Rural Health Clinics: More Opportunities Than Challenges

Case Study

Ryan Campbell, FACHE, FACMPE

September 27, 2016

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.

Rural Health Clinics: More Opportunities Than Challenges

According to the Kaiser Family Foundation, there are over 4,099 active Rural Health Clinics (RHC)[1] in 43 states across the United States[2] that provide health care to over 7 million people[3]. Rural Health Clinics are often the only point of care for people living in outlying areas. These clinics are vital to reaching a population in need of basic healthcare. For health care providers, Rural Health Clinics offer opportunities to expand market presence, provide a financially stable practice operation, and provide quality health care to a population that often go without basic healthcare or use the emergency room as their primary care source. This case study aims to provide insight into the opportunities and challenges that Rural Health Clinics provide as well as act as a guide for physician office managers looking to expand their clinic's reach into untapped rural markets.

Rural Health Clinics were developed as a result of the Rural Health Clinic Services Act of 1977[4] to financially support physician clinics in underserved areas where there is limited healthcare due to the rural nature of the area. The program was developed to encourage Advanced Practice Providers (APPs) and physicians to work together to provide vital services to these remote locations. In order to qualify as a RHC, a clinic must be in a non-urban area and be a designated Health Professional Shortage Area (HPSA) as designated by the Center for Medicare and Medicaid Services (CMS) or State Health Department and employ an APP at least 50% of the time.

There are two types of Rural Health Clinics, Provider Based and Independent. Provider Based clinics are majority owned by a hospital or health system while independent RHCs are majority owned by individuals or groups of individuals not associated with a hospital or health system. Most of the RHCs today are independent RHCs. The main difference in the two types of RHCs is the reimbursement level that is provided.

There is a six to nine month process to become a certified RHC. Due to the volume of paperwork required and the complexity of the CMS certification survey, many potential RHC

[1] as of October 2015
[2] Kaiser Family Foundation, Number of Medicare Certified Rural Health Clinics, http://kff.org/other/state-indicator/total-rural-health-clinics/
[3] National Association of Rural Health Clinics, http://narhc.org/about-us/about-us/

[4] Public Law 95-210

operators often choose to enlist the help of a consultant to work on their behalf to help in the process. The first step in the RHC process is to determine if the location of the proposed RHC meets the basic definition of a non-urban, HPSA designated area. The quickest way to determine your location is to input the address into the CMS HPSA website. Practice Administrators should use a consultant or reach out to their local State Rural Health agency and discuss with them the potential location so they can advise if they believe it would meet the CMS HPSA definition. Once your HPSA area has been confirmed, the next step is to gather all the documentation required to file the CMS 855A with CMS. Once CMS approves your 855A, the clinic is then ready to request its CMS certification survey. The certification survey is comparable to a Joint Commission survey for a hospital in which CMS assesses the clinic's environment of care, care of patients, administrative procedures, and operational capabilities. CMS has delegated, or deemed, the survey process to either State Health agencies or two private companies, which for a nominal fee will survey the clinic on behalf of CMS. Once you successfully pass your survey, the clinic is deemed to be a CMS Rural Health Clinic. There are a few additional forms that clinics must submit to CMS in order to get their RHC billing number but at this step in the process the clinic is now considered a RHC.

The purpose of a RHC is to provide health care to patients who otherwise would not have access to care in their community. There are many benefits to both the clinic and the local community when a RHC opens. First, community health is positively impacted which, usually helps local businesses keep employees at work and productive and in turns helps the local community thrive. Access to local healthcare often results in higher productivity and less time away from work which, in turns helps keep local industries from shutting their doors and leaving town. For the owners of a RHC, especially hospitals and health systems, it often helps take the strain off the nearest emergency room and expands their brand recognition into the area. Hospitals and health systems often see an uptick in referrals to their specialists since they are able to promote their services through the RHC. RHCs also provide vital jobs in small communities. Most of the RHC staff usually live in or near the clinic making it a local source of jobs as well.

For RHC owners, independent and provider based clinics, these clinics offer a financial opportunity to establish a clinical presence in an underserved area while almost eliminating financial risk. RHCs are provided an advantageous reimbursement strategy in order to help entice these clinics to open in rural areas. According to the 2000 Benefits Improvement and Protective Act (BIPA), CMS must use a prospective payment system rather than a cost based

reimbursement system[5] to pay RHCs. Under this model, clinics receive an interim payment for services rendered and then through a cost report at the end of the year clinics are reimbursed the difference between the initial payment and the cost report settlement.

A Critical Access Hospital (CAH) was looking to expand its reach and services to the communities it served. Several of the rural areas lacked basic primary care which, often resulted in either no health care until it was a health crisis or meant citizens had to drive an hour or more to a basic primary care physician. The Hospital Administrator decided to open two rural health clinics to help serve these communities and help prevent unnecessary emergency room visits. The Administrator identified two areas and began searching for a building that could serve as a clinic. As word began to spread, local business people came forward and assisted with the identification of property and buildings that could serve both locations. Local individuals who traveled for a healthcare job came forward to help staff the clinic and a local nurse practitioner joined on as the clinic provider. The result for both clinic locations was local access to primary health care using local resources and local community members as staff. Through provider based reimbursement, the clinic was financially stable and both clinics thrived in the communities they served.

The same CAH undertook a third clinic location to help provide health care in a small community that otherwise lacked a local provider. With this clinic the local community did not embrace the new clinic nor were there local clinical staff to work in the clinic. In the end the clinic did not survive because the community failed to embrace the new clinic and it shut down after 2 years of operation. In this instance there were not sufficient local resources to help support the clinic.

In some instances, the need for a RHC is brought up as a community need and not as an outreach mechanism. A small semi-rural hospital was approached by local elected officials in regarding the need for health care services and the current lack thereof. The hospital undertook a study of the community need and found an opportunity through the recent closing of a practice to step in with a RHC to help the community. This vacated clinic had everything that was needed to operate a clinic including all the equipment. Under the provider based model the hospital was able to step in, hire local clinicians, and start the process of obtaining the RHC certification without the usual large startup expenses associated with most practices. While this clinic has not

[5] US Department of Health and Human Services, Health Information Technology, "What are Rural Health Clinics?", http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html

yet achieved its RHC certification, early financial results show promise of this clinic being a long term financially viable operation while supplying the only health care provider in the county.

Why would a Practice Administrator want to consider a RHC as a new clinic with their current clinic set up? What financial benefits do RHCs provide that regular clinics do not? RHCs primary goal is to provide health care to the communities that lack providers while providing enhanced reimbursement for these patients. MGMA encourages Practice Administrators to always begin with the end in mind when thinking about strategic growth. Practice Administrators should consider RHCs for three reasons; 1) RHCs can be used as an outreach to new market segments, 2) RHCs improve the quality of health among rural communities, and 3) Financially RHCs pay for themselves.

With the current landscape of increased competition in the urban and suburban areas, Practice Administrators are being forced to look for new market segments for growth opportunities. With the onset of the Affordable Care Act and State expanded Medicaid, more and more individuals are becoming insured. RHCs offer opportunities to reach into market segments that most practices don't tap into yet offer a financially stable way to do so.

RHCs also provide health care where it sometimes is needed the most. In the third example, the RHC that opened found many of its patients had not seen a doctor simply because there was not one close by. While these patients are usually difficult to get back to health, providing these much needed services to this population of patients achieves the personal goals of why many healthcare professionals work in healthcare.

The third reason Practice Administrators should consider a RCH as a strategic opportunity is that RHCs are a financially stable way of running a clinic. If properly ran, the cost report model for a RHC with a high Medicare and Medicaid population almost always are financially good business opportunities for practices. With the intense pressure on traditional practices, RHCs do come with the same financial pressure, if run properly. In the second case example, the hospital selected an area that did not support the clinic from the start and thus was doomed before the doors opened. Practice Administrators should learn from this situation that conducting a thorough due diligence process is vital when selecting an area and clinic location within the area to ensure the local community would support a practice. Often a meeting with local officials and lunch at the closet restaurant will give Practice Administrators a feel for the community and whether they will support such an endeavor.

A key aspect of developing a Rural Health Clinic is the ability to run a practice for a short period of time without the enhanced RHC reimbursement. As the Practice Administrator develops their pro formas several items should be examined. First, Practice Administrators should figure out if they have the capital or access to capital to start a new clinic. Secondly, staffing a clinic should be a key concern. Finding a provider in a rural area is sometimes a very difficult task. One of the difficulties the second example encountered was staffing the clinic with a provider and full time staff. It was close to several urban cities and they had to compete for the same staff. Practice Administrators should examine the ability to hire and retain staff in rural areas.

With proper planning, RHCs can be financially advantageous to physician practices. With the onset of the Affordable Care Act (ACA), many rural individuals now have access to health insurance making these populations a sometime untapped market for physician practices. Under the RHC program, these rural clinics can both provide much needed health care in underserved areas while ensuring financial stability to a practice.