North Carolina	8	77,463	56,539	20,924	27
Tennessee	9	37,535	26,195	11,340	30
South Dakota	6	64,604	48,774	15,829	25
Total	a/35	$329,609	$222,746	$106,862	32

a/Cost reports were not obtained for one Maine clinic, one Vermont clinic, and three South Dakota clinics.

Although both the ceiling and the screens reduce clinic revenues, the screens have the greatest impact. The application of the $27.30 ceiling reduced the revenues at 17 out of 35 clinics, but only by an average of 6 percent. The screens, however, reduced the revenues at almost all clinics by an average of 26 percent.

Many clinics depend upon Federal assistance

In 1975, PHS started the Rural Health Initiative (RHI) to develop health care systems in rural areas. The programs included in RHI and their estimated fiscal year 1980 expenditures were:

Program	Expenditures (millions)
Community Health Centers (rural areas only)	$113.4
National Health Service Corps	74.2
Appalachian Health	26.5
Migrant Health (note a)	39.7

a/See our staff study entitled "Problems in the Structure and Management of the Migrant Health Program" (HRD-81-92, May 8, 1981) for a discussion of this program.

RHI assists rural communities to provide primary and supplemental health services to their residents. Grant amounts range from $25,000 to $200,000 and are awarded annually. Three-fourths of all certified rural health clinics receive PHS grants.

PHS recognizes that the need for health professionals is one of the keys to increasing health care in medically underserved areas. Accordingly, NHSC provides federally salaried health professionals to communities designated as medically underserved. As of September 1981, NHSC has placed 88 physicians, 80 physician extenders, and 35 dentists at 116 certified rural health clinics. 1/

Of the 40 rural health clinics we reviewed, 31 received Federal assistance. Specifically,

--13 clinics received PHS grants and had NHSC personnel,

--15 clinics received PHS grants only, and

--3 clinics had NHSC personnel only.

Federal grant assistance represented a substantial proportion of many clinics' total revenue. Of the 31 clinics receiving Federal assistance, 27 clinics provided us with detailed revenue information. PHS grants and the imputed value of NHSC personnel represented about 53 percent of the 27 clinics' total revenues. For example, one Tennessee clinic's total revenue for fiscal year 1980 was about $257,000 of which $201,000 (78 percent) were PHS grant funds. Another Tennessee clinic reported about $287,000 in total revenue for fiscal year 1980 of which about $180,000 (63 percent) was a PHS grant and about $38,000 (13 percent) represented

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1/According to PHS, it currently assigns a high priority to billing for NHSC medical personnel with all sites being billed. In the past, some centers were supplemented by federally salaried personnel. Such centers are now expected to support directly the NHSC personnel.

imputed NHSC salaries. A Maine clinic reported about $131,000 in total revenue for fiscal year 1980 of which about $100,000 (76 percent) came from a PHS grant.

Block grants signed into law

On August 13, 1981, the President signed the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) into law. The act created four health care block grants and placed a number of categorical programs under the block grant concept. Funds that were once earmarked for specific purposes (categorical grants) will be given directly to the States to be spent for any of the approved services.

Under the act, the community health center program (which includes rural health clinics) is extended for 1 year as a federally administered categorical program. The level of funding, however, has been reduced from $325 million to $284 million, a 13-percent reduction. Starting in fiscal year 1983, the community health center program will become a block grant consisting only of this program. Authorizations for fiscal years 1983 and 1984 are $302.5 million and $327 million, respectively.

Public Law 97-35 extended NHSC and the Migrant Health Centers as categorical programs through fiscal year 1984. The act also had no effect on Appalachian Health Programs, but according to the Appalachian Regional Commission's Director, the Commission's funds have been reduced by about 50 percent for fiscal year 1982.

Because States have greater control over funding decisions under the block grant concept, the financial impact on rural health centers is unknown. However, we asked officials of the 31 clinics receiving assistance what the impact would be if the grants were eliminated. Officials of 19 clinics believed that their clinics would close. The following table summarizes this information.

Impact of Eliminating Grant Assistance

State	Clinics reviewed	Clinics receiving PHS grants	Number of clinics	
			Would close	Remain open
Maine	7	7	3	4
Vermont	7	7	6	1
North Carolina	8	5	1	4
Tennessee	9	6	4	2
South Dakota	9	6	5	1
Total	40	31	19	12

Although officials of 12 clinics believed their clinics could remain open if grant funds were eliminated, officials representing 10 of these clinics said that to do so services would have to be curtailed.

CONCLUSIONS

Although a few clinics have been successful in attracting a majority of Medicare beneficiaries in their service areas, most have not. Rather than dissatisfaction with clinic services, however, the major reason Medicare beneficiaries did not use clinics appears to be personal preference for their private physician who they have used over the years. Another factor affecting clinic use is the proximity of many clinics to physicians, which raises the question of whether these clinics are needed.

We believe that, it is reasonable to conclude that, even if other barriers to broaden implementation of the act were removed, the condition of low Medicare usage would still remain in the settings where alternative providers are nearby.

CHAPTER 3

FEDERAL REQUIREMENTS FURTHER LIMIT THE IMPACT OF THE ACT

The principal reason that fewer clinics than expected have sought certification and that many clinics have relinquished their certification is that the reimbursement rates are perceived as too low. Clinics received substantially less in Medicare revenues than it cost them to provide the services and also incurred additional administrative expenses because of certification.

Intermediary administrative costs were also high when compared to the administrative costs to reimburse other providers.

NUMBER OF CERTIFIED CLINICS LESS THAN EXPECTED

During testimony in 1977, the Congressional Budget Office estimated that by December 1979 over 600 rural health clinics would be certified under the act. As of that date, however, 359 clinics were certified, excluding 72 clinics which had already relinquished their certification. As of September 30, 1981, 598 clinics were certified, but 176 clinics had relinquished their certification, leaving 422 certified clinics participating under the Rural Health Clinic Services Act.

REIMBURSEMENT RATES DO NOT COVER COSTS

Most clinics lose Medicare funds because they are unable to meet HCFA productivity standards and overhead cost limitations. According to various studies, the reimbursement method is the main reason clinics do not want to be certified. HCFA is currently considering a new prospective reimbursement method which would be more acceptable to the clinics than the existing one.

Clinic reimbursement methods

Some physician-based rural health clinics are not participating under the act and are reimbursed based upon the "reasonable charge" principles that apply to noninstitutional providers under Medicare. Using these principles, reimbursement is limited to the lowest of: (1) the individual provider's customary charge, (2) the upper limit of the prevailing charges for the area (prevailing rate), or (3) the provider's actual charge. For example, if the provider's customary charge is $80, the prevailing rate $100, and the actual charge $85, the Medicare reimbursement would be based upon the lowest amount ($80) assuming the beneficiary has paid the annual deductible. The provider would than receive 80 percent of $80.

However, participating independent clinics, which comprise about 95 percent of the 413 certified clinics as of March 31, 1981, are reimbursed using an all inclusive rate for each covered beneficiary visit or encounter. The all inclusive rate is determined by dividing the total allowable costs by total patient visits. Eighty percent of this rate, after subtracting the amount of any deductible for which the Medicare patient is responsible, is paid to the clinic. That is, regardless of the clinic's charge, Medicare will only reimburse 80 percent of the approved rate. Thus, if a clinic's rate is $20 and charges total $45, the clinic will receive 80 percent of $20, or $16. The beneficiary pays the clinic 20 percent of the $45, or $9.

States, under their Medicaid program, reimburse clinics for 100 percent of the Medicare rate for services furnished to Medicaid recipients. For a clinic which offers services covered by Medicaid but not by Medicare (e.g., eyeglasses and dental services) Medicaid will pay the clinic 100 percent of the reimbursement allowed under one of three optional methods:

--For services on a rate-per-visit calculated by Medicare, which includes Medicaid covered services.

--For each non-Medicare covered service according to the usual State practice for similiar services.

--For dental services on a separate cost-per-visit basis calculated by Medicare.

Reimbursement rate limits clinic certifications

Although the act permitted rural health clinics to receive Medicare and Medicaid reimbursement, the resulting reimbursement rate is the main reason clinics relinquish their certification or choose not to be certified. HCFA determined the reasons 76 clinics relinquished their certification and found that 35 clinics cited low reimbursement as being the principal reason. The National Rural Primary Care Association 1/ surveyed 36 uncertified clinics and found the most common reason for not seeking certification was the low Medicare reimbursement which would have been received if certified. (Noncertified clinics with physicians are reimbursed under the reasonable charge reimbursement methodology.)

We contacted 26 clinics in North Carolina and Tennessee which relinquished their certification. Officials at 12 clinics cited

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1/The National Rural Primary Care Association is comprised of a variety of rural health care providers including clinics and is concerned with improving rural primary health care.

the low reimbursement rate as being the reason for relinquishing certification. For example, one official said that Medicare beneficiaries generally require more laboratory services, but under the method HCFA uses to establish reimbursement rates, the Medicare rate failed to cover the costs of these additional services. The official said that since the clinic relinquished its certification and began receiving Medicare reimbursement based on reasonable charges, the amount of Medicare revenue has increased.

Another clinic relinquished its certification after it hired a full-time physician. The clinic administrator said that certification resulted in lower Medicare reimbursement than did billing under the physician reimbursement system. He noted that, when clinics are certified, a Medicare patient could incur $50 of medical charges, but the clinic would only receive $12.

Screens reduce reimbursement rates

HCFA has established guidelines (screens) which intermediaries use to test the reasonableness of clinic overhead costs and staff productivity. HCFA limits clinic overhead to 30 percent of total allowable costs and requires clinic personnel to meet productivity standards (three patients per hour for physicians and two patients per hour for physician extenders). In addition, HCFA set a payment limit of $27.30 per encounter regardless of the clinic's actual cost.

HCFA has stated that these screens are similar to those used in Medicare reimbursement of certain federally funded health centers and to standards used by PHS to evaluate grantees (two-thirds of which are certified rural health clinics). PHS standards include:

Indicator	Standard
Onsite encounters per staff equivalent physician per year (note a)	4,200
Percent of total ambulatory costs attributable to administration (note b)	c/Not more than 16 percent

a/Mid-level practitioners (i.e., physician extenders) are calculated as one-half of a physician.

b/Does not include housekeeping and maintenance.

c/For projects with total annual operating costs of $125,000 or less, the standard is 26 percent.

HCFA has defined full-time equivalency as a minimum of 1,600 hours. Therefore, PHS productivity standards would equate to about 2.6 encounters per hour for physicians and 1.3 for physician extenders as opposed to HCFA's 3.0 and 2.0 for physicians and physician extenders, respectively. Thus, HCFA's productivity screens are more stringent, especially for physician extenders.

In addition, a PHS official testified before a congressional committee that, while PHS productivity indicators are helpful in determining the general allocation of resources in relation to utilization and need, he believed they should not be used to determine reimbursement to clinics for services furnished to Medicare patients. He also noted that PHS hopes that:

> "* * * under the new [reimbursement] regulations, that screens will either be greatly reduced or totally eliminated, as being inappropriate. The PHS is opposed to the current screens because they are not based on clinical experience, do not take into account individual clinic differences, and are too rigidly applied."

Clinics included in our review had difficulty meeting HCFA's screens. For example, 26 of 35 clinics 1/ failed to meet the overhead screen, and 32 of 35 clinics failed to meet the productivity screen. As a result, these clinics experienced rate reductions. As shown below, the Medicare rate for nine clinics was reduced by more than one-third:

Clinic	Medicare rate		Percent reduction
	Before screens (note a)	After screens (note b)	
Arthur Jewell, Maine	$27.30	$16.00	41
Bingham, Maine	27.30	16.00	41
Community, Tenn.	27.30	16.00	41
Greensboro, Vt.	27.15	16.00	41
Walstonburg, N.C.	27.30	16.00	41
Champlain Islands, Vt. (note c)	26.75	16.00	40
Douglas, Tenn.	27.30	17.29	37
Gladeville, Tenn.	27.30	18.13	34

a/Rate limited to HCFA's payment ceiling of $27.30.

b/Productivity screens cannot reduce rate below $16.00.

c/Champlain Islands consists of two separate health centers--one located in Grand Isle and the other in Alburg.

1/Cost reports were not obtained for one Maine clinic, one Vermont clinic, and three South Dakota clinics.

Even three clinics with relatively high Medicare beneficiary use in terms of the beneficiaries in their service area had their rates reduced as a result of the screens. Aroostook Valley's rate was reduced from $16.61 to $14.52, or by 13 percent; Mountain Valley's from $27.30 (the maximum) to $19.18, or by 30 percent; and Hot Springs' from $22.17 to $16.00, or by 28 percent.

HCFA contends that the screens are guidelines and has informed the intermediaries that they have the authority to waive the overhead and productivity screens when a clinic provides reasonable justification. However, we found that intermediaries regard the guidelines as a requirement and the intermediaries we contacted have consistently applied them. The following table shows by State the amount of revenues clinics lost because of the application of the screens.

State	Number of clinics (note a)	Medicare reimbursement (before screens) (note b)	Medicare reimbursement (after screens)	Difference	Percent reduction
Maine	6	$ 49,059	$ 36,897	$12,162	25
Vermont	6	83,458	50,909	32,549	39
North Carolina	8	71,421	56,539	14,882	21
Tennessee	9	31,658	26,195	5,463	17
South Dakota	6	59,439	48,774	10,664	18
Total	35	$295,035	$219,314	$75,721	26

a/Cost reports were not obtained from a Maine and a Vermont clinic and three South Dakota clinics.

b/Although no screens were applied, we still imposed HCFA's ceiling of $27.30 per visit.

Eight clinics had their Medicare reimbursement reduced by more than 40 percent. For example, the screens reduced the Greensboro (Vt.) Health Center's Medicare reimbursement by $7,743, or 49 percent; the Arthur Jewell (Maine) Health Center's Medicare reimbursement by $2,260, or 49 percent; and the Bingham (Maine) Health Center's Medicare reimbursement by $2,775, or 53 percent.

HCFA has attempted to change the reimbursement system. These attempts and their outcomes are discussed in chapter 5.

ADMINISTRATIVE REQUIREMENTS ARE TROUBLESOME

Clinic officials report that HCFA administrative requirements are complex, time consuming, and costly. Accordingly, the additional amount received because of certification has been reduced by the costs incurred to meet administrative requirements.

At the time of the act's passage, congressional committees stressed the importance of simplicity in the certification and reimbursement processes. Yet, clinic officials commented frequently about the burden of HCFA's reporting requirements.

HCFA requires rural health clinics to prepare an annual cost report. The information reported is the basis for the clinic's Medicare reimbursement rate. The 16-page cost report consists of three sections. The first section reclassifies and adjusts the clinic's trial balance. The second section summarizes the costs to deliver rural health clinic services. The third section identifies the costs of rural health clinic services covered by Medicare versus other services not covered, such as dental, pharmaceutical, patient transportation, and social services.

Officials representing 23 of 31 clinics 1/ said that this cost report is burdensome and time consuming and/or requires too much detailed information. Because of the cost report's complexity three Tennessee clinics hired Certified Public Accounting firms to prepare their reports. The administrator of two Vermont clinics with full-time physicians noted that the two clinics received about $4,800 more in Medicare reimbursement because of certification, but he said it costs $2,000 to complete the cost reports.

Certified clinics receiving PHS grants or having NHSC personnel must also complete a 12-page semiannual report. Officials in these clinics complained that HCFA's annual cost report duplicated the PHS semiannual cost report. Officials representing 13 clinics said that both reports required similar information but in different formats. For example, both reports require cost information and the number of patient visits (encounters), but required the information to be presented differently.

(HCFA is aware of the administrative problems cited by the clinics. The agency's reaction to them and the actions taken, or planned to be taken, are discussed in ch. 5.)

1/Due to time constraints, we did not pose this question to the officials of the nine South Dakota clinics.

INTERMEDIARY COSTS ARE HIGH

Eight Medicare intermediaries process claims submitted by rural health clinics. The administrative costs for processing these claims are much higher than the administrative costs for processing Medicare Part B claims. For example, in fiscal year 1979, intermediary administrative costs equaled 51.6 percent of benefits paid and in fiscal year 1980, administrative costs equaled 28.9 percent of benefits paid. During the same periods, carrier administrative costs for paying Medicare Part B claims were 5.8 percent and 5.2 percent, respectively, of benefits paid.

The overall unit cost per claim is also higher for rural health clinic claims. The following table shows the unit cost to process a clinic Medicare claim:

	Fiscal year 1979			Fiscal year 1980		
Intermediary (note a)	Administrative cost	Claims paid	Cost per claim	Administrative costs	Claims paid	Cost per claim
Blue Cross of Maine	$ 5,309	389	$13.65	$ 17,638	9,922	$1.78
Blue Cross of New Hampshire-Vermont	34,956	3,846	9.09	31,333	5,185	6.04
Blue Cross of Western Pennsylvania	220,695	47,872	4.61	236,866	47,383	5.00
Blue Cross of Tennessee	331,431	59,167	5.60	393,604	69,079	5.70
Mutual of Omaha	54,600	10,285	5.31	52,404	18,938	2.77
Blue Cross of Colorado	120,815	23,770	5.08	102,012	27,502	3.71
Aetna	102,555	15,752	6.51	96,635	21,692	4.45
Total	$870,361	161,081	b/5.40	$930,492	199,701	b/4.66

a/There are only seven intermediaries listed because at the time there were no claims in Arkansas.

b/The overall unit cost per claim for the entire Medicare Part B program in 1979 was $2.82 and in 1980 was $2.61.

The administrative cost to process each claim is higher than Medicare Part B claims because of the fewer number of claims and the need to verify clinic cost data. For example, during fiscal years 1979 and 1980, intermediaries processed about 161,000 and 200,000 rural health clinic claims, respectively. During the

same 2 years, carriers processed about 134 million and 152 million, respectively, Medicare Part B claims. As shown in the table above, six of the seven intermediaries registered lower costs per claim during the year they paid more claims.

CONCLUSIONS

The Rural Health Clinic Services Act has not resulted in the anticipated number of clinic certifications. HCFA's reimbursement mechanism for clinics has been the primary reason clinics have relinquished their certification or not sought certification. Clinics generally receive Medicare reimbursement using an all inclusive rate-per-visit based upon clinic costs. HCFA, however, imposed a ceiling on rates and guidelines for administrative overhead costs and productivity that significantly reduced Medicare reimbursement rates which appear to have been rigidly applied.

HCFA requires all certified clinics to submit annual cost reports from which the clinics' Medicare rate is determined. Clinic officials frequently complained about the report's complexity, the amount of time and money involved in its completion, and its duplication of the PHS semiannual report.

Intermediary administrative costs continue to be very high in relation to benefits paid. Because of the relatively small number of claims and the low dollar value of each claim, we believe intermediary processing costs will remain high, especially in relation to the processing costs for Part B claims.

CHAPTER 4

STATE LAWS AND INSPECTIONS CAN AFFECT CLINIC CERTIFICATION

State laws which prohibit or substantially restrict physician extenders from delivering primary health care impede clinic certification. In addition, recent budget reductions will reduce State certification inspections and may result in otherwise eligible clinics being denied certification because States will not be able to conduct certification surveys.

SOME STATE LAWS HINDER CLINIC DEVELOPMENT

The act provides that State laws and regulations will continue to govern certification, licensure, and scope of physician extender practice. Some State laws, however, prohibit or substantially restrict the use of physician extenders in delivering primary health care. One form of restriction is requiring direct physician supervision for physician extenders. Although requiring such supervision does not prevent certification, it limits clinic development to locations with a full-time physician. However, because certified clinics are required to be located in medically underserved areas, a physician may not be available.

In August 1980, HCFA conducted a study of State medical and nurse practice acts. HCFA identified six States which recognize nurse practitioners and/or physician assistants, but require direct supervision for one or both. The States and number of certified clinics as of March 31, 1981, are:

States	Certified clinics
Colorado	5
Indiana	1
Oklahoma	1
Oregon	4
Texas	2
Wyoming	0

HCFA also identified five States (Delaware, Missouri, Montana, New Jersey, and North Dakota) where the States' attorneys general ruled that nurse practitioners and/or physician assistants could not provide primary health care. We visited two States, Montana and North Dakota, to determine if there had been any changes in State law regarding physician extender practice.

In North Dakota no legislative amendments had been passed affecting the State's medical and nurse practice acts since the HCFA study. The Executive Director of the North Dakota Medical Association said that he opposes physician extenders practicing without direct physician supervision. He also questioned the need for rural health clinics in North Dakota based upon the results of a study performed by the Medical Association. The Executive Director said that the Association determined the distances North Dakota residents lived from primary health care physicians and found that about 98 percent of the population live within 25 miles of a primary health care physician.

In Montana, legislation was recently passed affecting both nurse practitioners and physician assistants. The legislation related to physician assistants allows for their use but not their licensure. The State Board of Medical Examiners will develop rules relating to the supervision of physician assistants and set physician supervision requirements. According to the Director, Montana Department of Social and Rehabilitation Services, physician assistants will not be allowed to practice without direct physician supervision. We also discussed the potential effect of this bill with the Executive Director of the Montana Medical Association. He said that it was essential to have direct physician supervision over nurse practitioners and physician assistants to insure quality patient care. Accordingly, he did not believe the Board of Medical Examiners would approve the use of physician assistants without direct physician supervision. As a result, there is little chance of a physician-assistant-directed rural health clinic in Montana.

The amendment to the Nurse Practice Act, however, allows for nurse practitioner-directed rural health clinics in Montana. This amendment recognizes nurse practitioners (as opposed to physician assistants) under State law as nurse specialists under standards to be set by the Board of Nursing. According to the Social and Rehabilitation Services' Director, the recognition of nurse practitioners makes it possible for a rural health clinic to be operated by a nurse practitioner.

Although we cannot estimate the impact of the above change, the Director of the Montana Nurses Association said that at least three nurse practitioners had attempted to obtain clinic certification prior to the above amendment. All three were rejected by the Department of Health because at the time the State did not license nurse practitioners.

(HCFA recognizes that the laws in some States impede realization of the act's objectives. HCFA's views on this subject and its role in dealing with this matter are discussed in ch. 5.)

STATE INSPECTION OF CLINICS

The States inspect clinics to determine their compliance with Federal certification requirements and State standards. It has been alleged by some that States have imposed criteria which are arbitrary or more suited to small hospitals than to rural health clinics. However, in our discussions with clinic officials in four States, intermediary representatives and HCFA regional officials, we identified only one State, Maine, where such inspection procedures were considered troublesome.

Administrators representing 10 of the 13 certified rural health clinics in Maine believed the certifying agency criteria were inappropriate. Two clinic administrators said the certifying agency treats clinics like hospitals rather than physicians' offices.

HCFA budget revisions could reduce clinic certifications

On March 11, 1981, HCFA's Health Standards and Quality Bureau informed HCFA regions of the following revised fiscal years 1981 and 1982 budgets for Medicare survey (inspection) activities:

Fiscal year	Current budget	Revised budget	Change	Percent reduction
1981	29,760,000	23,760,000	-6,000,000	20
1982	26,535,000	17,500,000	-9,035,000	34

Because States inspect clinics and recommend their certification to HCFA on a reimbursable basis, we contacted State certifying agencies in Vermont, Maine, North Carolina, and Tennessee to determine the expected impact of the above reductions on their rural health clinic certifying activities. Officials from all four agencies said that because of the budget cuts they had to prioritize their inspection workloads. All four officials indicated that skilled nursing facilities would receive the highest priority while rural health clinics would receive a very low priority. 1/

A Vermont official said that HCFA reduced that State's inspection agency's budget by 42 percent for fiscal year 1981. The official said that Vermont normally spends about $22,000 quarterly, but because of the budget reduction and the expenditures to date, the agency only had $9,000 for the remaining 6 months (April 1 to

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1/In commenting on our report HHS stated that State agencies have been instructed to give initial surveys of all facilities first priority.

September 30, 1981). As a result, the agency did not plan to certify any new clinics or recertify existing ones for the remainder of the fiscal year. Clinics will not lose their certification if the State does not perform a recertification survey, but because onsite inspections will not be made there will be no assurance that clinic policies and procedures comply with Federal and State requirements.

A North Carolina official said that the agency's budget was reduced by about 40 percent for the last 6 months of fiscal year 1981 and expects a similar reduction for fiscal year 1982. As a result, the agency will not make onsite certification or recertification inspections and new clinic certifications will consist of only a desk review of material submitted by the clinic.

A Tennessee official expects the agency's budget to be reduced by 20 percent for the remainder of fiscal year 1981 and 20 to 25 percent for fiscal 1982. Tennessee plans to use a reduced survey team to perform onsite certification inspections for new clinics, and use a questionnaire (subject to HCFA approval) to recertify clinics.

A Maine official said that the State agency had its fiscal year 1981 budget reduced from about $170,000 to about $128,000 and its fiscal year 1982 budget is $82,000. The official had not yet assessed the impact of the 1982 budget reductions on certification activities, but said that scheduled recertification surveys will not be made.

CONCLUSIONS

There are currently 10 States which restrict physician extenders to such a degree that they cannot practice consistent with one of the objectives of the act. One type of restriction requires direct physician supervision of physician extenders. In locations without physicians or without physicians willing to provide such supervision, clinics cannot be established.

State certifying agencies inspect clinics to ensure their compliance with Federal and State requirements. In the four States surveyed, only clinic officials in Maine had complaints about the certification process.

HCFA budget reductions for fiscal years 1981 and 1982 may result in fewer clinics being certified. Officials from four State certifying agencies report that a low priority will be assigned to clinic certification activities. However, as previously stated, HHS told us that HCFA has instructed States to give first priority to initial surveys for all facilities.

CHAPTER 5

COMPARISON OF HCFA GOALS AND OBJECTIVES WITH ACTUAL ACCOMPLISHMENTS

This chapter responds to questions contained in the congressional request relating to HCFA's goals and objectives for implementing the act.

HCFA has established goals to address many of the obstacles which have prevented the program from fulfilling the act's expectations. HCFA, however, has not accomplished these and other goals nor has it in all instances established specific time frames by which progress can be measured.

LITTLE PROGRESS MADE BY HCFA TO MEET ITS GOALS

Although HCFA has established goals which address many of the obstacles preventing the act from meeting its expectations, the goals have not been met. HCFA has developed two reimbursement systems to replace the existing one which was scheduled to be replaced by March 1980. The first proposal was withdrawn after protests from both intermediaries and clinics regarding its complexity and difficulty in administration. The second proposal--which appears to be a more acceptable system--is not scheduled to be implemented until early 1983.

Partially because of the delay in changing the reimbursement system, HCFA has not adopted a common cost report with PHS. HCFA has likewise not encouraged States to modify their laws to permit physician extenders to practice independently in providing primary health care.

In August 1981, HCFA officials identified the following five goals related to the act:

--Develop a prospective reimbursement mechanism.

--Implement a common cost report (with PHS).

--Identify the universe of potential rural health clinics.

--Encourage States to adopt laws allowing physician extenders to deliver primary health care.

--Ensure that State Medicaid agencies reimburse certified clinics based on the Medicare rate established for clinics.

A HCFA official said that the above goals were never formally incorporated into written policy, but nevertheless are generally recognized within HCFA as program goals.

HCFA unable to develop acceptable prospective reimbursement system

As noted in chapters 2 and 3, under the current reimbursement system, clinics usually lose Medicare revenue because they are unable to meet HCFA productivity and overhead screens. This reimbursement system, however, was intended to be an interim system until HCFA could implement a prospective reimbursement system. 1/

Regulations required HCFA to implement a prospective reimbursement system no later than March 1, 1980. Although initial work on the prospective payment system was begun in July 1978, proposed regulations were not published until September 1980. According to HCFA, the major reason for the delay was the difficulty experienced in reaching a consensus within HHS regarding the method of prospective rate setting.

The above payment method, which was discarded before it was implemented, would have retained the use of all inclusive rate per encounter methodology, but rates would have been preestablished for up to 3 years. The rate would have been established at the lower of an individual clinic's rate or a statewide target rate established by HCFA. The individual clinic rate was to be based on the clinic's cost per visit in the year preceding the start of the prospective payment cycle and would be increased by 15 percent per year. The statewide target rate would be based on 115 percent of the median cost for all clinics and would be adjusted for differences in State wage levels by means of a wage index. 2/

The statewide target rate would also be adjusted annually by the Medical Economic Index which is based on the level of the changes in worker earnings and physicians' practice costs. The index, which is published annually by HCFA, is currently used to limit increases in Medicare prevailing rates for physician services. The September 1980 proposal also included complex provisions for recalculating rates sooner than 3 years for changes in individual clinic circumstances.

1/Prospective reimbursement restrains expenditure increases by establishing reimbursement limits before a fiscal year begins. Currently, clinics are reimbursed retroactively whereby end of year settlements are made to adjust reimbursements to reflect actual costs. Under a prospective reimbursement system, this retroactive adjustment would not be made.

2/This is similar to the methodology used for establishing Medicare reimbursement limits for hospitals and nursing homes.

Comments on this proposal identified several problems. For example, Blue Cross/Blue Shield of Colorado commented that the proposed reimbursement regulations were "extremely complicated, ambiguous, inconsistent and appear to pose unsound administrative processes to the rural health clinics, their intermediaries and HCFA." The Aetna Life and Casualty Company noted that, under the provision where a clinic's rate would be recalculated if the increase in utilization was 15 percent or more, 67 percent of the clinics would probably have their rate recalculated each year, placing a burden on clinics by requiring more paperwork, increased costs, and decreased efficiency.

HCFA also brought individual rural health clinics into the rulemaking process. These clinics also criticized the proposal as too complex and cumbersome, particularly the variance of 15 percent in utilization to trigger a recalculation of the rates. Because of these comments, HCFA withdrew this proposal in February 1981.

In place of the above, HCFA is currently developing a "specific" cost-related payment mechanism based on clinic charges. For the clinics, this charge-related payment would permit Medicare and Medicaid billing in the same manner as is done for other third parties and self-pay patients. It would eliminate the adjustment necessary to reconcile the cost-based all inclusive rate with charge-based deductible and coinsurance because both the Medicare rate and coinsurance will be based on the same amount. Under the existing system, a clinic's rate is based on clinic costs while the coinsurance is based on clinic charges. For example, if a clinic's rate is $20, but a patient incurs charges of $40, the Medicare reimbursement is 80 percent of $20, but the patient's coinsurance is 20 percent of $40. As a result, clinics must maintain two sets of records to account for this one encounter.

The proposal also contains a prevailing charge limitation which would ensure that the program pays no more for clinic services than the maximum allowed for similar services provided by a physician in the same locality. It would also be more equitable for clinics which provide more than the basic array of services because the total revenue received would be based on the services provided and not limited by the all inclusive rate.

The proposed system would work as follows, a percentage would be established for each clinic based on the percentage of clinic cost to its total charges. For example, if a clinic's costs were $90,000 and its total charges were $100,000, Medicare's reimbursement for a particular service would be based on 90 percent of the charge. Thus, for a $10 charge, Medicare would allow 90 percent, or $9 and the clinic would receive 80 percent of that figure, or $7.20 if this charge was below the prevailing rate. The clinic could also receive $1.80 from the Medicare beneficiary.

The proposed reimbursement system is similar to the reasonable charge payment system used to reimburse private physicians. The major difference is the basis for Medicare's allowable charge. A private physician's allowable charge is the least of the physician's customary charge, the actual charge, or the prevailing rate in the physician's locality. A clinic's allowable charge will be based on a ratio of clinic costs to clinic charges or, if lower, to the local physician's prevailing rate. HCFA cannot use the same reimbursement method for reimbursing clinics as used for private physicians because the act requires clinic reimbursement to be based on costs.

The HCFA proposal also eliminates the overhead and productivity screens resulting in a Medicare payment that more accurately reflects clinic costs. In addition, HCFA proposes to replace the national ceiling of $27.30 with an upper limit based on the prevailing rates for general practitioners in each clinic's locality. This change equates a clinic's charges with those of other providers of similar services in its area rather than with a composite national average charge.

The described payment system is still under development and subject to change. This prospective reimbursement mechanism is not expected to be implemented until early 1983, or about 3 years later than required.

HCFA, however, plans to make some interim changes to the existing payment system. Specifically, it plans to

--eliminate the overhead screen,

--modify the productivity screens to agree with PHS productivity guidelines (see p. 23 for a description of the PHS guidelines), and

--increase the rate ceiling to $32.10.

These changes will increase the reimbursement rate for many clinics. For example, past application of the administrative overhead and productivity screens resulted in an average rate reduction of $9.81 per encounter in a clinic's reimbursement rate. HCFA analyzed the new productivity screens' impact on 239 clinics and determined the average rate per visit will increase by $1.59.

The increase in HCFA's payment limit from $27.30 to $32.10 will also benefit some clinics. As noted previously, 18 of 35 clinics we reviewed had their reimbursement rate limited by the $27.30 ceiling. Using a $32.10 ceiling, 9 of the 18 clinics would have had their rates lowered.

The above interim changes are not yet final. A proposal for the change in the maximum rate was published on December 23, 1980. All changes will be retroactive to March 1, 1980. The change, however, even if made retroactive, probably will not affect the decision of at least 69 clinics which relinquished their certification since March 1980.

Common cost report delayed pending revised reimbursement system

As discusssed in chapter 3, clinic officials consider HCFA reporting requirements complex, time consuming, and costly--an opinion made known to HCFA shortly after the establishment of the reporting requirements. In September 1979, in recognition of these criticisms, HCFA began working with PHS to develop a single reporting system. In August 1981, a HCFA official told us that no target date had yet been set for the common cost report's implementation. The official paid that the development of a common cost report has been delayed pending the development of a new reimbursement system and a definition of the new PHS role under the block grant concept.

HCFA, however, released a "simplified" version of the existing cost report in the autumn of 1980 to be used for fiscal year 1981. The original report consisted of 16 pages while the new report has been shortened to 8 pages. A HCFA official said that, under the new reporting requirements, clinics do not do calculations, but just provide a trial balance and utilization statistics, and the intermediaries do the calculations. Our analysis of the new cost report, however, showed that the same information is required on the revised report. The reasons the revised report has half the pages are the rearranging of the schedules and the use of longer paper.

The extent to which PHS reporting requirements will be eliminated or modified by the States under the block grant approach is not known.

Unknown number of potential certified rural health clinics

No accurate listing of potentially certifiable rural health clinics has been developed. As a result, HCFA cannot effectively market the program to eligible clinics. Initially, HCFA mailed about 2,500 applications to clinics believed to be eligible for certification. The mailing list was compiled quickly from several sources including PHS, the Indian Health Service, the National Rural Center, the Appalachian Regional Commission, and State agencies. The list included such obvious ineligibles as facilities not in rural areas and contained duplications. One HCFA official characterized this as a "shotgun approach" and believed it effectively reached all potential clinics. Many of these clinics, however, subsequently failed to qualify.

HCFA is currently compiling a revised list of potential rural health clinics. The new list is being compiled because HCFA has been criticized by HHS' Office of Service Delivery Assessment 1/ for not effectively marketing the program. In its August 3, 1979, report one-fourth of the clinics surveyed were not familiar with the act. The report said no summary discussion or brochure (apart from the Federal Register) was available, although PHS did contract with the National Rural Center for distribution of its summary. Many clinics did not receive the summary, however, because a comprehensive mailing list did not exist.

HCFA's approach toward State restrictions on physician extenders

As discussed in chapter 4, 10 States prohibit or substantially restrict the use of physician extenders in delivering primary health care. HCFA's stated goal is to encourage these States to modify their laws to allow independent practice by physician extenders, but HCFA has done very little to accomplish this goal.

HCFA reviewed State medical practice and nurse practice acts affecting physician extenders, obtained opinions from State attorneys general, and analyzed the basis for the opinions. For example, HHS regional counsels concurred with the opinions of the attorneys general in North Dakota and Montana, but disagreed with the opinion rendered by the Delaware Attorney General. According to an HHS regional counsel, no further action is planned to clarify differing positions held by HHS and Delaware.

Under this goal, HCFA has developed a report on the status of State medical practices' laws. The report is a compilation of information on nurse practitioner and physician assistant acts and the type of supervision required of them by the various States. The report identifies the States where the prohibition, nonrecognition, or direct supervision of nurse practitioners and/or physician assistants impedes establishment of certified clinics. However, because States retain the right to establish rules for medical practice, HCFA has limited its role to the above activities and not participated in efforts to change State laws.

All States reimburse clinics under Medicaid

HCFA's goal was to have all States include rural health clinic services as part of their Medicaid coverage. According to a HCFA official, all States with certified rural health clinics are

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1/The Office of Service Delivery Assessment was created within the Office of Inspector General to conduct short-term studies of HHS programs and services.

providing Medicaid reimbursement. New York and California, however, are the only States not reimbursing clinics using Medicare rates. In these States officials oppose using a Medicare fiscal intermediary to calculate payment rates for Medicaid. As a result, the State reimburses clinics under their Medicaid reimbursement system, using Medicare methodology.

HCFA VIEWS ON OMBUDSMAN

During September 1979 hearings, the Subcommittee on Rural Development, Senate Committee on Agriculture, Nutrition, and Forestry, expressed the view that officials from clinics, which are basically very small entities, need an ombudsman in HCFA headquarters and its regions to resolve problems quickly. While HCFA appointed a headquarters official to act as contact point for clinics, the creation of a regional position was left to the discretion of each regional office, and only Region I (New England) chose to do so.

The Region I ombudsman sent letters to rural health clinics to make them aware of his appointment, but he has had little contact with the clinics beyond this. For example, officials of two Maine clinics said they would contact their regional PHS project officer if they had a problem with the act. Officials representing four other Maine clinics said they invited the ombudsman to explain his role and discuss the act, but were refused because the ombudsman said he only responds to specific problems.

The two other HCFA regional offices contacted have assigned their staff rural health clinic responsibilities along with their other duties. Consequently, their involvement with the act and its implementation has been minimal. For example, neither HCFA's Atlanta nor Denver regional office staff communicates with clinics. An official from the Atlanta office further said that no special efforts are made to accommodate the rural health clinic program, such as visiting clinics or sponsoring workshops.

CONCLUSIONS

HCFA management of the act's implementation has been characterized by delays. The implementation of a more acceptable reimbursement system is expected to be about 3 years behind original estimates and not scheduled to be implemented until early 1983. This has resulted in HCFA's failure to develop a common cost report with PHS which could alleviate a major cause of clinic complaints concerning HCFA administrative requirements.

HCFA is currently working on its second attempt to establish a new reimbursement mechanism. This system should alleviate many of the existing problems. HCFA's proposed mechanism eliminates the overhead and productivity screens and replaces the national

ceiling with an upper limit based on the prevailing rates for general practitioners in each clinic's locality. This proposal should result in more acceptable Medicare reimbursement to clinics while placing an upper limit on charges which is consistent with the limits set for other primary health care providers.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We believe that the act has the potential to bring health care to the poor and elderly who live in rural areas and need supplemental health facilities. However, because many clinics we visited were located near physicians or other providers whom Medicare beneficiaries used, the act in this setting will never fully meet expectations.

Since HCFA has established goals which address some of the obstacles preventing broader implementation, our recommendations concern the reimbursement system which is the principal reason clinics relinquish their certification.

We recommend that the Secretary require HCFA to:

--Eliminate the administrative cost screen, adopt more realistic and flexible productivity standards, and replace the current rate ceiling with the planned $32.10.

--Replace the above system as soon as feasible with a prospective reimbursement system similar to the one currently being discussed, i.e., one without screens, with rates based upon the ratio of cost to charges, and with rates limited to the prevailing rate for similar services performed by physicians within the same geographical area.

HHS COMMENTS

In commenting on this report (see app. VIII), HHS told us that it shared our concerns about the effect on clinics of the administrative cost and productivity screens and the payment limit. HHS told us that it is currently analyzing public comments on its December 1980 proposed rule in preparation of publishing a final notice soon. Regarding prospective reimbursement, HHS is preparing a notice of proposed rulemaking which is expected to be published shortly.

APPENDIX I

CERTIFIED RURAL HEALTH CLINICS AS OF SEPTEMBER 30, 1981

Region I:	
Connecticut	0
Maine	20
Massachusetts	2
New Hampshire	3
Rhode Island	3
Vermont	7
	35
Region II:	
New Jersey	0
New York	14
Puerto Rico	0
Virgin Islands	0
	14
Region III:	
Delaware	0
District of Columbia	0
Maryland	0
Pennsylvania	21
Virginia	1
West Virginia	18
	40
Region IV:	
Alabama	18
North Carolina	50
South Carolina	5
Florida	12
Georgia	23
Kentucky	6
Mississippi	14
Tennessee	36
	164
Region V:	
Illinois	2
Indiana	1
Michigan	4
Minnesota	2
Ohio	13
Wisconsin	9
	31
Region VI:	
Arkansas	0
Louisiana	0
New Mexico	22
Oklahoma	1
Texas	2
	25
Region VII:	
Iowa	4
Kansas	5
Missouri	0
Nebraska	0
	9
Region VIII:	
Colorado	8
Montana	0
North Dakota	0
South Dakota	16
Utah	7
Wyoming	1
	32
Region IX:	
American Samoa	0
Arizona	6
California	35
Guam	0
Hawaii	1
Nevada	1
	43
Region X:	
Alaska	5
Idaho	6
Oregon	5
Washington	13
	29
Total	422

APPENDIX II

DESCRIPTION OF TERTIARY, SECONDARY, AND PRIMARY MEDICAL CARE 1/

Tertiary Medical Care and Health Services

Quality specialty care in a personalized fashion:

- --Specialized medical, diagnostic, and therapeutic services for unusual and complicated cases.
- --Specialized surgical care for unusual and complicated cases (neurosurgery, organ transplants, etc.).
- --Specialized dental care for unusual and complicated oral disease and surgery.
- --Emergency medical care.
- --Part of a comprehensive health care system.

Secondary Medical Care and Health Services

Quality secondary and referral care in an available and personalized fashion:

- --Medical and surgical diagnostic services for complicated problems.
- --Surgical care and medical care for complicated problems.
- --Services for major surgical and medical emergency problems.
- --Specialty dental care--orthodontics, endodontics, and periodontics.
- --Emergency medical care.
- --Part of a comprehensive health care system.

Primary Medical Care

Quality primary care and health services in an available, personalized, and continuous fashion:

- --Preventive services, case-finding services, and diagnostic and treatment for usual and uncomplicated illnesses and diseases.

1/Source: PHS' Health Care Initiatives Program Guidance Material, dated April 1978.

--Minor surgery and medical care for uncomplicated problems.

--Home care programs--nursing services.

--Preventive, diagnostic, and restorative dental services.

--Part of a comprehensive health care system.

--In large Area Health Centers, services for surgical and medical problems not requiring specialized personnel and equipment.

HCFA RESPONSIBILITIES BY ORGANIZATIONAL UNIT

Organizational unit	Overall responsibility	Rural Health Clinic Services Act
Bureau of Program Operations	--provide direction and technical guidance for the nationwide administration of HCFA's health care financing programs	--implement the act --implement any other rural health initiatives assigned --coordinate the overall administration of the the act --serve as a focal point for inquiries about the act
Bureau of Program Policy	--review existing policy and develop new policy concerning eligibility, coverage of benefits, utilization effectiveness of providers of services, reimbursement, limits to the cost of health care, and other administrative and technical matters for the Medicare and Medicaid programs	--simplify the cost report process --develop and interpret reimbursement and coverage policy
Health Standards and Quality Bureau	--direct activities to assure that health care services provided under Medicare and Medicaid are furnished economically consistent with recognized professional standards of care	--develop, interpret, and implement certification policy under the act --conduct training of surveyors who perform clinic certification surveys --monitor and report on survey and certification activities --market the program to potential rural health clinics --estimate the potential universe of clinics --analyze the effects of restrictive nurse practitioner/ physician assistant State laws
Office of Research, Demonstrations, and Statistics	--provide leadership and executive direction within HCFA for health care financing research, demonstrations, and statisticial activities pertaining to HCFA programs	--the office has awarded a 3-year grant to the University of Washington to evaluate the impact of the act--expected completion date is June 30, 1983

INTERMEDIARIES PROCESSING RURAL HEALTH CLINIC MEDICARE CLAIMS

1. Blue Cross of Western Pennsylvania--serving clinics in HHS Regions I, II, and III (except Vermont and Maine).
2. Blue Cross of Tennessee--serving clinics in HHS Region IV.
3. Mutual of Omaha Insurance Co.--serving clinics in HHS Regions V and VII.
4. Blue Cross of Colorado--serving clinics in HHS Regions VI and VIII (except Arkansas).
5. Aetna Life and Casualty--serving clinics in HHS Regions IX and X.
6. Blue Cross of New Hampshire-Vermont--serving clinics in Vermont.
7. Associated Hospital Service of Maine--serving clinics in Maine.
8. Arkansas Blue Cross --serving clinics in Arkansas.

RURAL HEALTH CLINICS INCLUDED IN REVIEW

Maine

Aroostook Valley Health Center, Ashland.

Arthur Jewell Community Health Center, Brooks.

Bingham Health Center, Bingham.

Bucksport Regional Health Center, Bucksport.

DFD Russell Medical Center, Leeds.

Madison Area Health Center, Madison.

Sacopee Valley Health Center, Kezar.

Vermont

Champlain Islands Health Center, Grand Isle.

Champlain Islands Health Center-North, Alburg.

Danville Health Center, 1/ Danville.

Mountain Valley Health Center, Londonderry.

Northern Counties Health Center - Greensboro, 1/ Greensboro.

Northern Counties Health Center - Hardwick, 1/ Hardwick.

Shorewell Health Center, Shoreham.

North Carolina

Aurora Medical Center, Aurora.

Bladenboro Community Medical Center, Bladenboro.

Hookerton Medical Center, 2/ Hookerton.

Hot Springs Health Program, Hot Springs.

Mountain View Medical Center, Hays.

Newton Grove Health Center, Newton Grove.

Snow Hill Medical Center, 2/ Snow Hill.

Walstonburg Medical Center, 2/ Walstonburg.

Tennessee

Community Medical Center, Deer Lodge.

Douglas Community Health Clinic, Stanton.

Gladeville Primary Care Center, 3/ Gladeville.

Hancock County Primary Care Center, Sneedville.

Hawkins County Health Department - Church Hill, Church Hill.

Hawkins County Health Department - Rogersville, Rogersville.

Lake County Health Department, Tipton.

Mid-County Primary Care Clinic, 3/ Lebanon.

Watertown Primary Care Clinic, 3/ Watertown.

South Dakota

Alcester Medical Clinic, Alcester.

Buffalo Community Health Center, Buffalo.

Faith Community Health Center, Faith.

Hamlin County Health Center, Bryant.

Lennox Area Medical Center, Lennox.

Mellette County Ambulatory Care Clinic, White River.

Miner County Health Center, Howard.

Mission Satellite Clinic, Mission.

Wall Rural Ambulatory Care Clinic, Wall.

1/One of the health centers comprising Northern Counties Health Centers, Inc.

2/One of the health centers comprising Greene County Health Care, Inc.

3/One of the health centers comprising Cumberland Family Health Care, Inc.

SCHEDULE SHOWING PRECISION ESTIMATES AT A 95-PERCENT CONFIDENCE LEVE

TO UNIVERSE OF MEDICARE BENEFICIARIES LIVING IN CLINICAL SERVI

State/clinics	Estimated Medicare population that used Part B services other than specialists (N)	Number in sample that used Part B services other than specialists (n)	Number that principally used clinics
Maine:			
Aroostook Valley Health Center	332	149	109
Bucksport Regional Health Center	726	133	31
Bingham Area Health Center	476	146	55
Madison Area Health Center	995	195	44
Arthur Jewell Community Health Center	410	151	44
DFD Russell Medical Center	846	164	50
Vermont:			
Northern Counties Health Centers	1,028	343	132
Champlain Islands Health Centers, Inc.	415	138	40
Mountain Valley Health Center	443	147	85
North Carolina:			
Aurora Medical Center	773	200	37
Bladenboro Community Medical Center	2,142	258	23
Newton Grove Medical Center	296	141	41
Mountain View Medical Center	2,064	247	11
Hot Springs Clinic	191	116	60
Greene County Health Care, Inc.	1,372	243	40

State/clinics	Estimated Medicare population that used Part B services other than specialists (N)	Number in sample that used Part B services other than specialists (n)	Sample: Number that principally used clinics	Sample: Percent that principally used clinics (P)	Precision estimates (note a) for projection (±) percent
Tennessee:					
Community Medical Center	184	94	26	28	6.3
Hancock County Primary Care Center	486	152	32	21	5.4
Hawkins County Health Department	2,054	153	1	1	1.5
Lake County Health Department	949	150	33	22	6.1
Watertown Primary Care Center	360	104	15	14	5.6
South Dakota:					
Alcester Medical Clinic	567	132	29	22	6.2
Buffalo Community Health Center	125	78	34	44	6.8
Faith Community Health Center	236	109	51	47	6.9
Hamlin County Health Center	523	171	39	23	5.2
Lennox Area Medical Center	1,181	179	29	16	4.9
Mellette County Ambulatory Care Clinic	162	95	72	76	5.5
Miner County Health Center	562	173	49	28	5.6
Mission Satellite Clinic	84	51	38	75	7.4
Wall Rural Ambulatory Care Clinic	643	164	36	22	5.5

1/Precision equals $t\sqrt{Pq \times N - n}$ where t = 1.96

P = percent who used clinics

q = 1 - P

n = sample size

N = Estimated Medicare Population that used Part B services other than specialist. The estimate was developed by obtaining ratio of n to total sample size and applying it to total Part B beneficiaries living in a clinic's service area.

APPENDIX VI

APPENDIX VII

STATISTICAL TEST OF RELATIONSHIP BETWEEN CLINIC CHARACTERISTICS AND MEDICARE BENEFICIARY UTILIZATION

To gain some insight into the differences in utilization rates between clinics, we tested the statistical relationships between Medicare beneficiary utilization and various clinic characteristics. Our analyses included determining Pearson product-moment correlation coefficients as discussed below. Although this test showed some statistically significant relationships, it should be noted that they are based on a relatively small number of clinics and that the tests do not prove the existence of any cause-effect relationships.

Correlation tests

The Pearson product-moment correlation coefficient measures the strength of linear relationships between two variables. The coefficient can assume any value from +1.00 to -1.00: +1.00 indicates a perfect, direct relationship between the two variables; -1.00 indicates a perfect, inverse relationship; and 0.00 indicates no relationship. Significance tests associated with the correlation coefficient measure the probability that the correlation observed was due to chance.

As shown below, three clinic characteristics had relatively high correlations with Percent Utilization by Medicare beneficiaries, and the relationships were statistically significant (less than 10-percent probability that they were due to chance).

Clinic characteristic	Correlation with beneficiary utilization	Significance (note a)	Number of clinics (note b)
		(percent)	
Percent of clinic revenue derived from patient fees (includes Medicare and Medicaid)	.584	1.4	17
Miles between clinic and closest alternate provider	.479	5.1	17
Total patient fees	.459	5.5	18

a/Probability that correlation observed is due to chance.

b/For some of the 20 clinics we could not obtain data on various characteristics.

APPENDIX VII

The correlations shown on the previous page provide some support for the hypothesis that large clinics (as measured by patient revenue) and clinics relatively distant from alternate providers have comparatively higher Medicare beneficiary utilization than other clinics.

APPENDIX VIII

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 22 1982

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "The Rural Health Clinic Services Act Has Not Met Expectations." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

For Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report Entitled, "The Rural Health Clinic Services Act Has Not Met Expectations"

Background

HCFA grants-sponsored research with the University of Washington has produced preliminary findings for certified clinics (i.e. meeting certain criteria for participation in Medicare and Medicaid) in Region X consistent with the GAO's conclusions and recommendations. Included in those findings are the following:

- Present cost-reporting and physician supervision requirements are perceived by rural health care providers as creating financial burdens, thereby deterring these clinics from seeking certification. The University is studying the utilization patterns of seven clinics in Washington who are not certified and where physician extenders are providing services to Medicaid recipients and Medicare beneficiaries (at no cost to Medicaid or Medicare).

- Utilization of 12 certified clinics by Medicaid recipients in Washington parallels the GAO's findings for Medicare beneficiaries. On average, only 16 percent of outpatient encounter visit claims (for non-aged Medicaid recipients residing in the service areas of these 12 clinics) were to these certified clinics. Even assuming seasonal adjustments, which are important because of employment patterns in logging and fishing, rural health clinic (RHC) use by Medicaid recipients is low; a wide divergence in use occurs between clinics. This can be attributed to two factors: the comparative geographic isolation of certain clinics; and, the historical relationship of the clinic to its surrounding community. For example, clinics which have depended on National Health Services Corps personnel are more apt to have high turnover, thus making it more difficult and less desirable for patients to establish ongoing relationships with these providers.

In addition to the University of Washington grant, we are also sponsoring research to determine if ambulatory care delivered by rural health clinics substitutes for inpatient hospital care. As yet, there are no findings available from this study. We are also in the process of selecting sites to implement the urban health clinics reimbursement study mandated by Congress under the Rural Health Clinics Act, P.L. 95-210. That study will provide data with regard to reimbursing physician extenders in cost-based and fee-for-service modes in physician-directed clinics located in urban medically underserved areas.

GAO Recommendations

That the Secretary require HCFA to:

-- eliminate the administrative cost screen, adopt more realistic and flexible productivity standards and replace the current rate ceiling with the planned $32.10;

-- replace the above system as soon as feasible with a reimbursement system similar to the one currently being discussed, i.e., one without screens, with rates based upon the ratio of cost to charges, and with rates limited to the prevailing rate for similar services performed by physicians within the same geographical area.

Department Comment

The Department shares GAO's concerns about the effects of the current administrative cost and productivity screens and the payment limit. We published the changes that GAO recommends in proposed form in 1980. We have analyzed the public comments received in response to these proposals and are preparing a final notice which is expected to be published in the near future. With respect to the recommendation regarding the prospective reimbursement methodology, we are preparing a notice of proposed rulemaking which we expect to publish shortly.

Technical Comments

The statement on page 2 regarding the Medicaid State plan requirements for RHCs would be stated more accurately as "The Act required States to include RHC services in their State plans when State law or regulation authorized independent practice by physician extenders."

On page 3, the report lists certain requirements clinics must meet to be certified. While these are the basic requirements a clinic must meet, the report should note that there are other regulatory requirements, i.e., concerning the facility and its operation, which must be met before it can be certified to participate.

With respect to the discussion on page 12, we note that at the 1979 congressional hearings, the Health Care Financing Administration (HCFA) was criticized because, although Congress had estimated 600 clinics should have been certified by 1979, only 371 were certified. We have since conducted a study of all clinics that met the locational and physician extenders requirements and found that of a total of 837 clinics, 597 are certified (176 have withdrawn).

The analysis on page 22 concerning the Medicare and Medicaid contributions to total revenue would be improved by comparison with utilization statistics. Because Medicare and Medicaid patients only comprise a small fraction of a clinic's total patients, it should not be surprising that Medicare and Medicaid payments are a small fraction of total revenues. A statement that a particular clinic's Medicare and Medicaid revenue is less than 10 percent could be better evaluated if its Medicare and Medicaid utilization were known.

We agree with GAO, as discussed on page 36, that intermediary costs are high; however, they are decreasing. The report should mention that intermediary costs are high in comparison to benefits paid, because of the low benefits paid per claim. The cost of processing a claim is less than the average cost per claim on Medicare Part A. GAO's chart on page 37 shows that, as volume increases, the average cost per claim usually decreases.

APPENDIX VIII

The report, on page 43, states that due to reductions in budget "... on-site inspections will not be made (and) there will be no assurance that clinic policies and procedures comply with Federal and State requirements." In light of budget reductions, we have been evaluating the survey process to determine if a more flexible method of resurveying could be instituted which would accommodate the budget reductions without compromising the health and safety of patients receiving treatment at these facilities. This would not only be used for RHCs; but, all other providers which are surveyed. As for initial surveys for RHCs not being performed, all State agencies have been instructed that initial surveys for all facilities are the first priority.

Finally, GAO discusses HCFA's attempts to develop an acceptable prospective reimbursement system. HCFA had developed a prospective reimbursement system in September 1980. As a result of HCFA sponsored meetings with the RHC community, it was determined that an alternative method should be developed. Accordingly, GAO should recognize HCFA's efforts in developing mechanisms to elicit more reaction from clinics with respect to the Notice of Proposed Rulemaking.

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