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Report to the Chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Reform and Oversight, House of Representatives

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RURAL HEALTH CLINICS

Rising Program Expenditures Not Focused on Improving Care in Isolated Areas

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Health, Education, and
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November 22, 1996

The Honorable Christopher Shays
Chairman, Subcommittee on Human Resources and
Intergovernmental Relations
Committee on Government Reform and Oversight
House of Representatives

Dear Mr. Chairman:

Two decades ago, the Rural Health Clinic (RHC) program was established to provide Medicare and Medicaid reimbursement to health clinics in underserved rural communities. Today, Medicare and Medicaid continue to reimburse RHC providers on the basis of their actual costs for providing care. Most other providers treating Medicare and Medicaid patients generally receive lower payments that are limited by set fee schedules. Since the fee schedules were established in 1989, the number of clinics participating in the RHC program has grown by over 30 percent a year to nearly 3,000. Combined Medicare and Medicaid payments to them are expected to be over $1 billion annually by the year 2000. This trend has raised questions about the benefits that program expenditures are providing to underserved Medicare and Medicaid populations.

In response to your request, we studied the following questions:

- Is the RHC program serving a Medicare and Medicaid population that would otherwise have difficulty obtaining primary care?
- Are controls in place to ensure that costs claimed for reimbursement are reasonable and to target the cost-reimbursement benefit of the program to clinics needing it for financial viability?

Our review was performed using available national statistics and information from our own detailed analysis of RHCs in four states—Alabama, Kansas, New Hampshire, and Washington. Our detailed analysis included such matters as where clinics were located, how many Medicare and Medicaid beneficiaries they served, the amounts and types of costs they claimed for reimbursement, and how their service patterns had changed from 1992 to 1994. Details of our objectives, scope, and methodology are in appendix I.

Results in Brief

Contrary to its original purpose, the RHC program is generally not focused on serving Medicare and Medicaid populations having difficulty obtaining primary care in isolated rural areas. Rather, our work suggests that the additional Medicare and Medicaid payments (estimated at $295 million for 1996) provided to RHCs increasingly benefit well-staffed, financially viable clinics in suburban areas that already have extensive health care delivery systems in place. Most RHCs are conversions of existing physician practices that generally do not need or use the benefits under the program to enlarge the size of the practice or take other actions to expand care provided to underserved portions of the area's population. Nevertheless, RHC providers receive extraordinarily high reimbursement for each patient visit for Medicare and Medicaid services at many clinics, as much as $214 for each patient visit at one clinic in our sample compared with an average of $37 received by providers on the Medicare fee schedule.

Contributing to this problem are the program's broad eligibility criteria, and the requirement that the Health Care Financing Administration (HCFA) reimburse all RHCs at cost, even if they are already financially viable using standard Medicare and Medicaid payment methods. The situation is exacerbated by HCFA's not using its authority to set maximum payment limits for nearly half of the RHCs that are operated as a part of a hospital or other facility or implementing the screens necessary to determine whether claimed costs at independent or facility-based RHCs are reasonable. As a result, we found examples where a hospital-owned clinic claimed overhead costs that were 120 percent of the direct costs of running the clinic and an independent clinic claimed $270,000 in compensation for each of its four staff physicians. In addition, once certified, RHCs remain eligible for cost reimbursement indefinitely, even if the area they serve no longer qualifies as rural or underserved.

To bring about improvements needed to direct assistance toward those rural areas that the program was originally intended to serve, both the Congress and the Secretary of Health and Human Services (HHS) will need to establish additional eligibility criteria and controls over the cost-reimbursement benefit of the program.

Background

In 1977, many rural communities were facing a disconnect between their health care delivery systems and Medicare and Medicaid, the nation's primary health insurance programs for the elderly and the poor. Many isolated rural communities that had not been able to attract or retain a physician had come to rely on clinics that did not follow the traditional

model of physician delivery of medical services. These rural clinics were staffed by specially trained nurse practitioners and physician assistants who acted as either the primary care provider or assistants to overworked sole physicians. However, services rendered by these nonphysician providers were not covered by Medicare unless they were under the immediate supervision of a physician, and coverage under Medicaid was at the state's discretion. As a result of this and other factors, some rural clinics were confronted with serious financial problems. The Congress became concerned that without Medicare reimbursement, many of these clinics could never become self-sufficient and would be forced to close, leaving many areas without primary health care services. Therefore, Public Law 95-210 authorized Medicare and Medicaid reimbursement to nonphysician primary care practitioners in RHCs.[1]

The RHC program is one of the few federal programs that is able to address underservice in small communities that do not have a traditional health care system in place. Other assistance programs, such as the National Health Service Corps, which places providers in underserved areas, generally require that such a system be present. With their nontraditional approach, RHCs can provide care in areas where a traditional system is not financially viable. Appendix II shows where RHCs were located throughout the nation near the end of 1995.

The RHC program is administered by HCFA, which must certify as RHCs all primary care providers requesting this status if they practice in a rural and underserved area and meet the conditions of participation for the Medicare program as determined by the state's survey agency. An RHC may be operated as an independent clinic or as part of a larger facility, such as a hospital. Medicare and Medicaid pay independent and facility-based RHCs differently, but both generally reimburse RHCs on the basis of the actual costs of providing services. This practice continued in the 1980s, when the Medicare program established maximum fees for services that would be paid to most other providers. These new payment systems were developed because paying for services on the basis of costs or charges created incentives for inefficiency and cost escalation. However, RHCs continue to receive cost-based reimbursement out of recognition that some clinics might not be financially viable under a fee schedule approach.

[1]Certified Nurse-Midwives in RHCs also became eligible for reimbursement in 1989 (P.L. 101-239).

Program Is Not Targeting Underserved Medicare and Medicaid Populations

The RHC program has grown rapidly since 1990, but not in those locations where Medicare and Medicaid populations are having difficulty obtaining primary care. At many of the locations that we were able to analyze in depth, primary care was already available to the Medicare and Medicaid population, and certifying an RHC appeared to have little or no effect on the availability of care for any remaining underserved segments of the population.

Growth Primarily in Areas With Established Health Care Systems

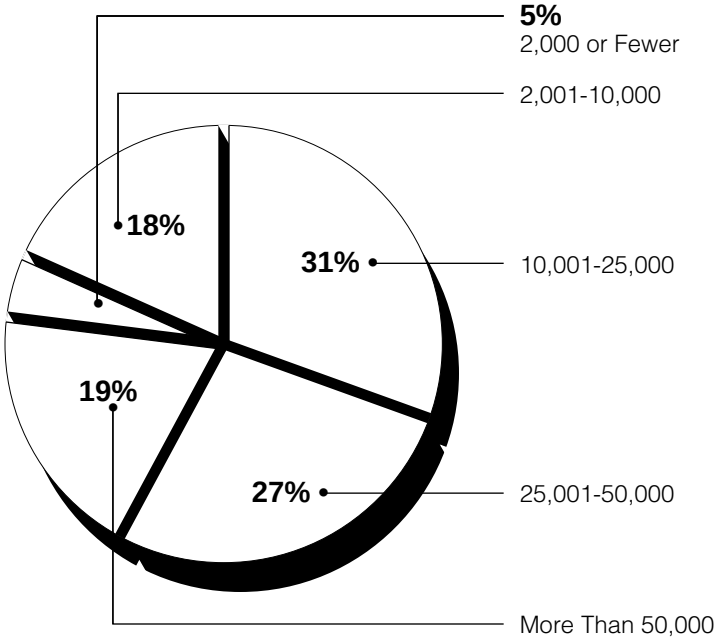
RHCs are increasingly being certified in areas with substantial populations rather than in remote rural areas. The program was designed to primarily benefit areas where population densities are insufficient to attract and support a physician-run clinic.

The National Health Service Corps' benchmark for the minimum number of people needed to place a full-time primary care physician is 2,000, according to the Chief of Site Development and Placement; however, as of November 1995, only 5 percent of all RHCs were in areas with fewer than 2,000 people[2] living within 15 miles[3] (see fig. 1). Even adjusting this benchmark upward to 10,000 people would account for less than 25 percent of RHCs.

[2]Population data as of 1990 census.

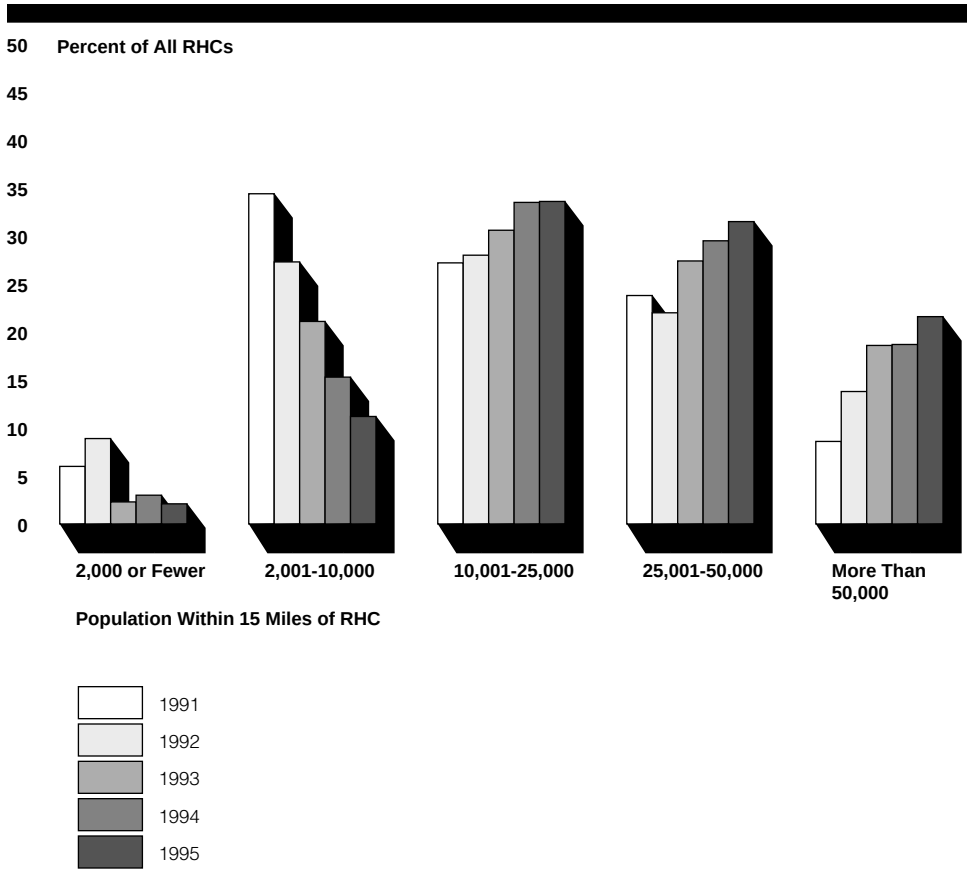
[3]The Bureau of Primary Care within HHS considers that in rural areas with poor access roads, 15 miles is the maximum acceptable distance for patients to have to travel to a primary care provider. For areas with better roads, the normal acceptable distance is 20 to 25 miles.

Figure 1: Distribution of RHCs by Population Living Within 15 Miles



In contrast, 19 percent of RHCs had 50,000 or more people living within 15 miles of them, and this trend is increasing. As figure 2 shows, the percentage of RHCs certified each year in areas with 50,000 or more people increased from almost 9 percent to 22 percent from 1991 to 1995, while the percentage for areas with populations of 10,000 or fewer decreased from 34 percent to 11 percent.

Figure 2: RHCs by Population and Year Certified, 1991-95



Appendix III provides more detailed information on where RHCs are located in our four sample states.

Our analysis indicates that many of the areas in which RHCs are being certified are not only well-populated but also have existing—and extensive—primary health care systems. We performed a more detailed review of communities in Alabama, Kansas, New Hampshire, and Washington, where 144 RHCs had been certified. Of these locations, 75 percent had primary care available to Medicare and Medicaid beneficiaries before an RHC was certified. The main reason for this was that over 65 percent of the 144 RHCs were conversions of existing physician practices in the community that had been reimbursed by Medicare and Medicaid for years. For example, physicians in New Hampshire had been

practicing an average of over 18 years before converting their practices to RHCs, while those in Kansas and Alabama had been practicing an average of over 15 years.[4]

Moreover, most communities also had additional health resources available before RHC certification, indicating the presence of a well-developed health care delivery system. For example, at the time the RHC was certified in Moses Lake, Washington, this community—with a surrounding population of 25,000—had 17 practices with primary care providers, a number of specialty practices, one hospital, two skilled nursing facilities, a mental health facility, a hospice, and a home health agency. Of the 144 RHCs in the four states reviewed, 57 percent had anywhere from 2 to 18 primary care practice sites already in place, as well as a combination of other specialized health care providers and facilities.

Sparsely populated, underserved communities still exist, and efforts to establish RHCs in such locations appear minimal. For the four states in our analysis, we noted that many communities with fewer than 5,000 people had no Medicare or Medicaid primary care provider. Neither HCFA nor the state rural health offices were aware of any efforts to actively target and establish RHCs in these locations.[5] Instead, many RHCs were certified in the same city where existing RHCs or other federally funded clinics were already in place. Nationwide, 37 percent of the 2,599 RHCs certified near the end of fiscal year 1995 were located in the same community as other RHCs or federally qualified health centers (FQHC),[6] with 74 cities having 3 to 6 RHCs. For example:

- 31 percent of the 144 RHCs in our four-state sample were in cities having 1 to 3 other RHCs or FQHCs and
- the city of Marianna, Florida, now has 7 RHCs for the 30,000 people living within 15 miles, and 4 additional RHCs are 20 miles away in Chipley, Florida, a community of 3,800.

[4]Similarly, a nationwide survey conducted by the National Rural Health Clinic Association in 1994 found that nearly 74 percent of 487 RHCs had been in operation as private practices an average of over 12 years before they were certified as an RHC.

[5]HHS' Inspector General reported that a more rational and strategic placement of RHCs was needed to ensure that government funding increased access to care. See Rural Health Clinics: Growth, Access and Payment, HHS Office of the Inspector General, OEI-05-94-00040 (Washington, D.C.: 1996).

[6]Like RHCs, FQHCs receive cost reimbursement from Medicare and Medicaid, and they may also receive federal grant funding to address underservice.

RHCs Generally Not Decreasing Distance to Care

While the RHC program was created to develop or expand the availability of health care in local communities, we did not find indications that the growing number of clinics were decreasing the distance that beneficiaries traveled for care. Our review of Medicare and Medicaid claims data for 119 clinics in our four-state sample showed that the availability of care within communities did not change appreciably for at least 90 percent of Medicare and Medicaid beneficiaries after the RHC was certified. At least 73 percent of the more than 42,000 Medicare and Medicaid beneficiaries using RHCs in our sample had previously obtained care from a primary care provider in the same city in which they lived or the same city in which the RHC was. For example, of 203 Medicare and Medicaid beneficiaries currently obtaining primary care at an RHC serving a surrounding community of nearly 60,000 in Hutchinson, Kansas, only 15 were traveling more than 15 miles for care before the RHC was certified.

Claims data were not available to identify the increased access to care that the RHC program provided for populations other than Medicare and Medicaid beneficiaries; however, RHCs are not required to address underservice in the community. While many RHCs qualify for the program because the overall population is designated as underserved, less than half of the 76 RHCs we surveyed said that they used the program to expand their staff or increase the number of patients they see. Even when certified for areas underserved only for specific population groups, 86 percent of the RHCs said that the program had not influenced the type of patients they serve in the community. Regardless of how the underserved area is defined, most RHCs believe that the uninsured poor make up the majority of underserved people in their community; however, only 16 RHCs offered services on a sliding fee scale based on the patient's ability to pay for care.[7] One RHC said that some of its physicians would not accept Medicaid beneficiaries as patients unless they were in the state's managed care program.[8]

Program's Benefits Best Exemplified by RHCs in Smallest Locations

Despite the lack of clear program effect in most locations, we did find instances in which the RHC program improved access to care for Medicare and Medicaid beneficiaries. About 3,500 of the 42,500 Medicare and Medicaid beneficiaries in our four-state sample reduced the distance that they had to travel for care by a median of 20 miles (to fewer than 15 miles)

[7]Most clinics said that they would treat or refer all patients requesting care; however, other federal programs require a sliding fee scale to improve the likelihood that the uninsured poor will seek care.

[8]In some states, such as Washington, that have Medicaid managed care programs, RHCs receive higher capitated payments than other providers.

by using the RHC. Those RHCs most successful in improving access tended to locate in communities without Medicare or Medicaid providers or in areas having a population of fewer than 5,000 within a 15-mile radius. Following are some examples:

- Wadley, Alabama, a community of just over 500, was unable to support a primary care practice until a nearby hospital set up an RHC staffed by a part-time nurse practitioner. Distance to care was reduced by a median of 18 miles for 46 of the 118 Medicare beneficiaries using this clinic in 1994.
- A hospital district in eastern Washington uses three family physicians and two physician assistants to run an RHC in Ritzville and two satellite clinics, about 15 and 30 miles away, respectively. Distance to care was reduced by a median of 48 miles for at least 80 of the 507 Medicare beneficiaries using these clinics in 1994.

Broad Eligibility Criteria Allow Growth in Areas Where Need Is Minimal

A key reason that RHCs may be certified in areas unlikely to improve access to care is the broad eligibility criteria, which provide no requirement or incentive for RHCs to locate in places with little or no existing medical infrastructure. To be certified as an RHC, a practice must basically meet two tests in addition to meeting the normal conditions for participation in Medicare:[9] it must be located in a rural area, and the area must be designated as underserved. However, both tests are easily met, and there are no additional requirements to ensure that the enhanced payments under the program will be used to hire more providers or see more patients.

Definition of Rural

Under the law authorizing the RHC program, rural refers to any area not designated as urbanized by the Bureau of the Census. Under this definition, cities, towns, or census areas with populations under 50,000 are considered rural. While the Census Bureau generally defines rural as areas with populations of fewer than 2,500, even these areas may be located near other cities that together constitute a substantial population base. Nearly 500 RHCs have populations of from 50,000 to more than 1 million within 15 miles of them.[10]

Definition of Underserved

Under the law authorizing the RHC program, underserved refers to a federally designated health professional shortage area (HPSA), a medically

[9]Under federal law, clinics meeting the conditions of participation for Medicare automatically meet conditions of participation for Medicaid.

[10]The median population surrounding these clinics was 83,000.

underserved area (MUA), or a state-designated underserved area.[11] In an earlier report, we pointed out several problems with the federal underservice designations that need to be addressed before these designations can be effectively used for targeting resources to the underserved.[12] For example, more than half of the underservice designations may be invalid because they are outdated or do not consider a significant number of primary care providers, such as nurse practitioners or physician assistants, whose services are promoted by the RHC program. Using the designations as they currently stand provides no assurance that RHCs are only being permitted in areas that have insufficient numbers of primary care providers. HHS' Inspector General[13] and administrators of the underservice designation systems have said that HCFA needs to establish additional program-specific screening criteria to better identify areas needing RHCs; however, HCFA has not yet decided whether to request a change in legislation for this purpose.

Controls Are Not in Place to Ensure Reasonable Costs and Effective Targeting of Funds

Because the RHC program's cost-based reimbursement is usually more generous than Medicare and Medicaid fee schedules, adequate controls over claimed costs are particularly important. Using 1993 claims data, we estimate on average that Medicare paid at least 43 percent more for cost-based reimbursement to RHCs than it paid to other providers who were paid using the fee schedule, while Medicaid paid at least 86 percent more. Assuming this same difference between cost-based and fee schedule payments continues, reimbursing RHCs will cost Medicare around an additional $100 million and Medicaid about $195 million in 1996.[14]

We found four problem areas that may result in unneeded expenditure of a portion of these Medicare and Medicaid funds: (1) no limit on payments made to facility-based RHCs, (2) no screening to determine if claimed costs are reasonable, (3) an inability to target cost-based reimbursement where needed for financial viability, and (4) no mechanism to discontinue cost-based reimbursement if the RHC's location is no longer rural or underserved.

[11]An HPSA is generally defined for a geographic area or a specific population group having fewer than one primary care physician for every 3,500 people. An MUA uses additional factors besides primary care shortages, such as the infant mortality rate, percentage of population with incomes below the poverty level, and percentage of population age 65 and older. HHS may also designate areas as underserved on the basis of the recommendation of state governors.

[12]Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995).

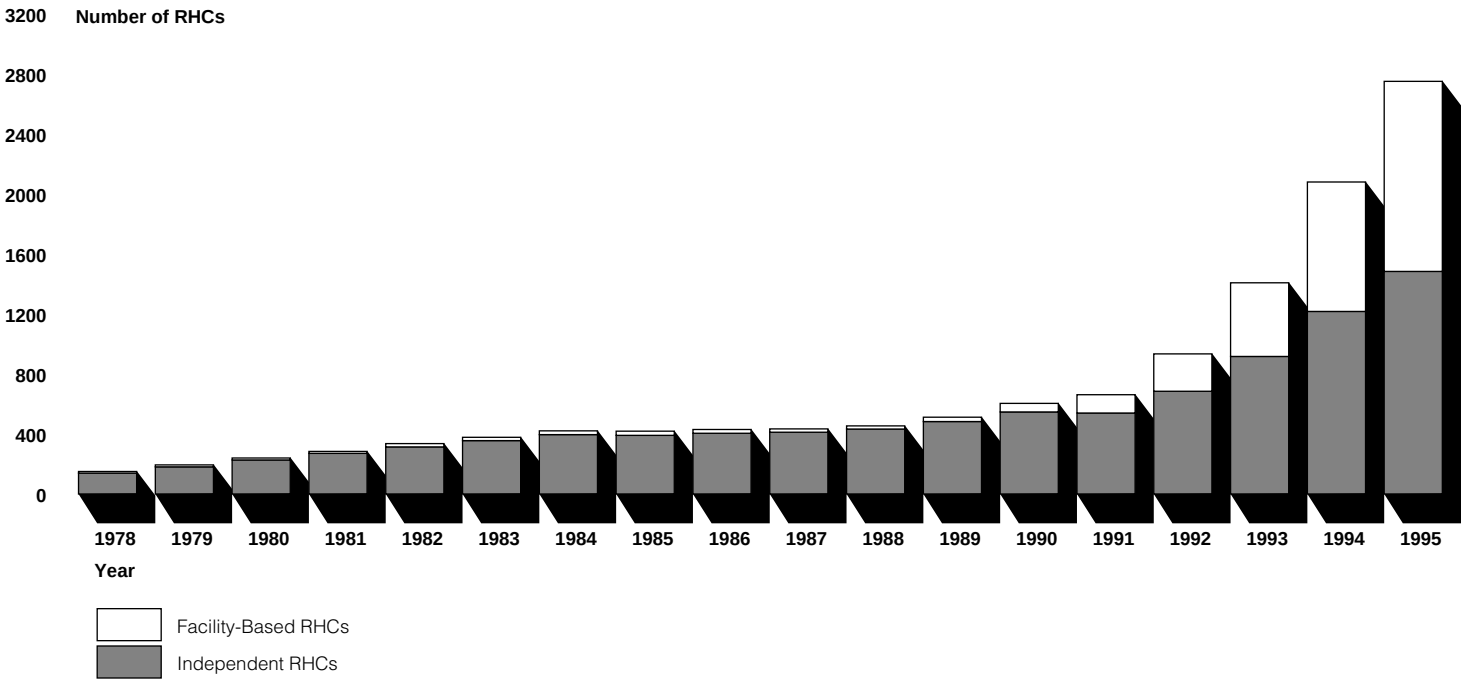
[13]See Rural Health Clinics: Growth, Access and Payment, OEI-05-94-00040.

[14]The actual added cost to the Medicare and Medicaid programs is likely to be higher due to data limitations explained in app. I.

Controls Are Lacking on Payments to Facility-Based RHCs

Nationwide data on ownership patterns show that nearly half of all RHCs are operated by a facility such as a hospital, skilled nursing facility, or home health agency.[15] As of 1990, there were only 57 facility-based RHCs, but their number has grown so rapidly in recent years that at the end of 1995 there were 1,267, or 46 percent of all RHCs (see fig. 3).

Figure 3: RHCs by Ownership Type, 1978-95



This ownership trend has implications for Medicare and Medicaid expenditures because facility-based RHCs are not subject to the same cost-reporting requirements[16] and the annually adjusted limit, currently $56, on the cost per visit as are independent RHCs. HCFA has not determined

[15]Facility-based clinics may be located within the facility or set up as separate clinics either in the same community or in a different city and state.

[16]Cost reports for facility-based RHCs include only summary cost data, while those for independent RHCs include a break out of costs by line item; the number and type of clinic staff; and the number of patient visits at the RHC, which is subject to a productivity standard for Medicare and Medicaid payment. Facility-based RHCs are exempt from these requirements even though they are often operated as a separate clinic in a different community from the administering facility.

how much more these facility-based RHCs receive from Medicare and Medicaid as a result, but indications are that their average cost per visit is often substantially higher. For example, our review of cost reports submitted by a sample of 28 facility-based RHCs in 1993 and 1994 showed that they were paid up to $214[17] per Medicare patient visit while the maximum amount paid to independent RHCs in these years was about $55.[18]

HCFA officials said that they did not establish cost limits for facility-based RHCs, as they did for independent RHCs, because few facility-based RHCs were certified when the program began and it was easier to reimburse these RHCs the same way as Medicare paid the facility's other outpatient departments, on the basis of the lower of costs or charges for services. Similarly, while HCFA estimates that Medicare and Medicaid payments to RHCs will be close to $1 billion by the year 2000, this estimate excludes Medicare payments that will be made to facility-based RHCs as well as year-end adjustments that can increase payments to RHCs. HCFA has established a working group that is addressing the issue of payment limits for facility-based RHCs but has no estimate of when regulations will be issued.

Screens for Reasonable Costs Not Used for RHCs

While HCFA has established an overall payment limit for independent RHCs, it has not implemented screening guidelines to assess whether claimed costs of operating both independent and facility-based RHCs are reasonable. These screening guidelines can be used to disallow costs in cases where provider salaries are excessive or overhead costs are disproportionately high. Because these guidelines were never implemented, RHCs have no apparent limits on the amount or type of costs they claim for Medicare and Medicaid reimbursement. For independent RHCs, our sample of 228 cost reports provided the following examples:

- Compensation for physicians at 23 percent of the RHCs exceeded the national mean of $127,000 by up to 50 percent or more. One clinic, for example, claimed the equivalent of $270,000 for each of its four physicians.
- Some clinics claimed substantial costs related to hiring consultants or incorporating the business. For example, one independent RHC with a full-time physician, nurse practitioner, and other clinical staff claimed just

[17]The range of Medicare payments was $24 to $214, with a median payment of $73. Only cost reports covering a full 12-month period and those with Medicare charges consistent with HCFA claims data were used for this analysis.

[18]Costs claimed for reimbursement by independent RHCs in 1993 ranged from about $16 to $130 per patient visit, with about half of the independent RHCs claiming costs in excess of the payment limit.

under $140,000 during a 10-month reporting period for the compensation of a "clinical consultant."

Criteria to determine whether claimed overhead costs are reasonable are especially needed for facility-based RHCs. HCFA eliminated overhead screens for independent RHCs in 1982, stating that the maximum payment limit established for them was sufficient for this purpose. However, facility-based RHCs are not subject to this limit and their overhead costs are generally higher because in addition to the direct overhead costs incurred by the clinic, the administering facility allocates a portion of its own overhead costs to the clinic for Medicare and Medicaid reimbursement. This shifting of costs to RHCs for overhead categories such as the hospital cafeteria or nursing administration occurs whether the RHC is located within the facility or in a city that is 30 miles away. Our review of 28 cost reports for facility-based RHCs showed that indirect overhead costs allocated by the hospital added from 8 percent to 120 percent to the RHC costs claimed for Medicare reimbursement.[19]

Some states have reduced the amount of Medicaid payments for this cost-shifting at facility-based RHCs, while other states use Medicare's method.[20] An Alabama Medicaid official estimated that the state's action limits the amount Medicaid pays to hospital-based RHCs in the state to about 5 to 10 percent more than payments to independent RHCs. In contrast, HCFA officials estimate that Florida, which reimburses hospital-owned RHCs in the standard manner, paid these RHCs at more than twice the rate paid to independent RHCs.

We heard arguments both for and against allowing hospitals and other facilities to shift a portion of their overhead costs to RHCs. However, we found no evidence to support the assumption that the increased payments resulting from such allocations improved RHC service to Medicare beneficiaries. For example, costs for Medicare services at one RHC increased by 66 percent after converting its ownership status from independent to hospital-based. As an independent RHC in 1994, this clinic claimed costs of $50 per Medicare visit, while as a hospital-owned RHC in

[19]The median amount of hospital overhead allocated to the clinics was 33 percent.

[20]States have done so by limiting payment to the lower of costs or charges for services at the RHC. Under this methodology, payments are usually based on charges that include a lower percentage of facility overhead allocations. Other states follow Medicare's payment methodology, which combines the costs and charges of the RHC with all other outpatient departments and then pays on the basis of the lower of the aggregate costs or charges. Under this methodology, RHCs are generally paid on the basis of costs. This payment method, because it includes a higher percentage of facility overhead allocations, results in Medicare's paying some RHCs three times or more than what they charged for services.

1995, costs per visit rose to $84. The RHC reported the same staffing levels but 30 percent fewer Medicare beneficiary visits in 1995.

Cost Reimbursement Not Targeted to RHCs Needing the Subsidy to Survive

The decision to establish cost-based reimbursement for RHCs was largely made out of concern that this payment method could help increase beneficiary access by subsidizing the operation of clinics that might otherwise be unable to survive financially. For example, financial problems may exist for RHCs in communities too small to generate enough patient visits or until new clinics establish a sufficient patient base. However, under the law, all RHCs qualify for cost-based Medicare and Medicaid reimbursement even if they have a substantial patient base.[21]

We asked the 76 clinics in our four-state sample about the importance of cost reimbursement to their financial viability. Some newly established clinics said that it was necessary only for the first few years while an adequate patient base was being established. Most of the remaining clinics said that they would be financially viable without cost reimbursement, but they thought it should be continued because payments under Medicare and Medicaid fee schedules were too low. Representatives and consultants for small rural hospitals owning RHCs told us that the reimbursement benefits under the program helped keep their hospitals financially viable by offsetting the negative effects of Medicare and Medicaid reimbursement reform and helping them compete against other hospitals moving into the area. Representatives from independent clinics also said that cost reimbursement allowed them to better compete for patients by paying higher salaries to retain physicians or recruit additional ones to their practices.

Cost reimbursement—along with other financial assistance—is still important for clinics locating in areas with small populations, according to RHC officials. Starting RHCs in such areas appears to remain a somewhat risky financial venture that is helped by institutional sponsorship. In our four-state sample, those few clinics among our 76 that had been started as new RHCs in smaller locations were generally sponsored as satellite clinics by a hospital, government entity, or independent provider network trying to ensure coverage of its service area. For example, several such RHCs in Washington are owned by hospital districts that have taxing authority to support the clinics financially. Such sponsorship was considered

[21]For example, our review of 228 cost reports for independent RHCs for the years 1993 through 1995 showed that 44 percent of the independent RHCs reported patient visits in excess of the national average of 7,200 for a primary care physician practice, with over 10 percent having 20,000 or more visits.

necessary, officials said, because the benefits of the RHC program alone were not enough to overcome the difficulties associated with starting a clinic in a sparsely populated rural area. Our review of clinics established within the past 5 years showed that independent RHCs were more than twice as likely to be terminated than those owned by facilities. However, even facility-based RHCs fail without sufficient community support. For example, two hospital-sponsored clinics in Alabama and one in Washington, unable to attract a sufficient patient base for a full-time practice, closed within 2 years because patients chose to travel to providers in other communities for care or obtained care from competing providers within the same community.

Subsidies Are Not Discontinued When RHCs No Longer Meet Initial Program Criteria

Under current law, HCFA must continue cost-based subsidies to RHCs indefinitely, even for clinics that are no longer located in underserved or rural areas.[22] This is significant because many areas of the United States that were considered rural under the program in 1978 may now be part of an urbanized area. For example, an RHC was established in 1978 in Merced, California, when the city's population was about 36,000. Merced's 1990 population was more than 56,000—above the maximum of 50,000 under the program's eligibility criteria. Similarly, areas considered underserved 15 years ago may now have an adequate number of primary care physicians. For example, one RHC in Marysville, Washington, was the only Medicare and Medicaid provider when first established in 1978. Since that time, 15 other primary care practices have been established in an area that now has a population of 272,000 within 15 miles of the RHC. This RHC continued to receive cost-based payments under the program through 1994.

Conclusions

The RHC program is adrift without focus on its original goal of assisting underserved rural communities or controls over costs to the Medicare and Medicaid programs. As it continues to grow—primarily in well-populated areas with established health care systems—there is little evidence to demonstrate that this growth is directed at improving access to care on the part of Medicare or Medicaid beneficiaries or other underserved segments of the population. Creating controls to do so is important because the program is often used as a way to increase the revenue of existing clinics that may already be financially secure or to subsidize those clinics or hospitals that are failing due to inefficiency or lack of community support.

[22]RHCs may lose their certification, however, if they fail to meet the conditions of participation for the Medicare program or change ownership.

The law defines rural and underserved areas too broadly to ensure that the program is directed and maintained in those rural communities with a critical shortage of primary care providers. In our view, the key to reorienting the program is to ensure that its most attractive feature for providers—cost-based reimbursement—is tied to additional program criteria developed to meet a clear program goal and that it is not used merely as a competitive tool or avenue to indefinitely circumvent the effects of Medicare and Medicaid payment reforms. Success in meeting the original purpose of RHCs requires more active management at the federal, state, and local levels to identify specific locations where clinics are needed and to determine when financial assistance can reasonably be discontinued.

Recommendations to the Congress

To refocus the RHC program to meet its original purpose, the Congress should amend the law to

- restrict the cost-based reimbursement benefit of the program to (1) RHCs in areas with no other Medicare or Medicaid providers or (2) RHCs that can demonstrate that existing providers will not accept new Medicare or Medicaid patients and that the funding will be used to expand access to them and
- require periodic recertification to ensure that clinics continue to meet eligibility requirements for cost reimbursement.

Recommendations to the Secretary of Health and Human Services

For those RHCs that continue to be reimbursed on a cost-reimbursement basis, the Secretary of HHS should direct the Administrator of HCFA to

- revise Medicare payment policy (which Medicaid generally follows) to hold facility-based RHCs to the same payment limits and cost-reporting requirements as independent RHCs and
- apply reasonable cost principles to such categories as salaries and overhead claimed for reimbursement by RHCs.

Agency Comments and Our Evaluation

In commenting on a draft of this report (see app. IV), HHS stated that the results of our study clearly show that the RHC program is not maximizing its contribution to the safety net for underserved populations. HHS agreed with the report's overall conclusions and recommendations to the Department.

More specifically, HHS concurred with our recommendation that HCFA revise Medicare payment policy to hold facility-based RHCs to the same payment limits and cost-reporting requirements as independent RHCs. HHS stated that HCFA is in the process of developing proposed regulations that would implement a similar upper payment limit for facility-based RHCs. HHS also agreed with our recommendation that HCFA apply reasonable cost principles to such categories as salaries and overhead claimed for reimbursement by RHCs. HHS said that it would direct Medicare contractors to increase the level of scrutiny on all costs incurred by RHCs, particularly in such categories as salaries and overhead.

While HHS did not comment on our specific recommendation to the Congress that the law be changed to provide additional program eligibility criteria, HHS did concur with the basis for the recommendation. HHS agreed with our conclusion that the current program eligibility criteria for defining rural and underserved areas does not go far enough to ensure that the program is directed and maintained in rural communities with critical shortages of primary care providers. HHS suggested that further documentation of the need for health care services in the target community be required for RHC certification and cited the FQHC program as an example of the workability of this approach. We agree with HHS' comments on the critical need and possibilities for additional program eligibility criteria. However, to accomplish this, a change in law along the lines that we recommend would be necessary.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days after its issue date. At that time, we will send copies to the Secretary of HHS, the Director of the Office of Management and Budget, appropriate congressional committees, and other interested parties. We also will make copies available to others on request. Please contact me on (202) 512-7119 if you or your staff have any questions on this report. Major contributors to this report are listed in appendix V.

Sincerely yours,

Bernice Steinhardt
Director, Health Service Quality
and Public Health

Contents

Abbreviations

FQHC	federally qualified health center
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HPSA	health professional shortage area
MUA	medically underserved area
RHC	rural health clinic

Objectives, Scope, and Methodology

Improving Access to Care

Our first objective was to determine whether the RHC program was serving a Medicare and Medicaid population that would otherwise have difficulty obtaining primary care. The purpose of the program is to assist small rural areas relying on nonphysicians or overworked sole physicians for care. Therefore, we focused on where RHCs were located in terms of the population of the communities they served and the number of other primary care resources available. Because it is possible that these providers were not available to all Medicare and Medicaid beneficiaries, we identified the distances that beneficiaries had to travel to obtain primary care before the RHC was certified.

Using mapping software, we established each RHC as the center of a circle with a 15-mile radius and plotted 1990 population data from the Census Bureau to identify how many people lived within the area of these circles. We chose the area within a 15-mile radius as the RHC service area because this is the maximum distance that HHS' Bureau of Primary Health Care considers reasonable for travel for primary care given the worst type of existing rural road conditions.

We next focused our review on four states to determine the other primary care resources available to Medicare and Medicaid beneficiaries. We judgmentally chose Alabama, Kansas, New Hampshire, and Washington on the basis of differences in geography, types of underservice, number and mix of RHCs, and variances in the Medicare and Medicaid reimbursement rates. We excluded those states that had recently been reviewed by HHS' Inspector General and that were scheduled to be reviewed under an HCFA contract. For these four states where 144 RHCs had been certified,[23] we contacted the fiscal intermediaries processing Medicare and Medicaid claims and from each obtained the database of Medicare and Medicaid providers. We screened these databases for primary care providers using the provider type and specialty codes and aggregated them by practice address. We then counted how many primary care practice sites existed in communities before and after the RHCs were certified.

Our last step was to identify how far Medicare and Medicaid beneficiaries had to travel to obtain care before RHCs were certified in their community. We did this by analyzing Medicare and Medicaid claims data for all beneficiaries using any of the 119 RHCs in our four-state sample that were certified in 1993 and 1994. Our analysis included computing the differences in miles between where the beneficiaries lived and where the

[23]The 144 RHCs account for all RHCs certified in New Hampshire and Washington but only those certified in 1993 and 1994 in Kansas and Alabama.

RHC or prior primary care provider was located. We excluded those beneficiaries from our analysis that had moved during the time period and for which prior provider data were unavailable. We also telephoned 76 of the 119 RHCs within our four-state sample and asked them whether the program had any influence on expanding their staff, the number or type of patients they see, or changing their practice to address the reasons underservice existed in their communities.

Controlling Program Costs

Our second objective was to identify whether controls were in place to ensure that costs claimed for reimbursement are reasonable and to target the cost-reimbursement benefit of the program effectively. We developed an estimate of program costs, reviewed the controls over these costs, and telephoned a sample of RHCs to determine their reliance on cost reimbursement for financial viability.

Developing Program Cost Estimates

We used 1993 as our base year in estimating how much additional Medicare and Medicaid funding will be provided to RHCs in 1996 under the cost-reimbursement benefit of the program instead of using the standard fee schedules. We used 1993 as our base year for the estimate because this was the most recent year for which Medicare and Medicaid data were available.

In developing our estimate of program costs, we consulted with officials from HCFA's Office of the Actuary (Office of Medicare and Medicaid Cost Estimates), Office of Research and Development (Division of Reimbursement and Economic Studies), Bureau of Policy Development (Office of Payment Policy), and Bureau of Data Management and Strategy.

Using 1993 summary claims data published by HCFA, we determined the mean cost of a medical care visit paid from the fee schedule that HCFA officials said would most closely approximate an RHC visit.[24] We then compared this figure with the amount that Medicare paid RHCs on average for each RHC visit. We believe that this estimate is conservative for at least two reasons:

- it does not include the results of the year-end cost-report settlement that intermediary officials told us usually results in additional payments to RHCs and

[24]RHC services include medical services generally provided in a primary care office setting plus six basic laboratory tests. Other services, such as radiology, may be reimbursed separately under standard reimbursement methods.

- the fee schedule data include medical services provided by urban and specialist providers that generally receive higher reimbursement than rural primary care providers.

To obtain the 1993 differential cost to Medicaid, we had to back into the mean cost per visit on the Medicaid fee schedule by converting Medicare-allowed charges into Medicaid payments. We used allowed charges instead of payments because the latter excludes the beneficiary deductible and copay that would be an incurred cost of the Medicaid program. Next, we adjusted this cost using a Medicaid-to-Medicare fee ratio developed by HCFA in conjunction with the Urban Institute.[25] We then compared this estimate of the mean Medicaid fee schedule payments with the mean payments to RHCs.

We projected this estimate to 1996 Medicare and Medicaid RHC expenditures provided by HCFA's actuaries as follows:

- HCFA estimates Medicare expenditures only for independent RHCs. Because facility-based RHCs now comprise about half of all RHCs, we increased our initial estimate for Medicare accordingly.
- Medicaid estimates of RHC expenditures exclude payments to RHCs in Texas, Arizona, Hawaii, New York, and Oregon, which do not report these data separately to HCFA. Because the RHCs in these states comprise 16 percent of the national total, we increased our initial estimate for Medicaid by this percentage.

Evaluating Cost Controls

We next reviewed the controls that were in place to ensure that claimed costs for Medicare and Medicaid reimbursement were reasonable. We obtained a file of Medicare claims paid to all RHCs from 1991 to 1995 as well as Medicaid claims paid to the RHCs in our four-state sample from 1994 to 1995. The claims-paid file gave us information on the number of beneficiaries seen at the RHC, the number of visits, total charges, and total payments.

We also obtained a sample of year-end cost reports for independent and hospital-owned RHCs. The independent RHC cost reports provide detailed information on various cost categories, staffing levels, and patient visits at the RHCs. We used this information to identify the cost per visit at the RHCs and to compare the claimed costs at RHCs with the national mean for

[25]This ratio was developed to compare the Medicaid fee schedule rates with the Medicare fee schedule payment rates. The rate established for primary care in 1993 was 0.68.

similar providers. We used the national mean as a standard because neither HCFA nor the fiscal intermediaries had used their legislative authority to establish criteria for identifying whether claimed costs of the RHCs were reasonable.

The cost reports for hospital-owned RHCs did not provide this type of detailed information. However, in combination with other data sources, we obtained the data necessary to calculate the cost per visit, the amount of direct costs attributed to the RHCs, as well as the amount and type of hospital overhead allocated to them. We calculated the cost per Medicare visit for a judgmental sample of 28 facility-based RHCs[26] using a three-step process:

- First, we looked at schedule E, part B, of the cost report to see whether Medicare paid all hospital outpatient departments on the basis of the lower of either costs or charges for beneficiary services.
- Second, we looked at the RHC line item in schedule D, part IV, of the cost report to determine how much of these costs or charges were attributable to the RHC.
- Third, we obtained the number of Medicare beneficiary visits from either the Provider Statistical & Reimbursement Report[27] or from Medicare claims for each RHC provider during the period covered by the cost report.

Assessing Cost Reimbursement as a Factor for Clinic Viability

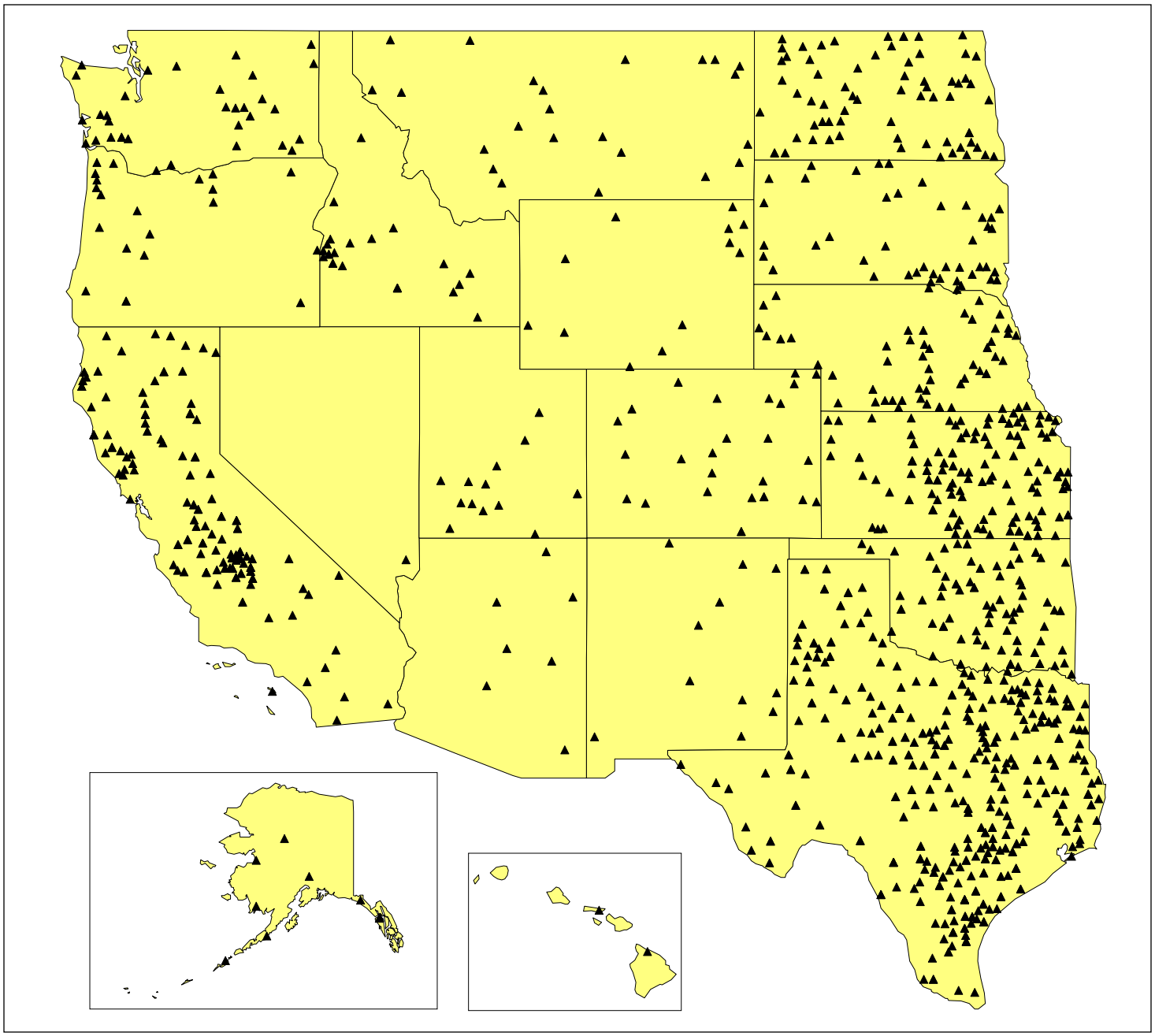
We next reviewed the extent to which the cost-reimbursement benefit was targeted to RHCs needing it to maintain or expand access. Because low patient volume was cited as the primary reason that RHCs would need cost reimbursement, we looked at the number of patient visits reported by a sample of independent RHCs in their cost reports. We could not perform this analysis on hospital-owned RHCs because HCFA does not require them to include these data in their cost reports. We also conducted a telephone survey of 76 RHCs in our four-state sample to determine their reliance on cost reimbursement for financial viability.

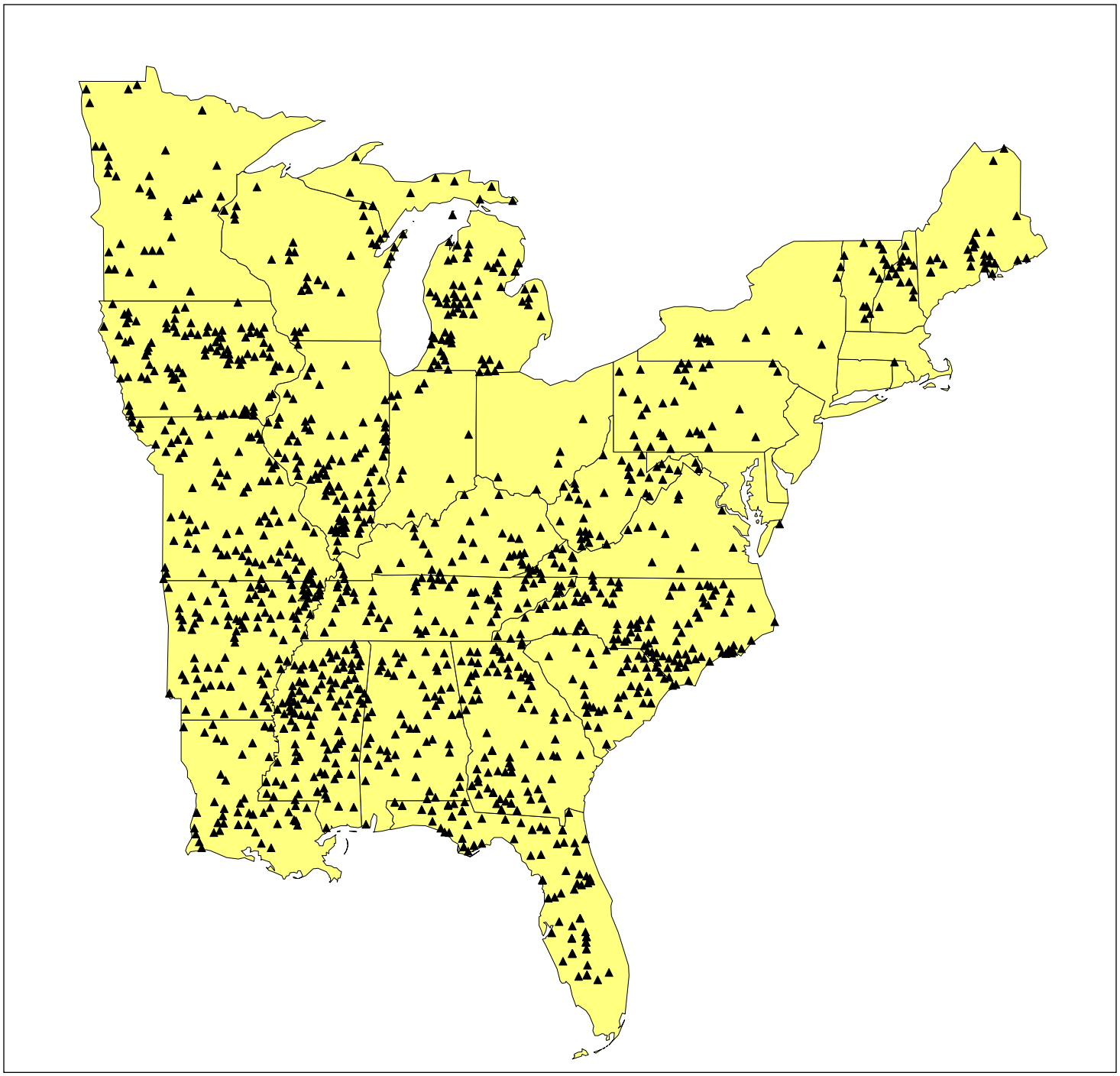
We conducted our fieldwork from September 1995 through July 1996 in accordance with generally accepted government auditing standards.

[26]Our sample of 28 cost reports excluded those that did not cover a full 12-month period and those in which RHC charges in the cost report did not match those in HCFA's claims data file.

[27]This HCFA report summarizes the number and amount of Medicare services and charges by revenue center for a facility. For each RHC, we used the number of charges for any clinic revenue center (excluding dental clinic charges) as a proxy for the number of clinic visits. We excluded charges at the RHC for ancillary revenue centers, such as laboratory services, which we assumed would be associated with a clinic visit.

Rural Health Clinics as of November 1995





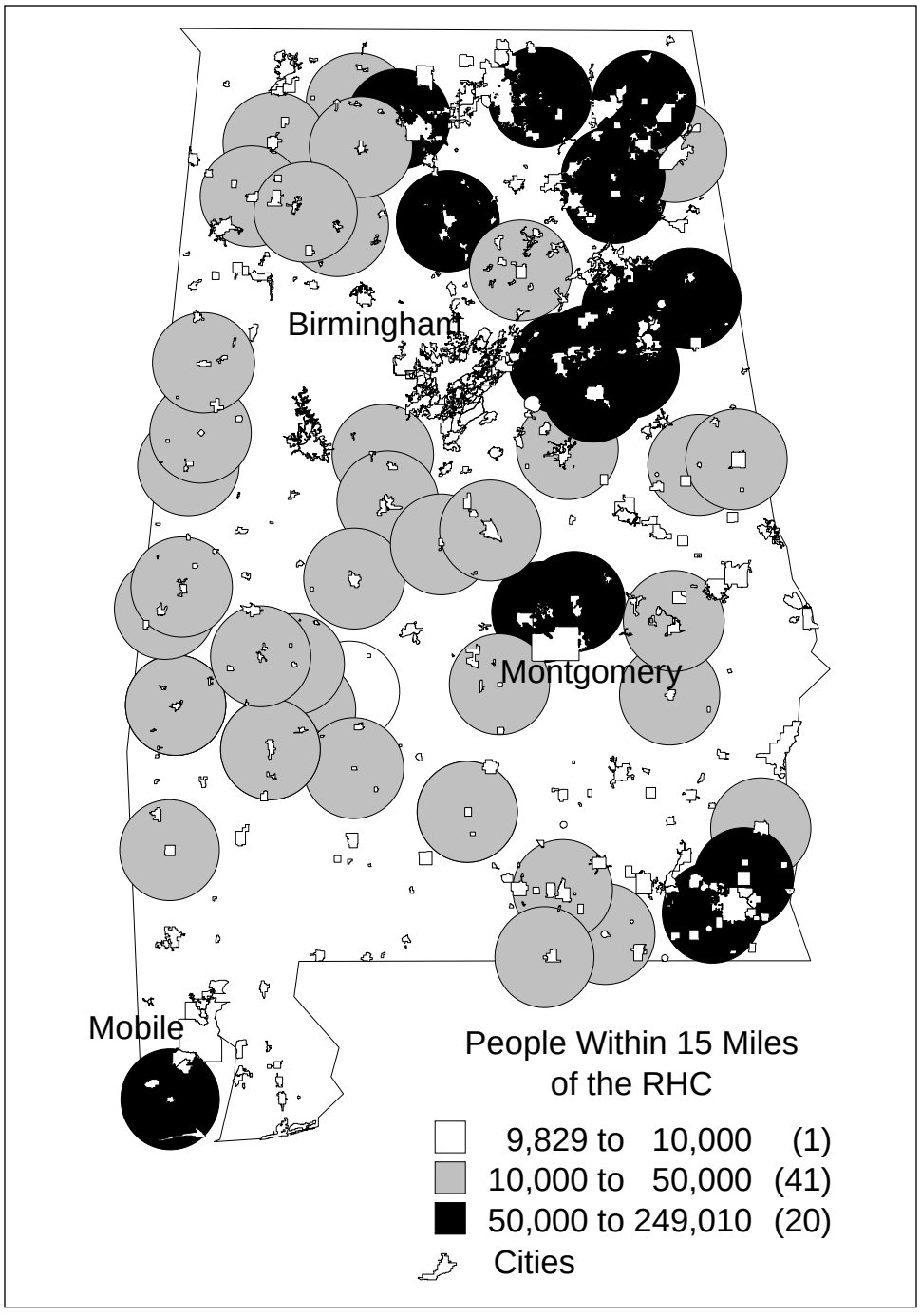
Note: Triangles may indicate more than one RHC.

Rural Health Clinics by Population Size in Our Four-State Sample

The following figures show the location of RHCs in our four-state sample of Alabama, Kansas, New Hampshire, and Washington. The RHCs are in the center of the 15-mile radius we drew around each one to count the number of people that live within a reasonable distance to care at the RHC per HHS criteria.

Cities within a state are denoted by the irregular white patches. How close RHCs are to these cities can be determined by comparing the area covered by each circle with the boundaries of these cities. The extent to which RHCs may be competing with providers in these cities or with each other for patients in a community can be seen by looking at the circles' overlap.

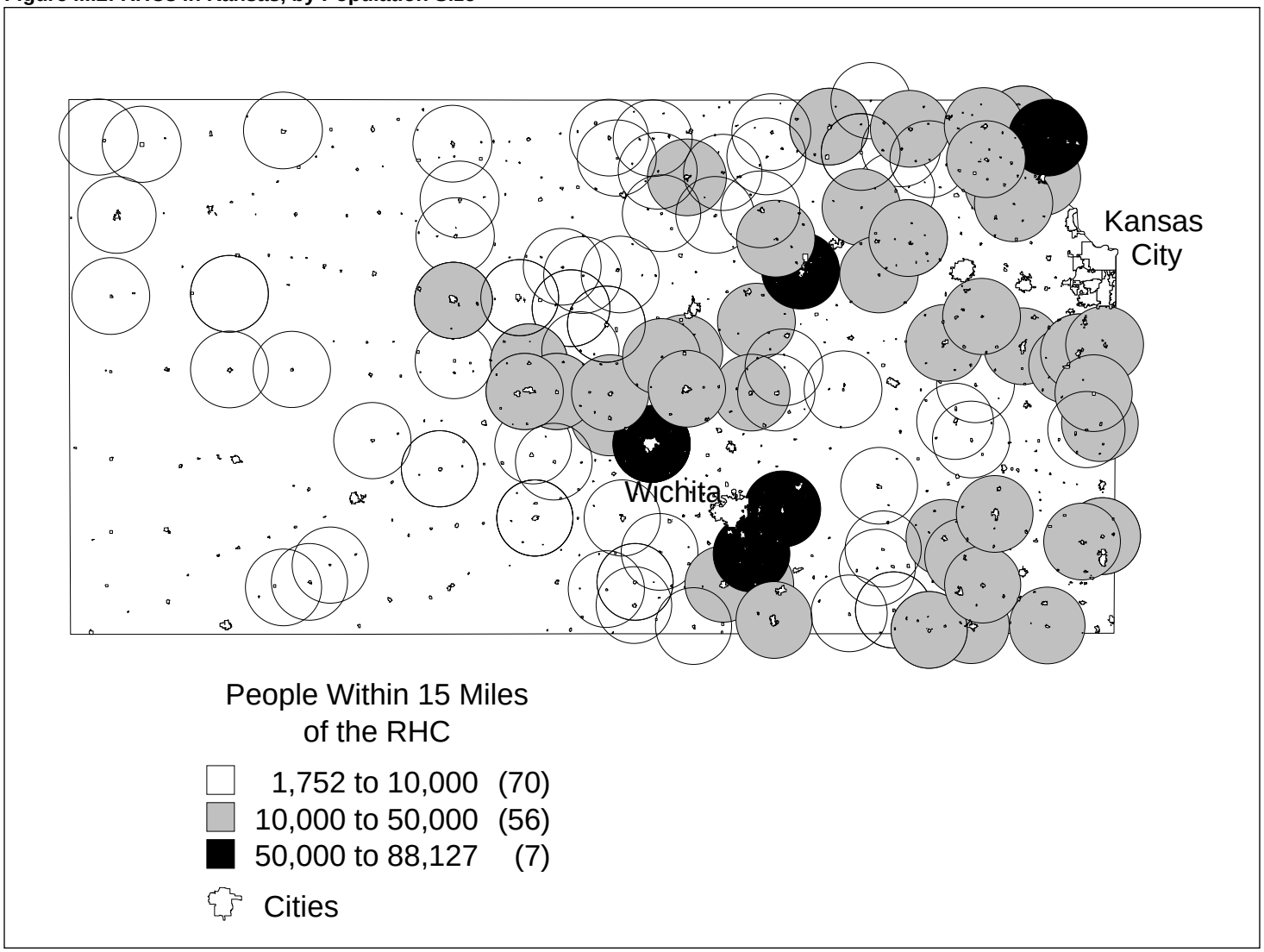
Figure III.1: RHCs in Alabama, by Population Size



Notes: Each circle may indicate more than one RHC within the service area.

Numbers in parentheses indicate the number of RHCs in each population size.

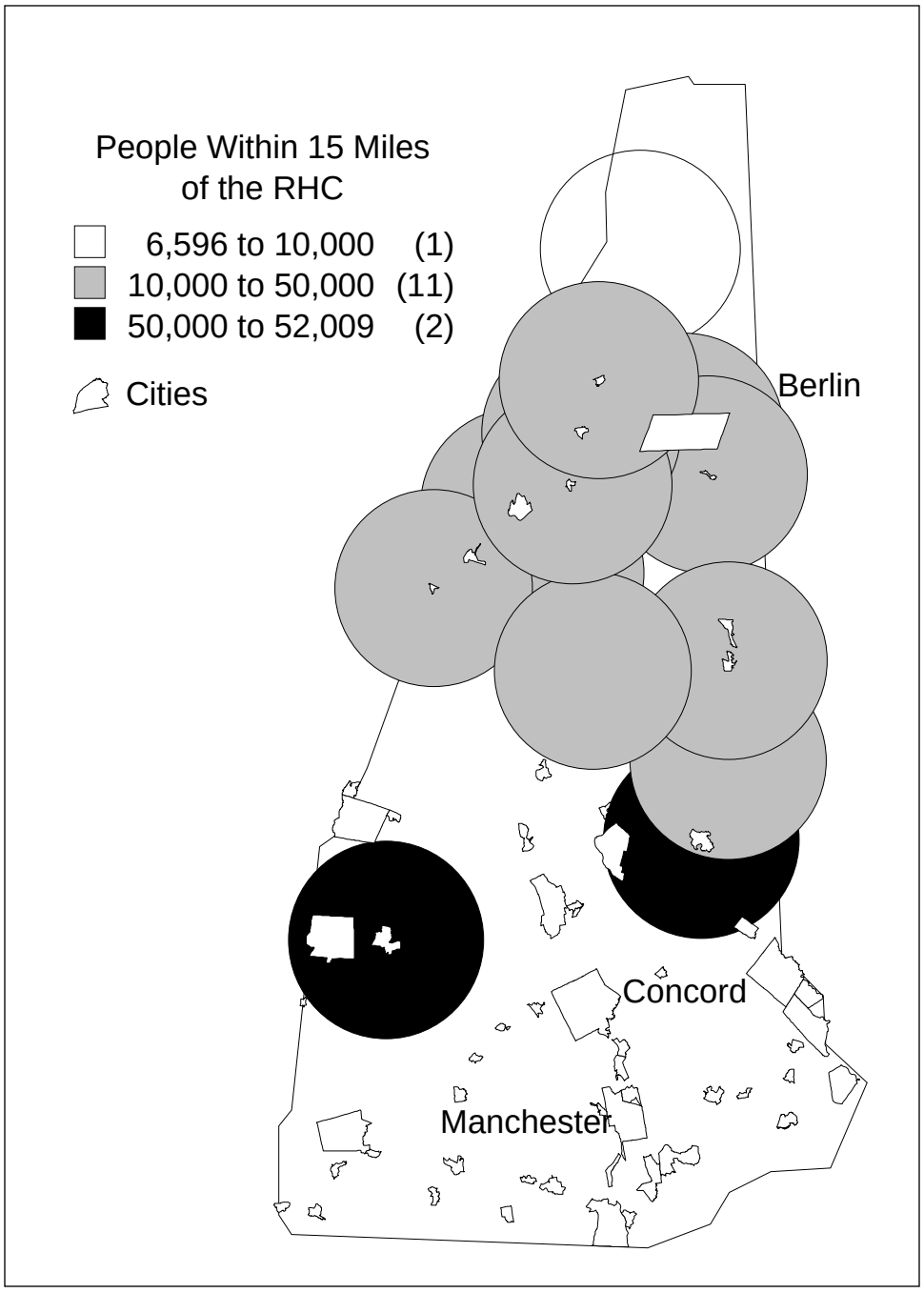
Figure III.2: RHCs in Kansas, by Population Size



Notes: Each circle may indicate more than one RHC within the service area.

Numbers in parentheses indicate the number of RHCs in each population size.

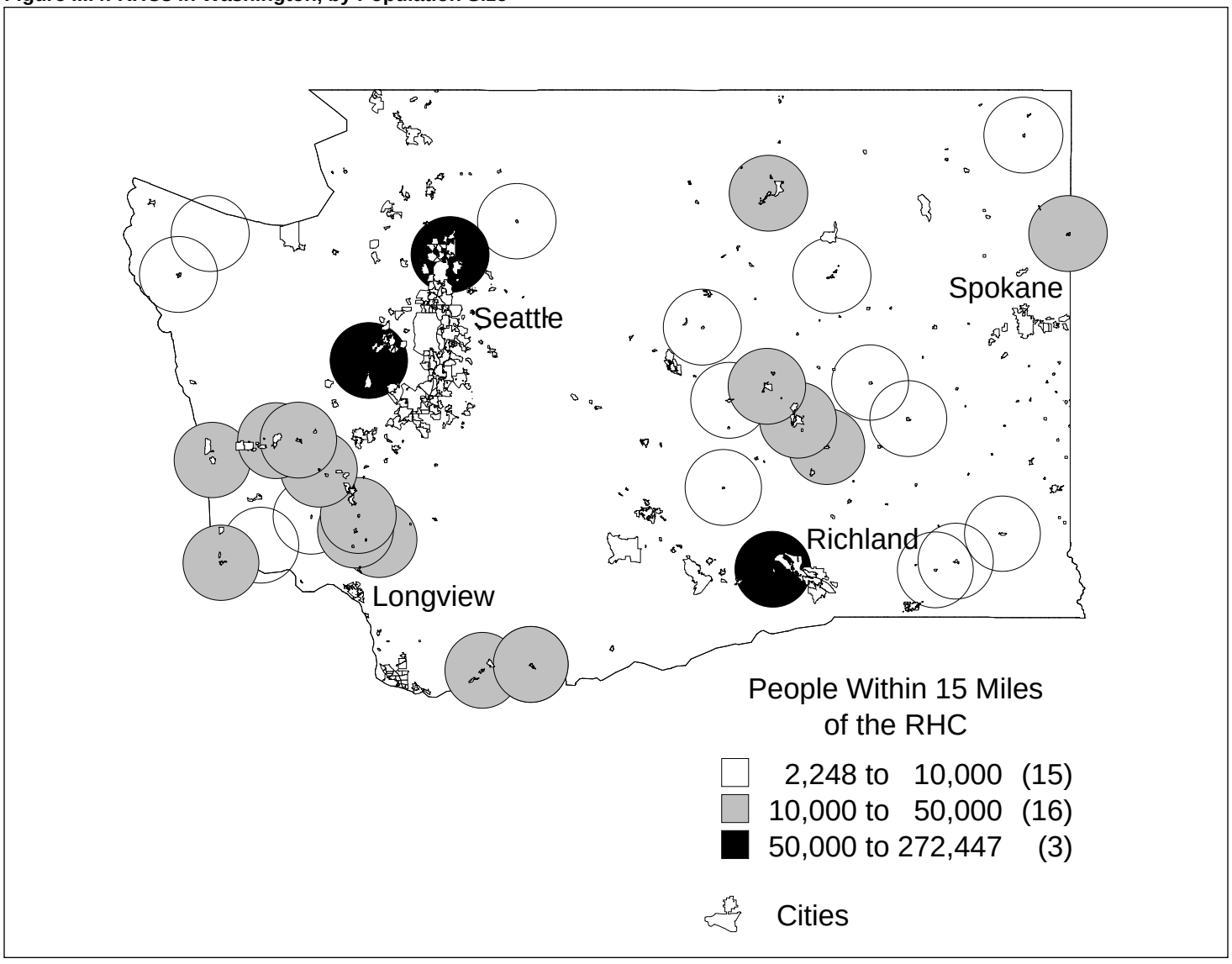
Figure III.3: RHCs in New Hampshire, by Population Size



Notes: Each circle may indicate more than one RHC within the service area.

Numbers in parentheses indicate the number of RHCs in each population size.

Figure III.4: RHCs in Washington, by Population Size



Notes: Each circle may indicate more than one RHC within the service area.

Numbers in parentheses indicate the number of RHCs in each population size.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT 31 1996

Ms. Sarah F. Jaggar
Director, Health Services Quality
and Public Health Issues
United States
General Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

The Department has carefully reviewed your draft report entitled, "Rural Health Clinics: Rising Program Costs Not Focused on Improving Care in Isolated Rural Areas." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano
for June Gibbs Brown
Inspector General

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services (HHS) on the General Accounting Office (GAO) Draft Report, " Rural Health Clinics: Rising Program Costs Not Focused on Improving Care in Isolated Rural Areas"

We concur with GAO's conclusion that the current program eligibility criteria defining rural and underserved areas do not go far enough to assure that the rural health clinic (RHC) program is directed and maintained in rural communities with critical shortages of primary care providers. We agree that success in meeting the original purpose of the RHC program, to extend access to care in rural medically underserved areas, requires active management at the Federal, state and local levels to identify specific locations where clinics are needed.

According to the draft report, the benefits of the RHC program are exemplified by RHCs in the smallest areas. We agree that there is unnecessary proliferation in certain larger areas. This is related to the fact that the placement of RHCs is not the only consideration in the current method of shortage area designation, done at the Federal level. Local and state agencies have an important role to play is assessing the placement of RHCs. In the Federal designation process, the recommendation of the Governor is a factor which must be considered in making designation decisions. Further, section 1861(aa)(2)(K) of the Social Security Act authorizes Governors to designate areas with a shortage of personal health services, subject to certification by the Secretary. By exercising these existing authorities, states have the opportunity to play an active role in targeting rural health clinics to areas of high need. The Health Care Financing Administration (HCFA) can continue to be of assistance to states that are evaluating shortage area designation under section 1861(aa)(2)(K) or that are attempting to do overall resource planning, for example through a Certificate of Need (CON).

Population changes and the growth of the health care industry have altered the environment in which RHCs function. We believe that the RHC program has done its part to encourage medical professionals to practice in nonurban areas. We believe that the RHC program continues to serve rural America successfully.

Additionally, given that the intent of the RHC program is to expand access to health care for the rural medically underserved, we are very concerned about GAO's finding that the RHC program is generally not focused on serving populations having difficulty obtaining primary care. Although we recognize and GAO has confirmed that some RHCs are contributing to the RHC program's purpose of enhancing access, we cannot dismiss the fact that, of the RHCs surveyed, less than half are using the program to expand their staff or increase the number of patients they see.

This is particularly troublesome considering that the number of RHCs has grown considerably in the last few years.

It is clear from the results of the GAO study that RHC reimbursement for health care services is not maximizing its contribution to the safety net for underserved populations. The foremost conclusion that we reach based on GAO's study results, coupled with other knowledge and our experience with RHCs and other safety net providers such as Federally Qualified Health Centers (FQHCs), is that some changes are necessary in the RHC program. We see the RHC program's lack of focus on underserved populations being primarily related to the RHC certification process. The limited success in achieving program intent is attributable to: (1) the fact that RHC certifications are based only on designations of underservice [i.e., health professional shortage areas (HPSAs) and medically underserved areas (MUAs)] and no additional assessments of need, and (2) the lack of an RHC recertification process.

We consider it critical to assess need and community impact by reviewing other factors in addition to the designation of an underserved area prior to certifying an RHC. The RHC program should start with the Health Resources and Services Administration's (HRSA's) designation process for HPSAs and MUAs, which is currently being improved, and additionally require that further documentation of need for health care services in the target community be submitted with the RHC request for certification. The process might be somewhat similar to the evaluation of FQHC applications. For example, FQHCs and FQHC Look-Alikes must show evidence of the lack of sufficient primary care providers in the service area to serve the target population by listing other available health resources in the service area. The HRSA does not encourage, but does allow FQHCs to have overlapping service areas with existing FQHCs and RHCs. In these instances, FQHCs must show that there is unmet need and that they will increase access to health care for a substantial number of additional underserved patients in the service area. Furthermore, the review process for FQHCs and FQHC Look-Alikes requires periodic reassessment of need and community impact, as well as reassessment of compliance with other program expectations.

GAO Recommendation

For those RHCs that continue to be reimbursed on a cost-reimbursement basis, the Secretary of HHS should direct the Administrator of HCFA to:

> Revise Medicare payment policy to hold facility-based RHCs to the same payment limits and cost reporting requirements as independent RHCs.

Page 3

Department Comment

We agree with GAO that the same payment limit and cost reporting requirements that apply to independent RHCs should also apply to facility-based RHCs. Under the statutory authority of section 1833(f) of the Act, HCFA applies an upper payment limit to the per-visit cost incurred by independent RHCs. HCFA also has a general authority, under section 1861(v)(1)(A) of the Act, to implement limitations on reasonable costs incurred by facility-based RHCs. Pursuant to this statutory authority, HCFA is in the process of developing proposed regulations which would implement a similar upper payment limit for facility-based RHCs as well.

GAO Recommendation

> Apply reasonable cost principles to such categories as salaries and overhead claimed for reimbursement by RHCs.

Department Comment

We agree with GAO that Medicare reasonable cost reimbursement principles should apply to these types of costs. In light of GAO's findings, we will direct our Medicare RHC contractors to increase the level of scrutiny on all costs incurred by RHCs, particularly in such categories as salaries and overhead.

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