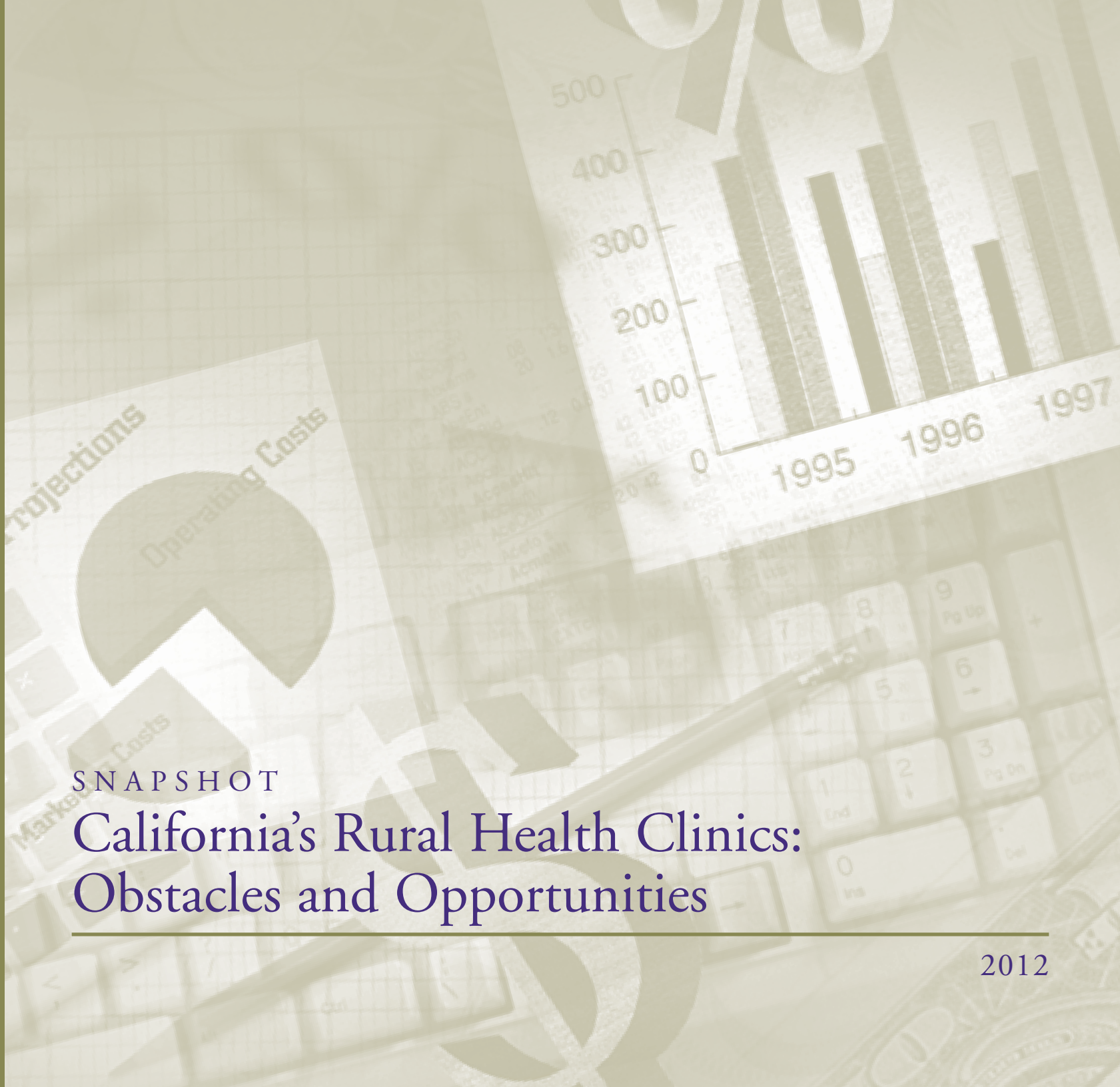


California HealthCare Foundation

SNAPSHOT

California's Rural Health Clinics: Obstacles and Opportunities

2012

Introduction

A rural health clinic (RHC) is a facility that meets federal criteria for being able to provide adequate primary care to elderly and low-income populations in designated rural areas. Providers certified as RHCs receive cost-based reimbursement for Medicare and Medi-Cal services. California's 271 RHCs play an important role in the state's health care safety net.

This snapshot presents an overview of RHCs and the patients they serve, to develop a better understanding of the care RHCs provide and the obstacles they face. It is based on a study of publicly reported data and a project-specific survey.

KEY FINDINGS INCLUDE:

- There were 271 active RHCs in California in fiscal year (FY) 2010, providing 44% of the total primary care delivered in rural areas.
- In FY 2010, 52% of RHCs were independent and owned by medical providers or community groups, while the other 48% were owned and operated by hospitals.
- Even though it is not required, 48% of RHCs reported that they offered sliding scale discounts to uninsured patients in 2011.
- Medi-Cal paid for 42% of visits and Medicare paid for 22% of visits to RHCs in the last fiscal years of the RHCs surveyed.
- Many RHCs reported feeling financially unstable; almost 40% self-identified as unstable or very unstable. In addition, 56% of RHCs did not make a profit in their last fiscal year.
- More than half of RHCs were using or implementing electronic health records (EHRs) in 2011.
- Although rural patients stand to benefit the most from telehealth applications, less than half of RHCs participated in telehealth activities in 2011.
- Costs and limited resources were reported as the biggest challenges for RHCs generally, and the most important obstacles to increased use of EHRs and telehealth.

CONTENTS

Rural Health Clinics: Background

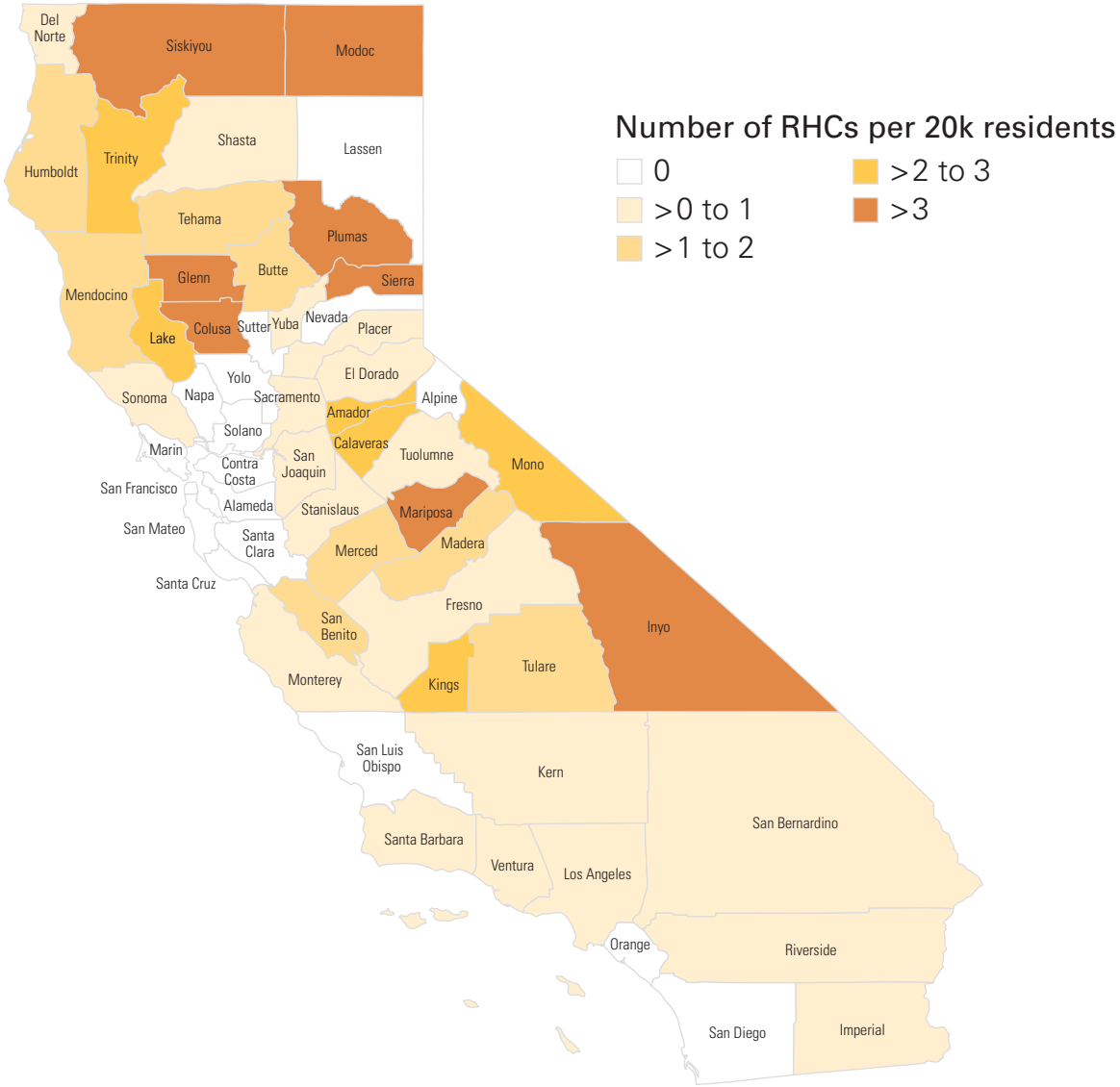
In 1977, Congress passed the Rural Health Clinics Act (RHC Act) to address the problem of an inadequate supply of physicians serving Medicare and Medicaid beneficiaries in rural areas. At the time, mid-level practitioners, such as physician assistants and nurse practitioners, were the main sources of care in rural communities. However, Medicare and Medicaid did not generally reimburse the services delivered by these practioners, which further constrained the health care options of rural beneficiaries. The RHC Act authorized reimbursement to mid-level practitioners in the hopes of increasing access to care for geographically isolated residents. In addition, the RHC Act created a cost-based reimbursement system to help financially sustain these clinics and the essential services they provide.

In order to qualify as an RHC, a clinic must meet several criteria. The most basic relate to location, staffing, and services. For example, to obtain RHC certification, a clinic must be located in a non-urban rural area that has been identified as having a health care shortage. In addition, it must employ at least one mid-level provider, such as a nurse practitioner, physician assistant, or certified nurse midwife, that is on-site to see patients at least 50% of the time the clinic is open. A physician must also be available to supervise these mid-level practitioners at least once every two weeks; physicians also may provide direct care to patients. Finally, an RHC must provide outpatient primary care services and lab services.

Source: Department of Health and Human Services, Office of the Inspector General, *Status of the Rural Health Clinic Program,* August 2005; WWAMI Rural Health Research Center, *State of the Health Workforce in Rural America: Profiles and Comparison,* August 2003; California HealthCare Foundation, *Fewer and More Specialized: A New Assessment of Physician Supply in California,* June 2009.

More than two-thirds of California counties have fewer than the minimum number of primary care physicians per capita considered adequate to meet demand. In general, rural counties tend to have far fewer physicians per capita than urban counties, largely due to low population density and lower income levels, which can make it difficult to financially sustain a health care practice.

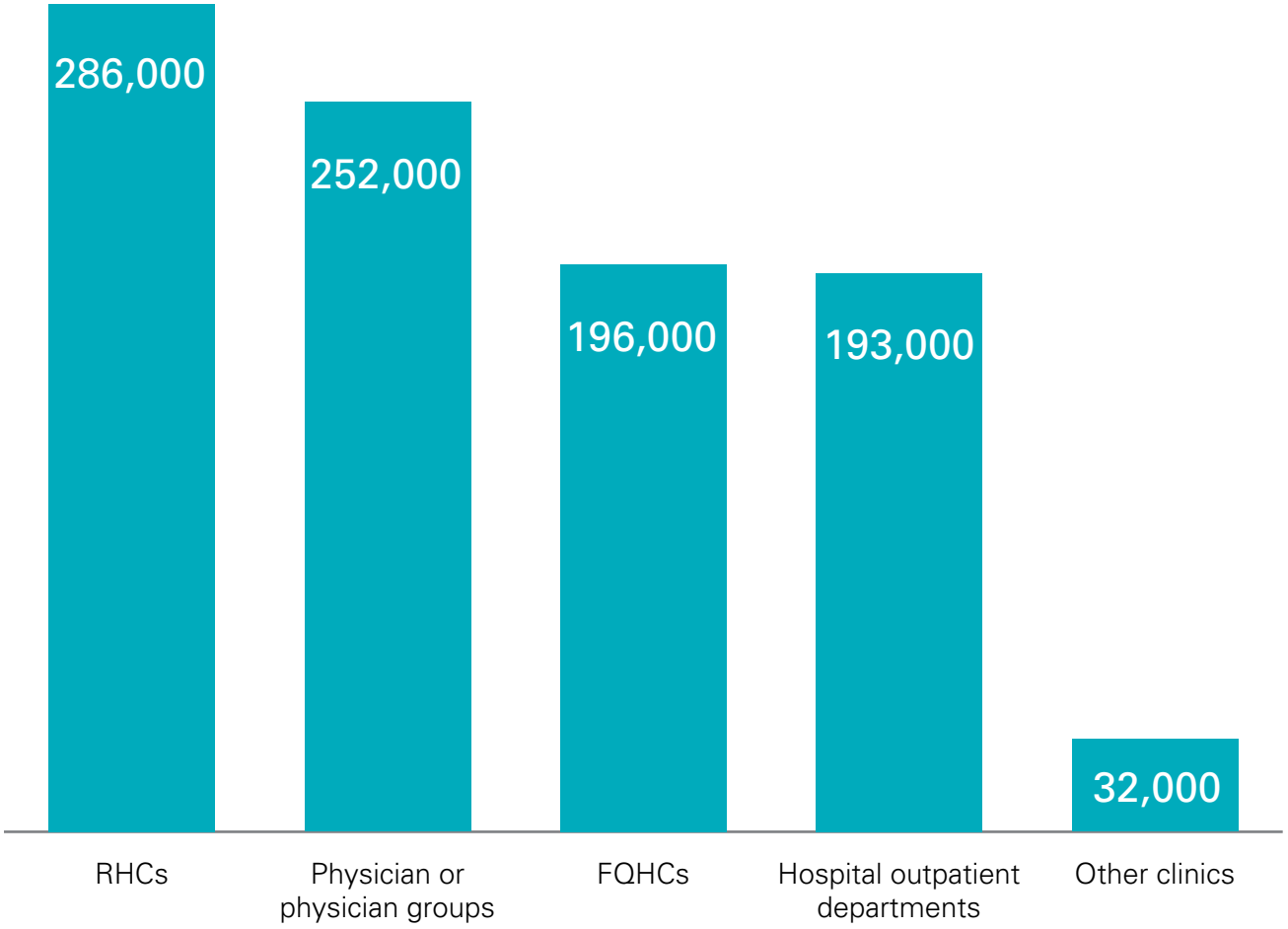
RHCs in California, by County, FY 2010



Source: State of California, Department of Health Care Services, Medi-Cal Program Fee-For-Service Paid Claims for FY 2010 (July 2009 to June 2010), September 2011.

In FY 2010, California was home to 271 RHCs in 41 counties, in non-urbanized locations designated as "health care shortage areas" according to federal criteria. Besides providing primary care for Medicare and Medi-Cal beneficiaries, these clinics also provide services to rural residents with private insurance, the uninsured, and those covered by county indigent care programs, including the County Medical Services Program.

Medi-Cal Patients Seen by Rural Outpatient Providers, FY 2010



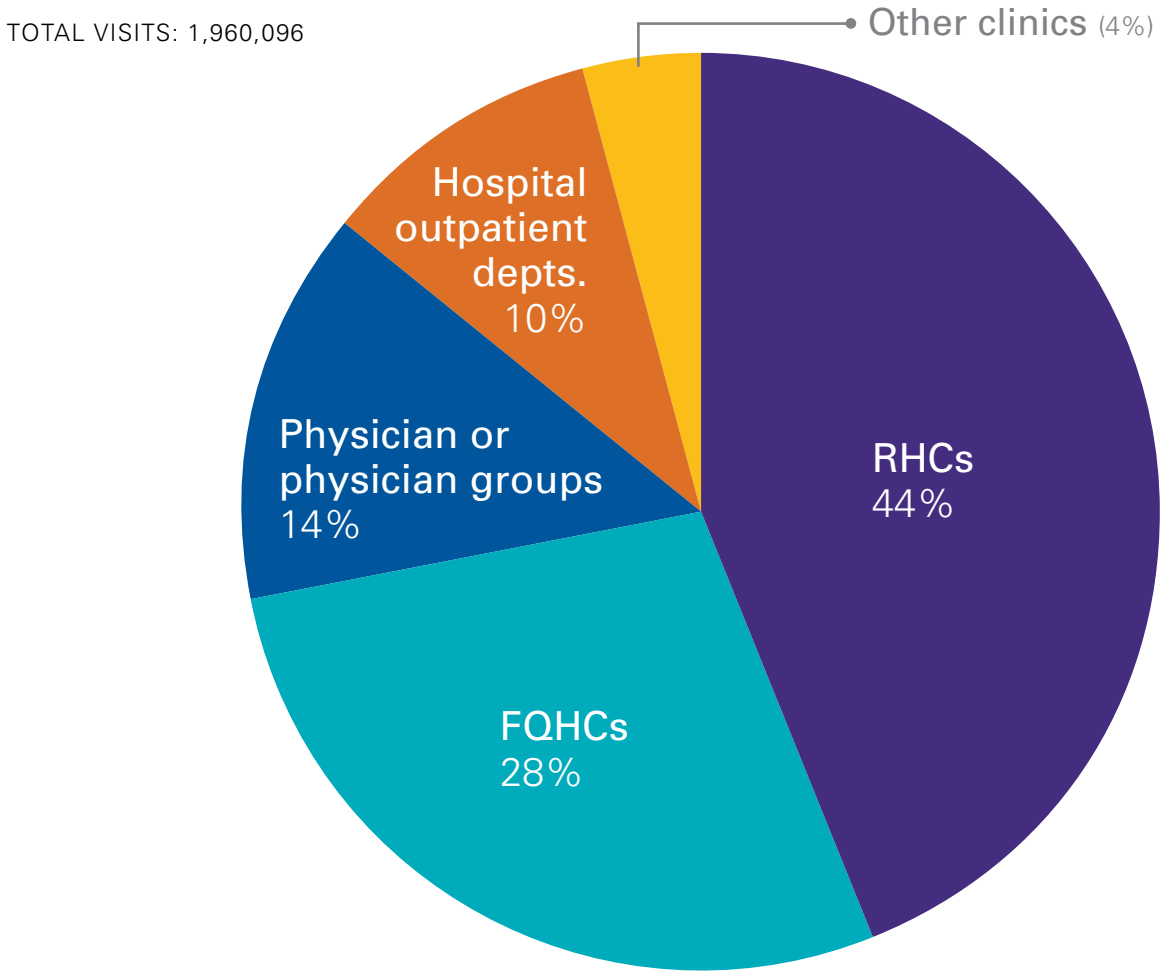
Notes: User counts represent unique visitors for each provider type, but some users visited more than one provider type. Therefore, the sum of the figures in the graph does not equal the total unique visitor count, which is approximately 566,000.

Source: State of California, Department of Health Care Services, Medi-Cal Program Fee-For-Service Paid Claims for FY 2010 (July 2009 to June 2010), December 2011.

According to Medi-Cal paid claims data, approximately 566,000 Californians visited rural outpatient providers* in FY 2010, often seeing more than one type of provider. Half visited an RHC, 45% visited private physicians, and 35% visited a federally qualified health center (FQHC).

*Outpatient providers are defined on page 31.

Rural Medi-Cal Primary Care Visits, by Provider, FY 2010

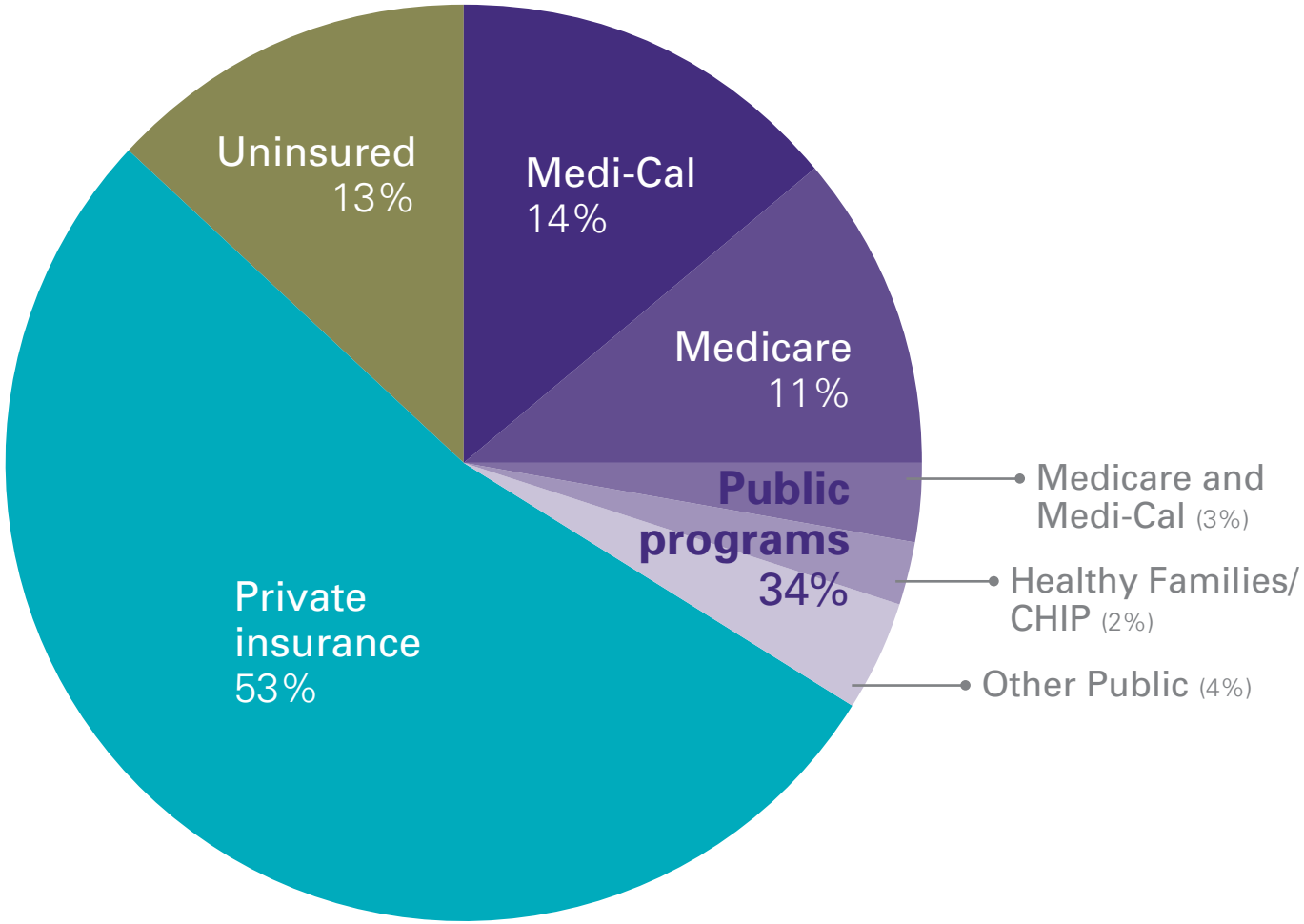


Notes: Primary care is defined as services within the top 20 Clinical Classification Software (CCS) diagnosis codes used by RHCs. CCS developed by the Agency for Healthcare Research and Quality was used to classify diagnosis codes into clinically meaningful categories. This tool aggregates ICD-9 (International Classification of Diseases, 9th Revision, Clinical Modification) codes into one of 285 mutually exclusive categories. Most of these categories are homogeneous; for example, category #1 is "Tuberculosis." Some categories combine several less common individual codes, such as category #3 which is "Other Bacterial Infections." Rural outpatient providers were selected using the same methodology as found in the previous slide.

Source: State of California, Department of Health Care Services, Medi-Cal Program Fee-For-Service Paid Claims for FY 2010 (July 2009 to June 2010), December 2011.

RHCs provided more primary care in rural areas than any other Medi-Cal fee-for-service (FFS) provider. RHCs provided 44% of rural primary care to Medi-Cal patients in FY 2010, while private physicians or physician groups provided just 14% of primary care.

Health Coverage of Rural Californians, by Type, 2009

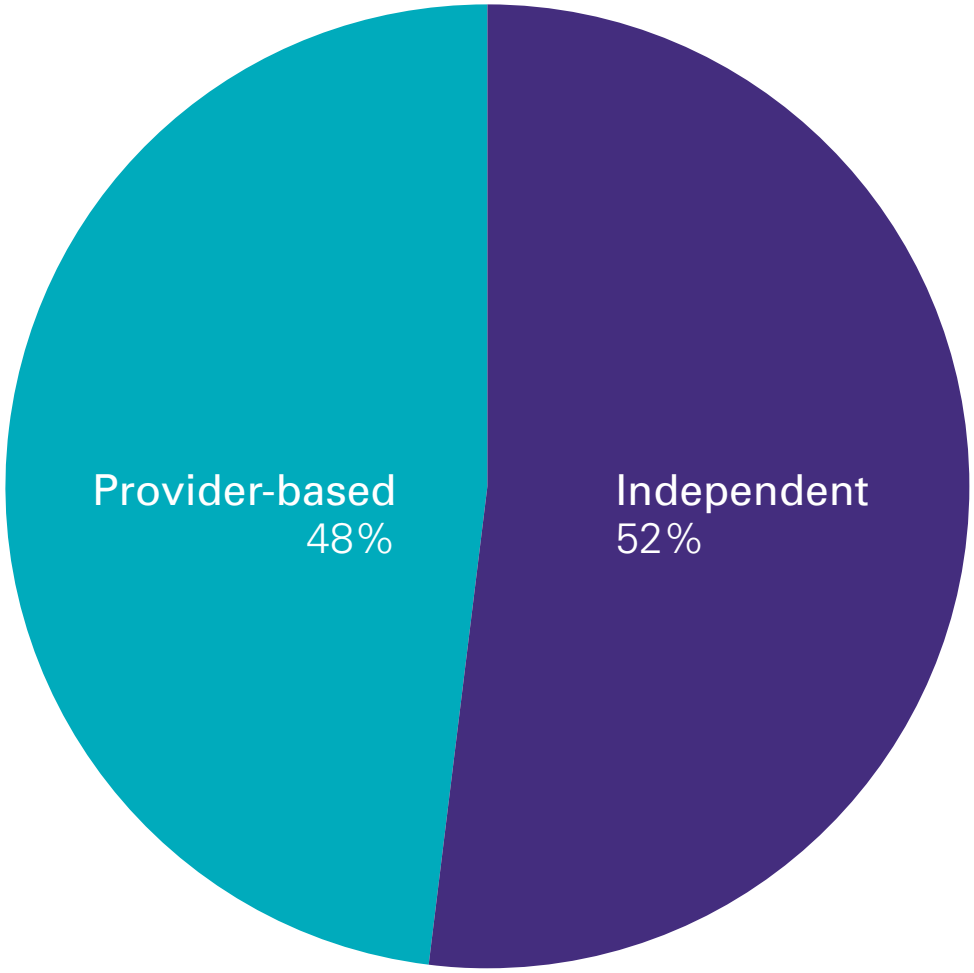


Source: 2009 California Health Interview Survey (CHIS). Rural population estimates were determined by CHIS using Claritas, Inc.'s rural ZIP code designations.

Public programs that pay for health care for elderly and low-income patients covered more than one-third of rural Californians. Medi-Cal and Medicare, the two programs for which RHCs receive enhanced reimbursement, constituted the majority of public program coverage. Besides Medi-Cal and Medicare enrollees, RHCs also provided primary care to rural residents with all types of insurance coverage.

RHC Ownership Structure, FY 2010

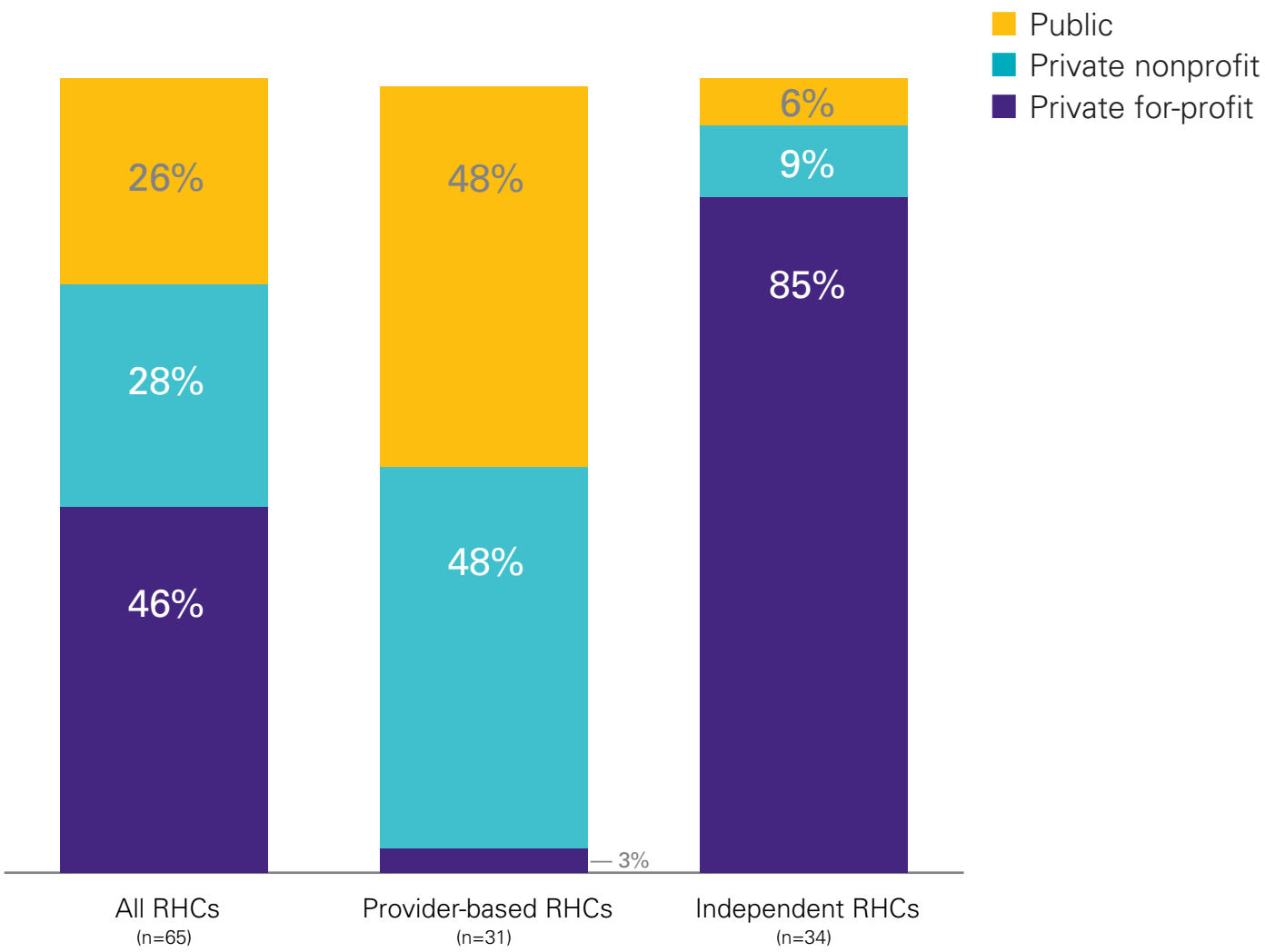
TOTAL NUMBER OF CLINICS: 271



Source: State of California, Department of Health Care Services, Medi-Cal Program Fee-For-Service Paid Claims for FY 2010 (July 2009 to June 2010), September 2011.

RHCs can be owned by private or public entities. Those owned by medical practitioners, community groups, or tribes are called "independent" while those that are owned by hospitals, skilled nursing facilities, or home health agencies are called "provider-based." In California, provider-based RHCs are run only by hospitals, and they made up just less than half of all RHCs in California in FY 2010.

RHC Ownership Type,* 2011



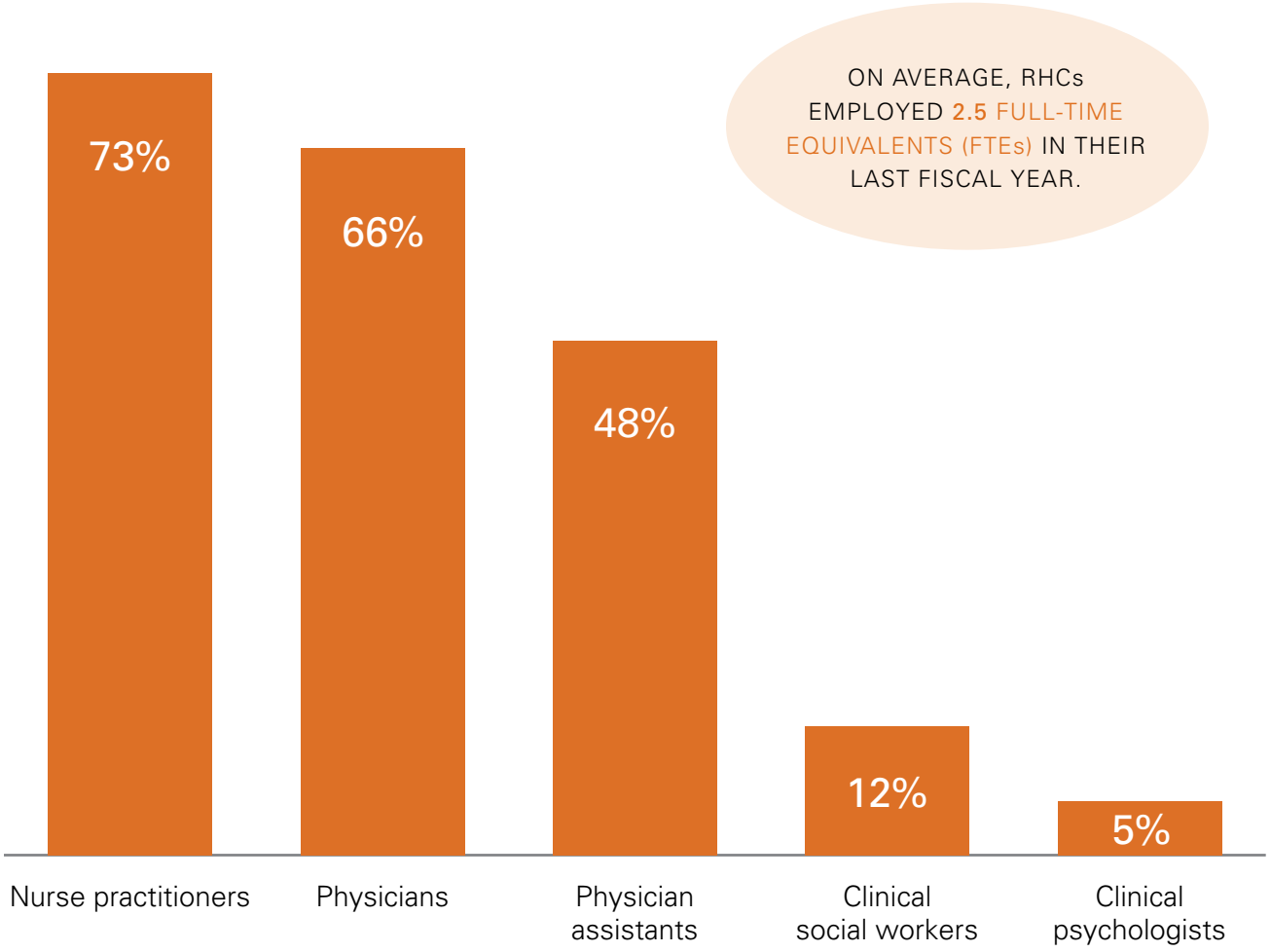
*Based on survey responses and represent estimates of the true distribution of nonprofit, for-profit, and public owners. District hospitals are classified as "public."
Note: Segments may not total 100% due to rounding.

Source: Rural Health Clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

Both RHCs and FQHCs receive increased reimbursement for serving public program patients. But, unlike FQHCs, RHCs can be for-profit entities. Half of RHCs reported that they were private for-profit entities, although ownership type differed markedly between independent and provider-based RHCs.

RHC Employment of Selected Provider Types

PERCENTAGE OF RHCs (n=169)

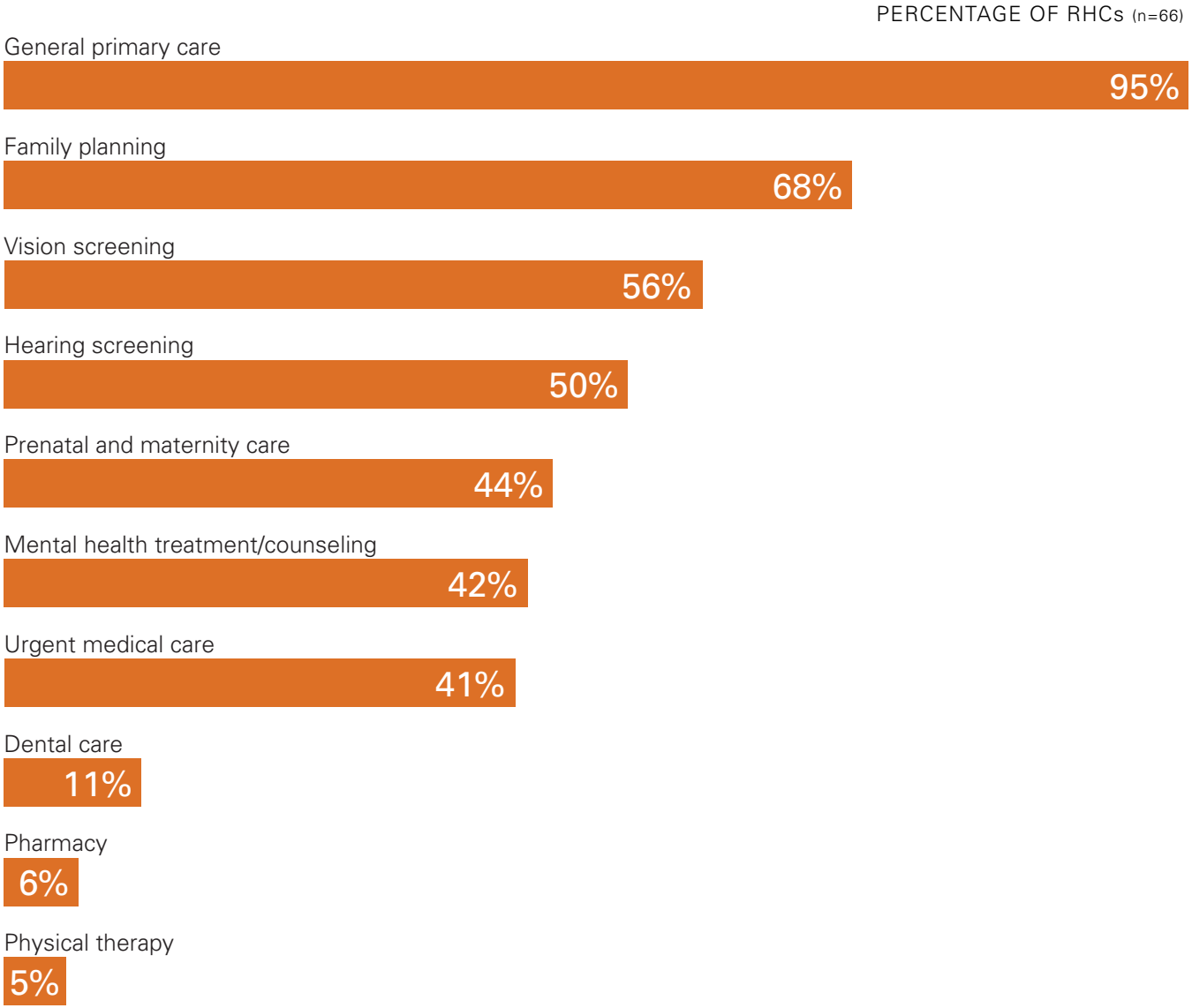


ON AVERAGE, RHCs EMPLOYED **2.5** FULL-TIME EQUIVALENTS (FTEs) IN THEIR LAST FISCAL YEAR.

RHCs are required to employ at least one nurse practitioner, physician assistant, or certified nurse midwife. Physicians must be available for oversight on-site at the clinic once every two weeks; they may also provide direct care to patients. Accordingly, nearly 75% of RHCs employed a nurse practitioner, and almost half employed physician assistants in their last fiscal year.

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Rural Health Clinic Cost Reports. Each RHC has its own fiscal year; the span of fiscal years reflected in the CMS reports analyzed for this snapshot is from late 2007 to the end of 2009.

RHCs Offering Selected Services, 2011

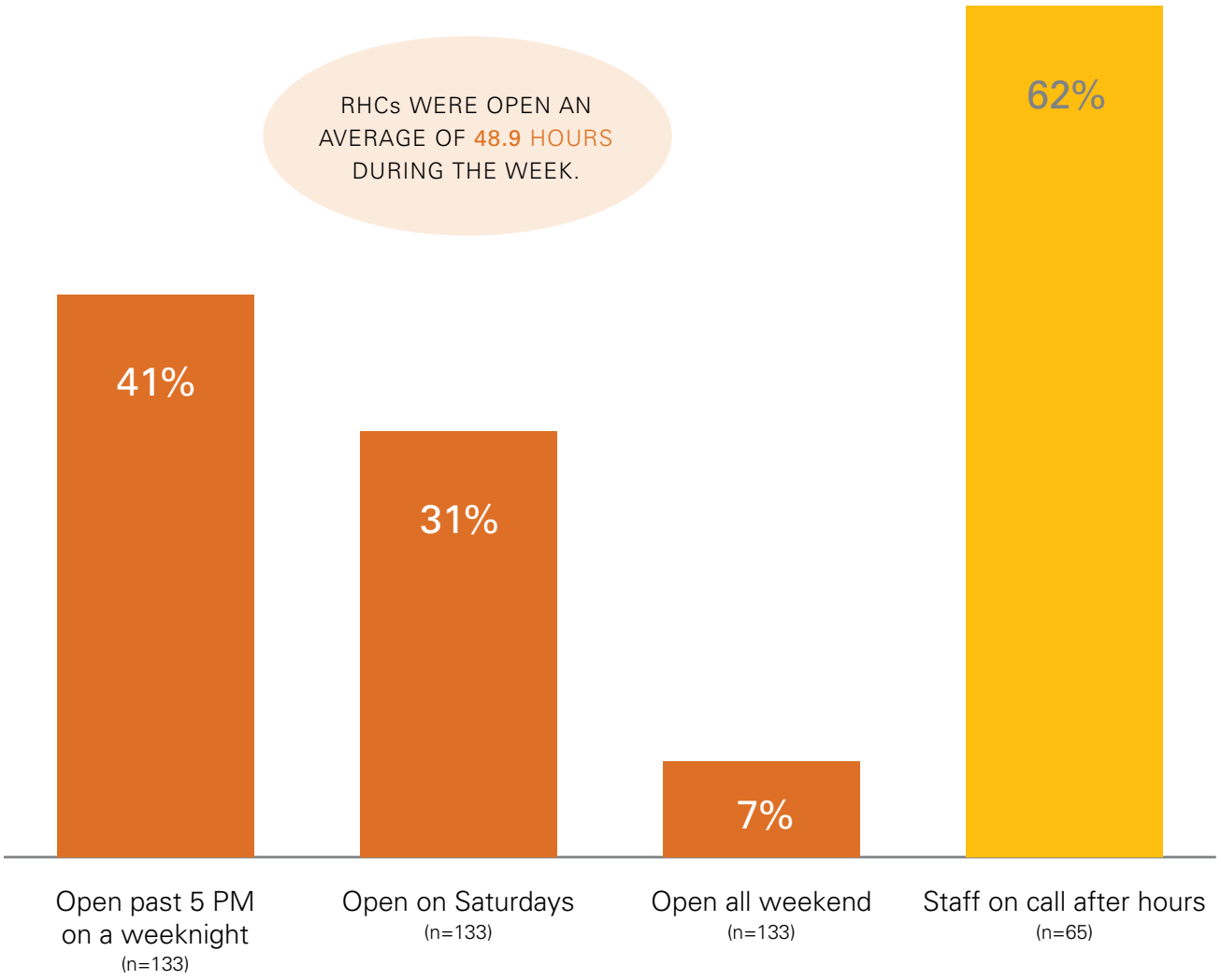


Note: Of the three clinics that did not offer general primary care, two provided pediatric primary care, and the other provided primary care to women.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

In addition to the outpatient primary care services that RHCs must deliver, many RHCs provide other services such as family planning and mental health treatment. Ninety-one percent of RHCs offered more than one non-primary care service to its patients (not shown).

RHCs with Extended Access

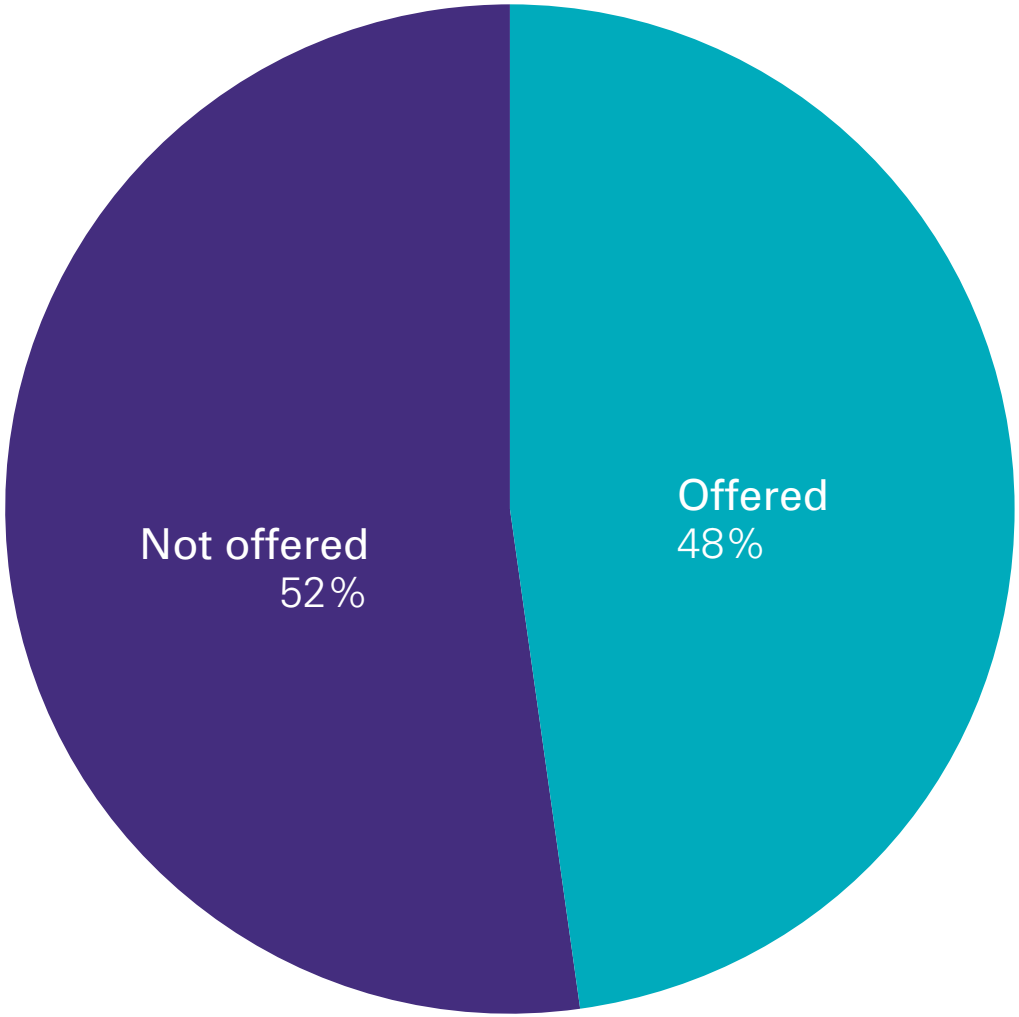


Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Rural Health Clinic Cost Reports; rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011. Each RHC has its own fiscal year; the span of fiscal years reflected in the CMS reports analyzed for this snapshot is from late 2007 to the end of 2009. Blue Sky's survey asked clinics to report current data.

Extended or weekend hours can improve health care access for underserved populations. On average, RHCs were open more than 48 hours per week. Still, fewer than half of RHCs provided care past 5 PM during the week. Almost one-third of RHCs were open on Saturdays. More than 60% of RHCs had staff on call after hours.

RHCs with Posted Sliding Scale Fee Schedules, 2011

PERCENTAGE OF RHCs (n=61)

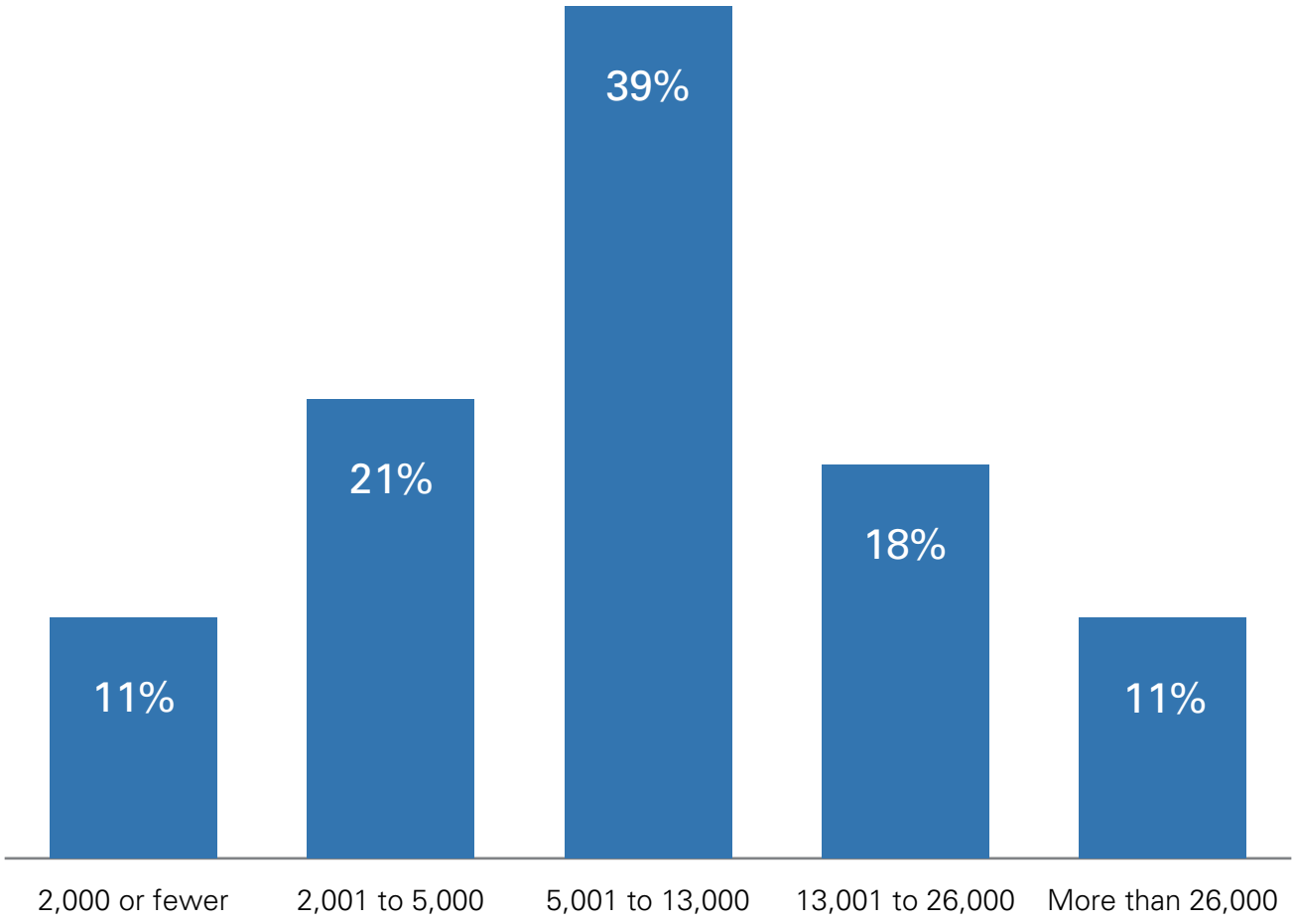


Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

Unlike FQHCs, RHCs are not required to provide discounted care to uninsured patients according to a posted sliding scale fee schedule if they are not licensed as a community clinic or participate in a federal program that requires this practice. Even though it wasn't required, 48% of RHCs reported that they did post a sliding scale fee schedule.

RHC Total Number of Patients, Last Fiscal Year

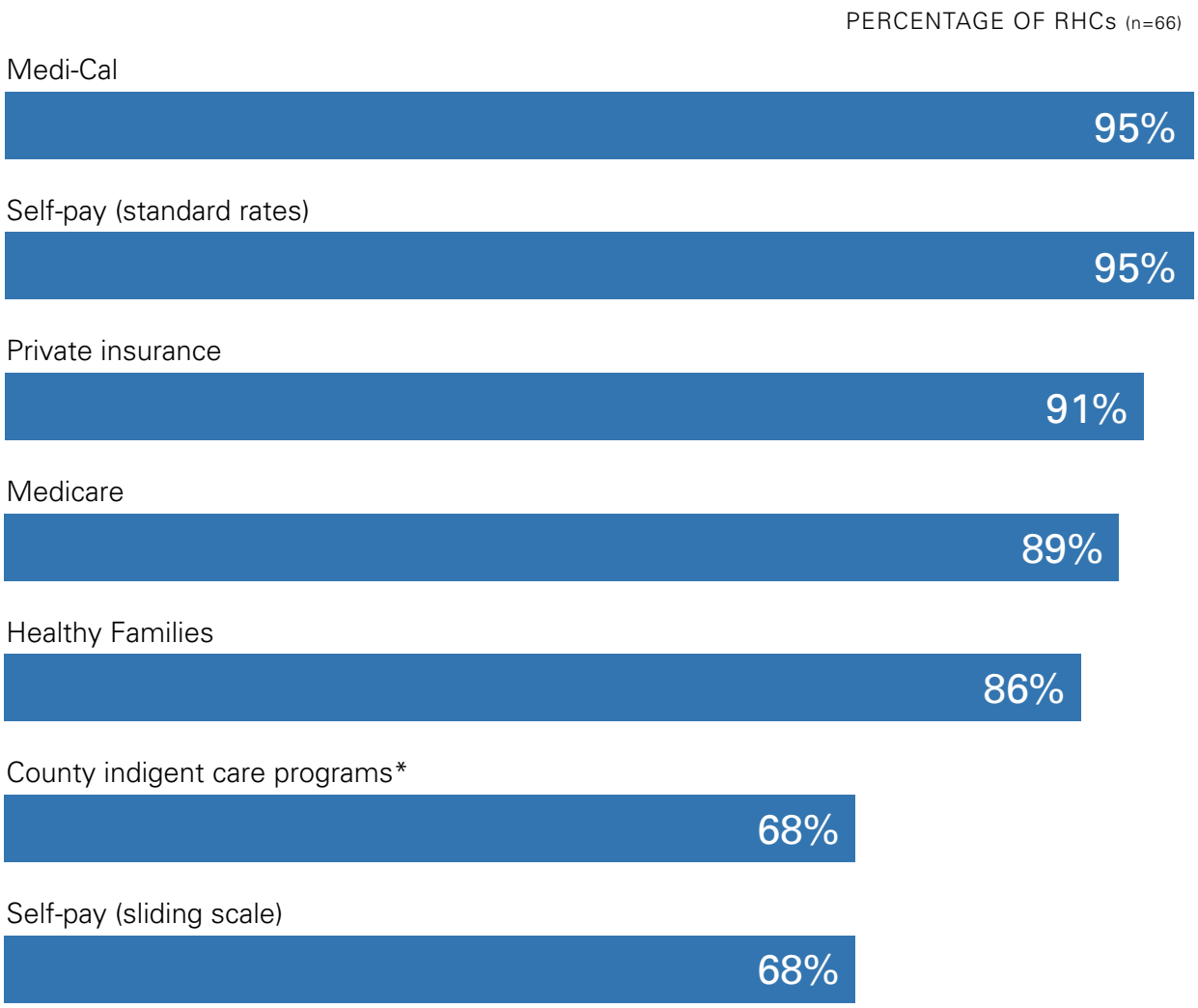
PERCENTAGE OF RHCs (n=38)



Among the clinics surveyed, the median number of patients per RHC in their last fiscal year was about 10,000. But patient totals varied widely. The smallest clinics had fewer than 2,000 patients, while the largest clinics had more than 26,000 patients.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for data from the clinic's last fiscal year.

RHCs Accepting New Patients, by Payer Type, 2011



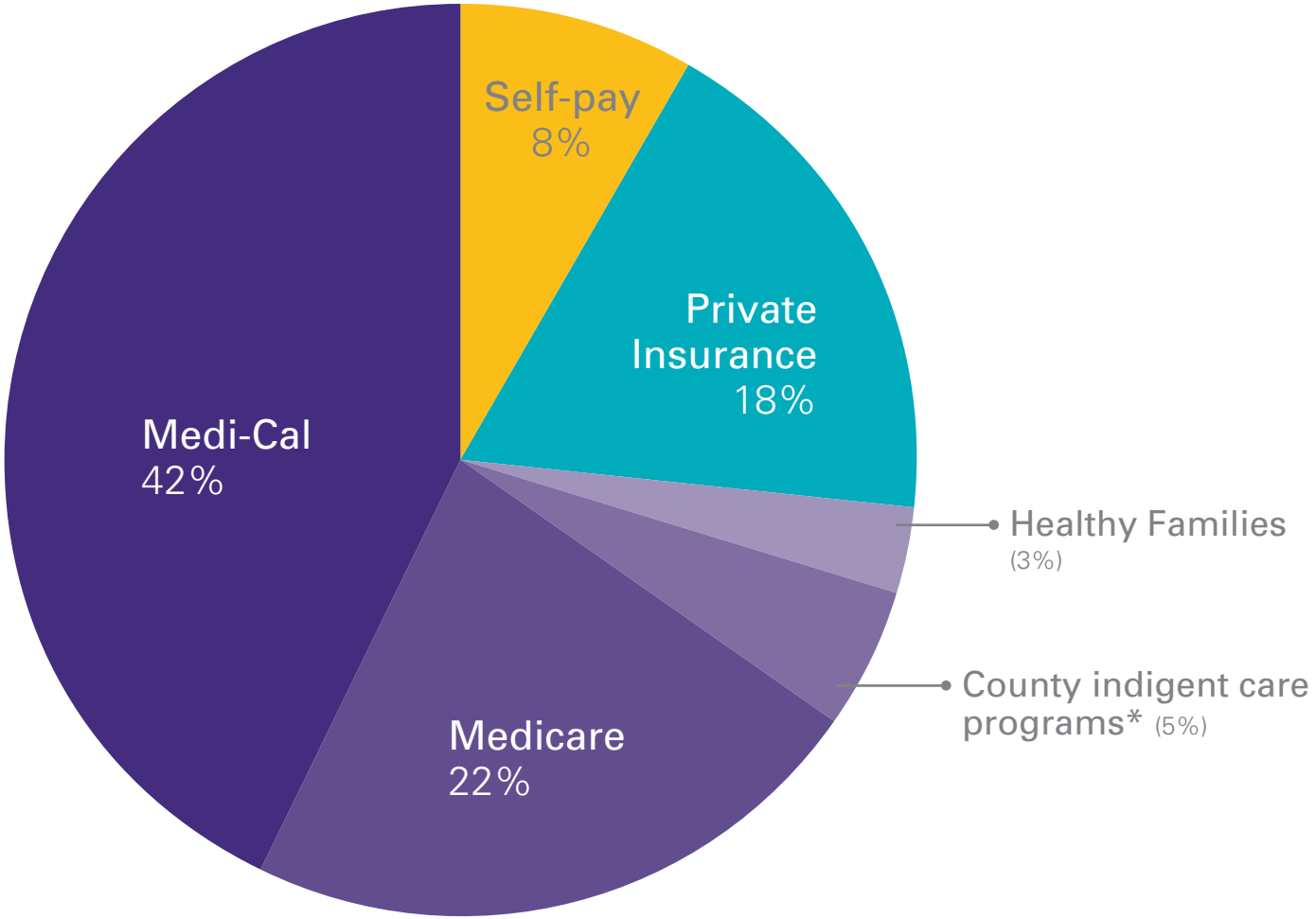
*This category includes the County Medical Services Program.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

While almost all RHCs accepted new patients in 2011, they also limited new patients to certain payers. For example, while almost all RHCs accepted new patients with Medi-Cal, only 68% accepted new patients enrolled in county indigent care programs. In addition, 95% of RHCs accepted new uninsured patients who paid standard rates, but only 68% accepted new uninsured patients who paid on a sliding scale based on income level.

RHC Visits, by Payer Type, Last Fiscal Year

PERCENTAGE OF ALL VISITS (n=45)



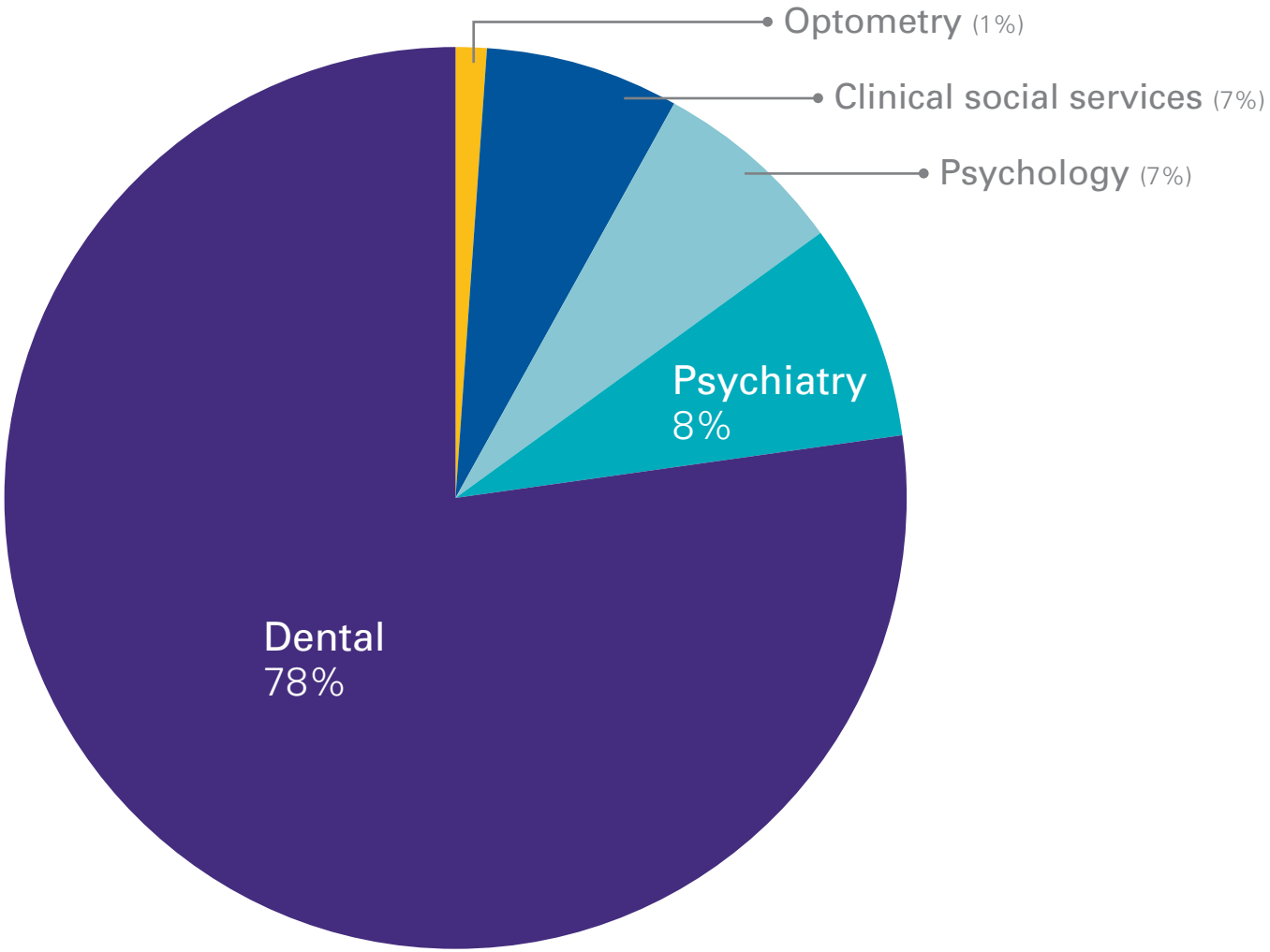
*This category includes the County Medical Services Program.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for data from the clinic's last fiscal year.

Nearly 75% of visits at RHCs were made by patients enrolled in public programs, twice the percentage of rural Californians enrolled in public programs (34%, not shown). Although 55% of rural Californians had private insurance (not shown), only 18% of RHC visits were by patients with private insurance.

Medi-Cal Optional Service Visits to RHCs, FY 2010

PERCENTAGE OF OPTIONAL VISITS
(271 clinics reported 65,825 optional service visits)

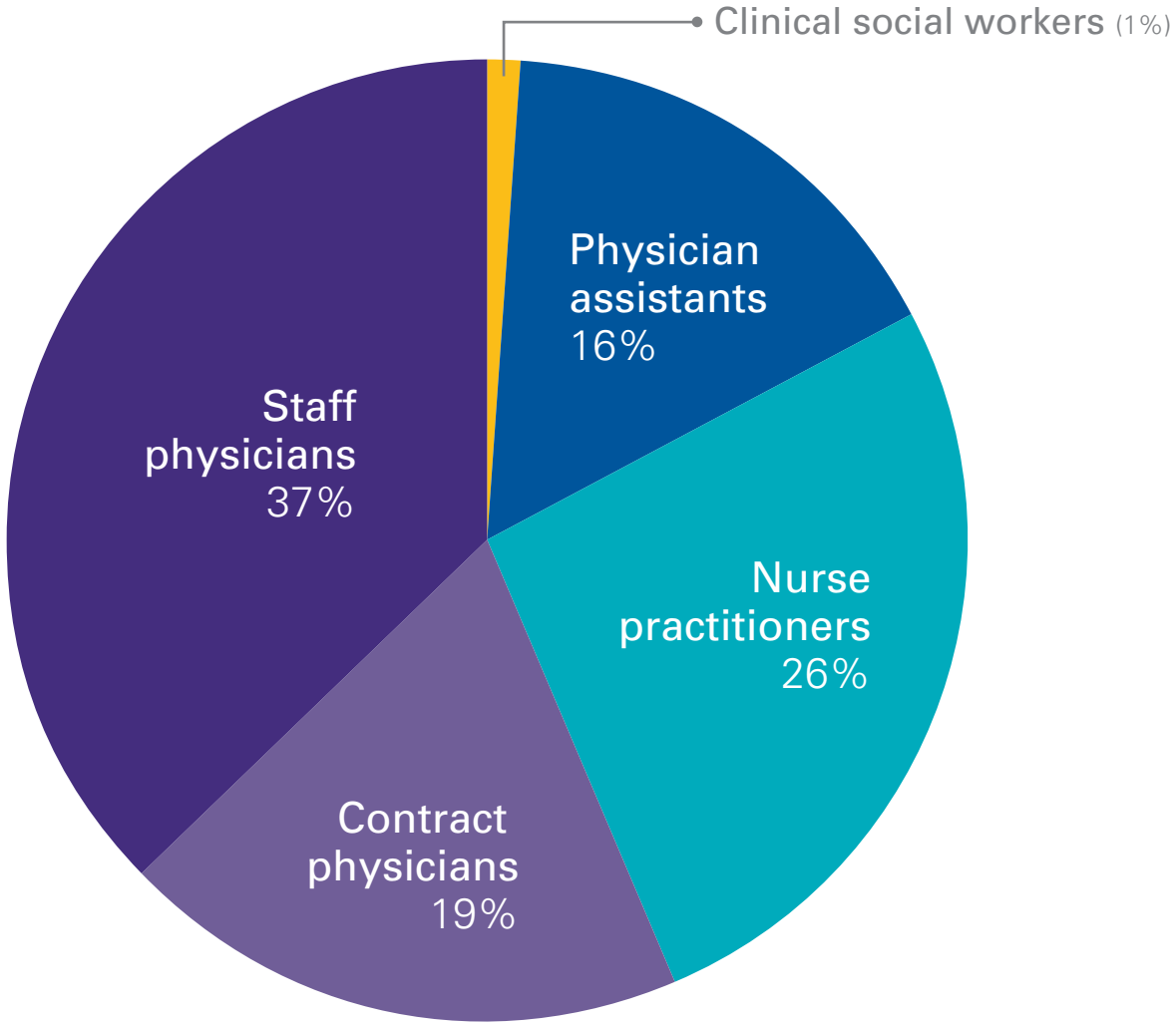


Source: State of California, Department of Health Care Services, Medi-Cal Program Fee-For-Service Paid Claims for FY 2010 (July 2009 to June 2010), September 2011.

Medi-Cal covers several optional medical services outside of traditional primary care. In FY 2010, RHCs provided Medi-Cal optional services for nearly 66,000 visits. The most commonly provided optional service was dental care (78% of optional visits), followed by mental health services (15%, a combination of psychiatry and psychology). Due to recent budget cuts, Medi-Cal no longer pays for these optional services for adults over 21 years old.

RHC Visits, by Medical Provider Type

PERCENTAGE OF ALL VISITS (n=170)

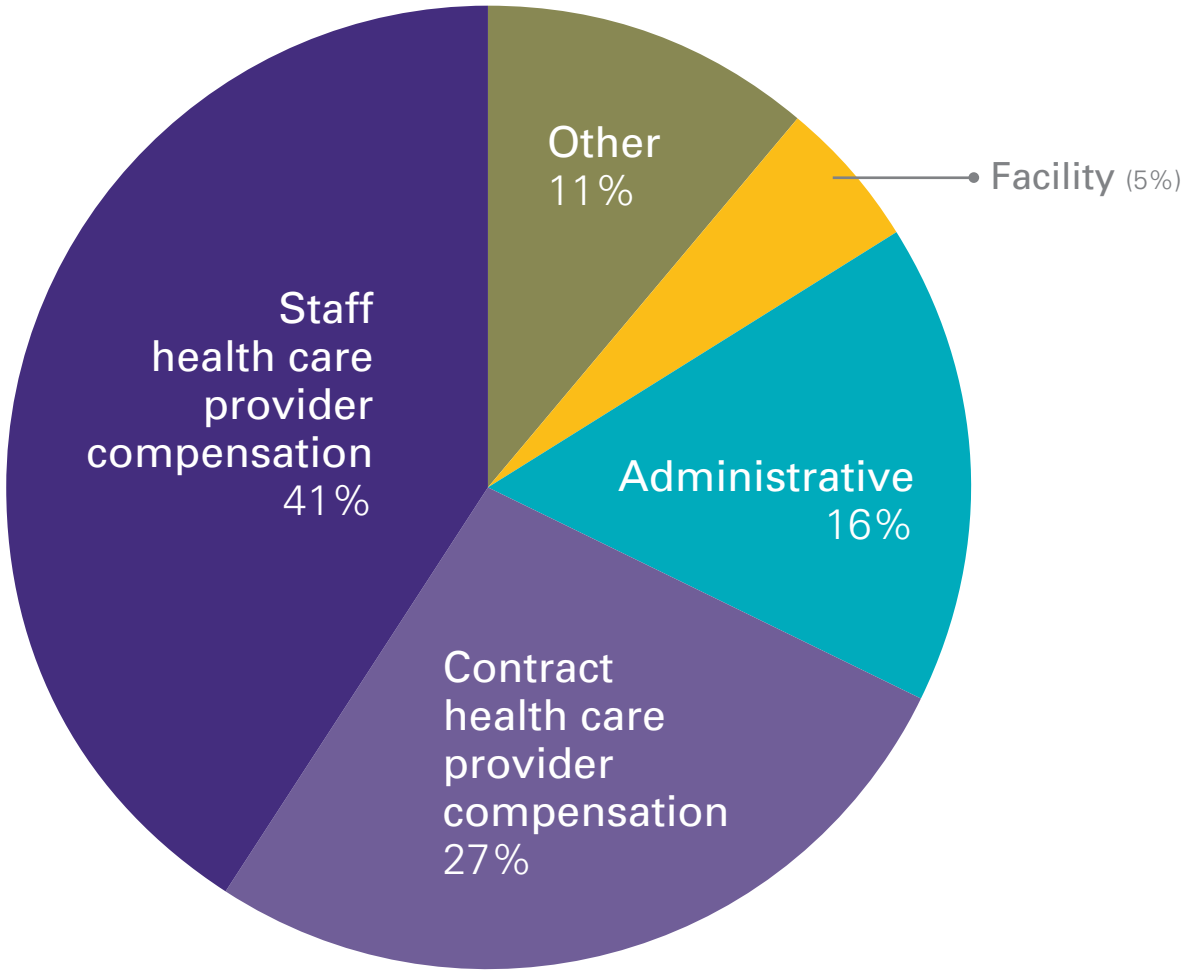


Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Rural Health Clinic Cost Reports. Each RHC has its own fiscal year; the span of fiscal years reflected in the CMS reports analyzed for this snapshot is from late 2007 to the end of 2009.

Most RHC visits were with physicians. Physicians permanently on staff as well as those acting as contractors conducted 56% of all visits. Nurse practitioners were responsible for a quarter of all patient visits, and physician assistants conducted 16% of visits.

RHC Costs, by Type

PERCENTAGE OF ALL COSTS (n=173)

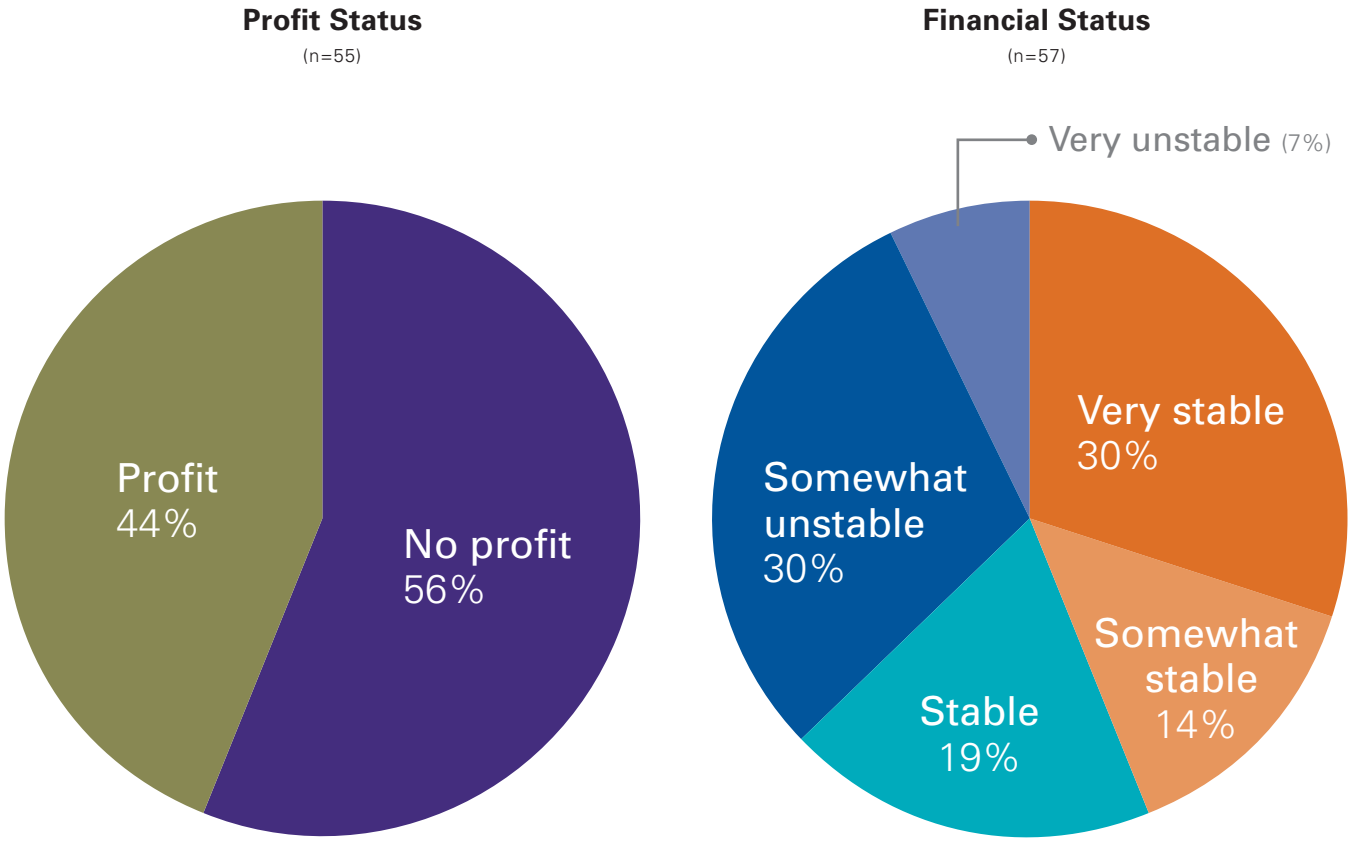


Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Rural Health Clinic Cost Reports. Each RHC has its own fiscal year; the span of fiscal years reflected in the CMS reports analyzed for this snapshot is from late 2007 to the end of 2009.

Nearly 70% of RHC costs were for health care professional salaries and reimbursements, but 21% were for overhead expenses such as facilities and administration.

RHC Profit Status and Financial Self-Assessment,
Last Fiscal Year

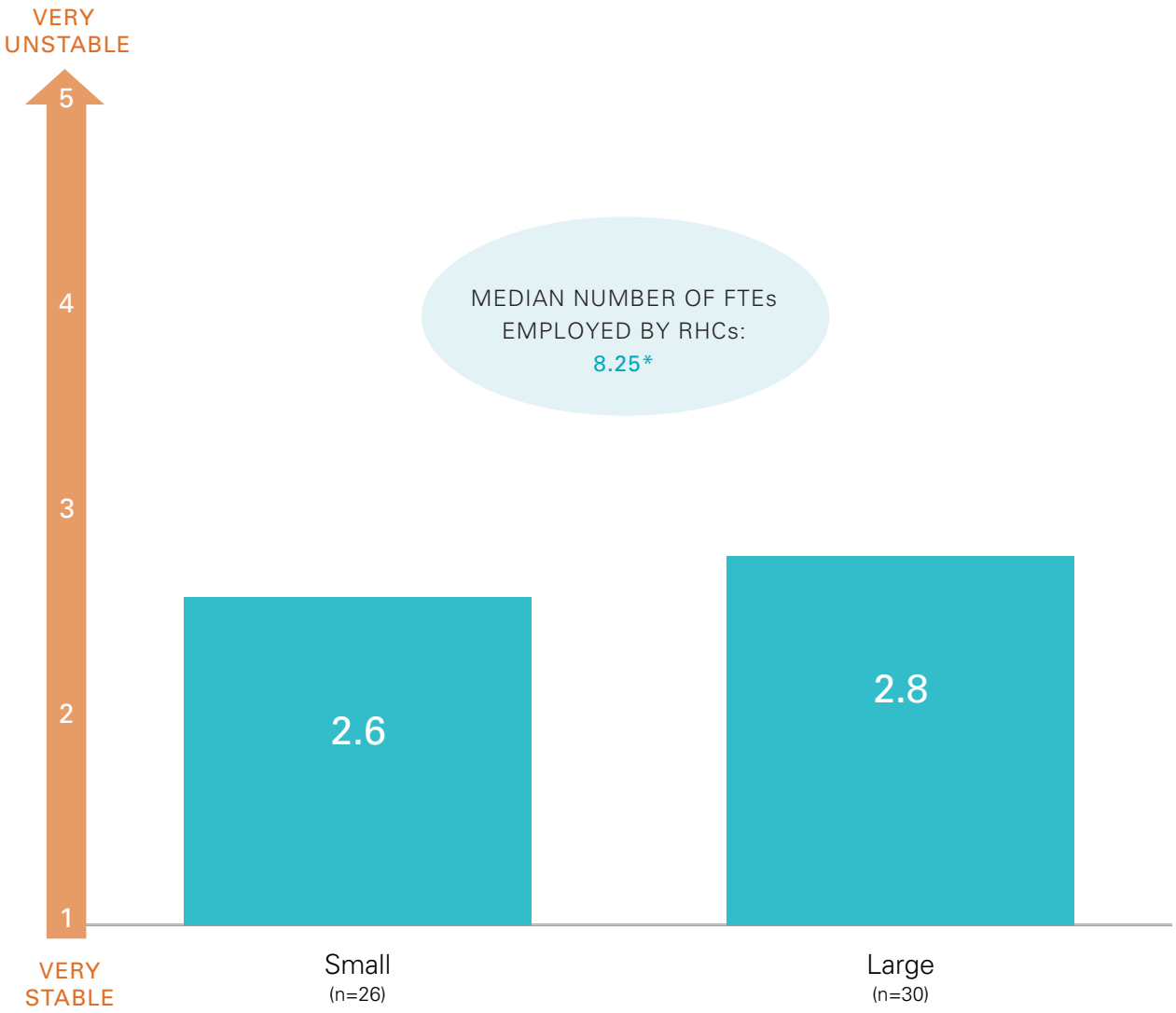
PERCENTAGE OF RHCs



Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data on stability, and last fiscal year data on profit.

Many RHCs struggle with profitability and financial stability. More than half of RHCs (56%) did not make a profit in their last fiscal year, and 37% reported their current financial situation as being somewhat unstable or very unstable. Less than one-third of clinics reported that they were very financially stable.

RHC Financial Self-Assessment, by Clinic Size, 2011

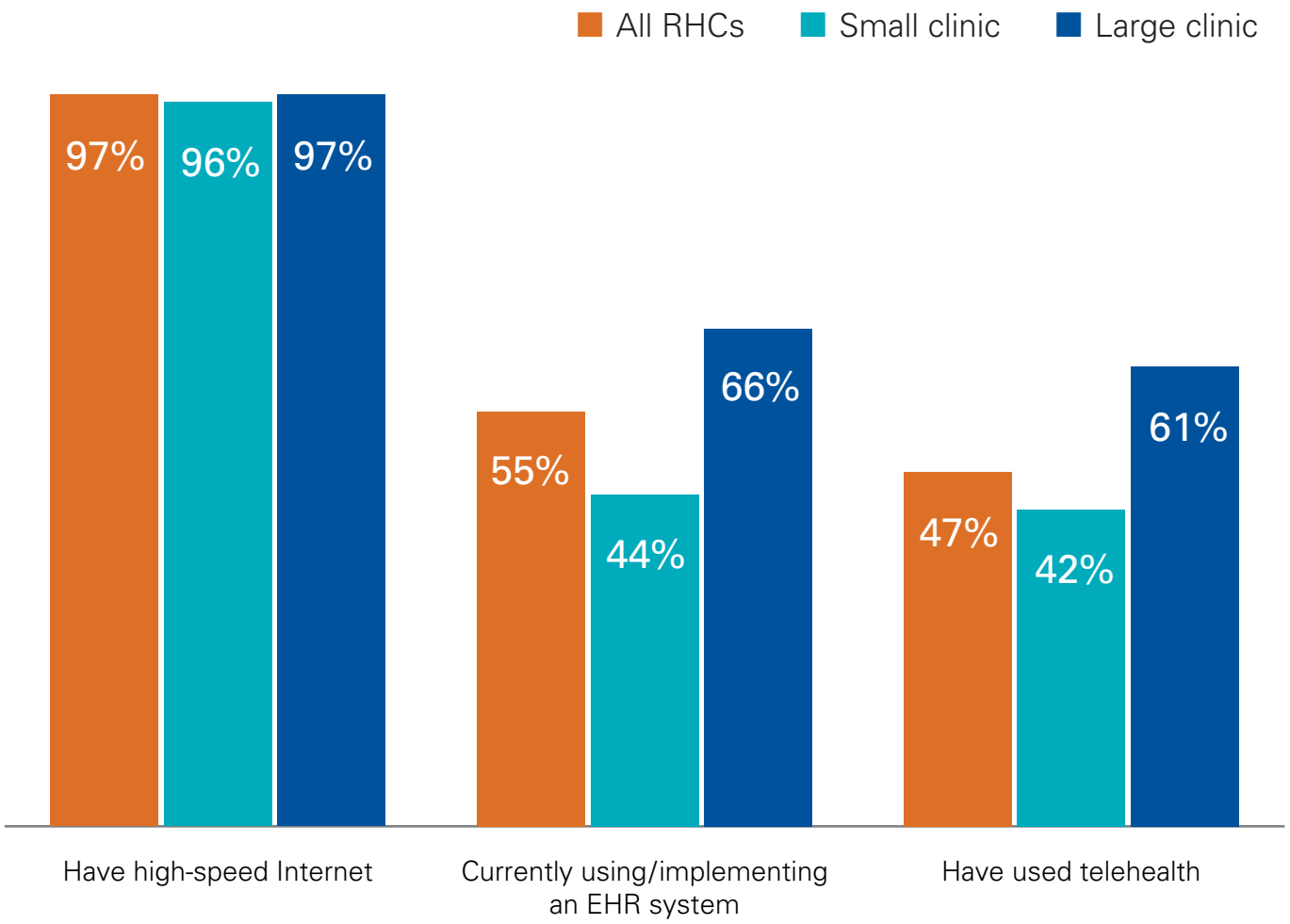


*Small clinics are defined as having fewer than the median number of FTEs (8.25); large clinics have an equal or greater number of FTEs than the median.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

Clinic size was not a factor in RHCs' self-assessments of financial stability. Financially stable clinics were both small and large.

RHC Use of Information Technology, by Clinic Size

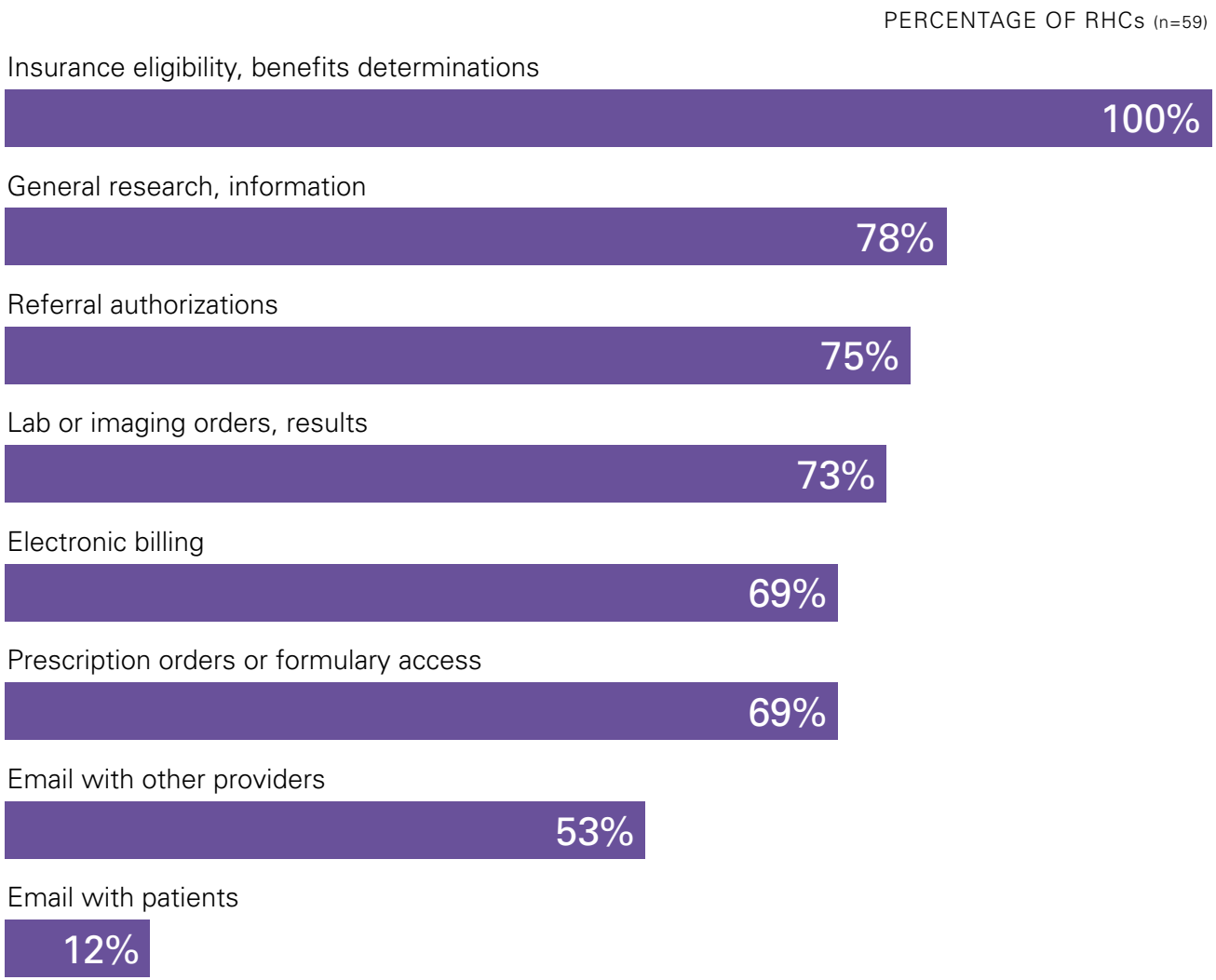


Note: Small clinics are defined as having fewer than the median number of FTEs (8.25); large clinics have an equal or greater number of FTEs than the median.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data on Internet and EHR use, and data from the last 12 months on telehealth use.

Information technology (IT) can change the way health care providers serve their patients. Rural practices in particular can benefit from better interconnectivity with distant providers. However, IT requires infrastructure investment, which is a challenge for some clinics. Large clinics were more likely to use electronic health record (EHR) systems and telehealth than small clinics.

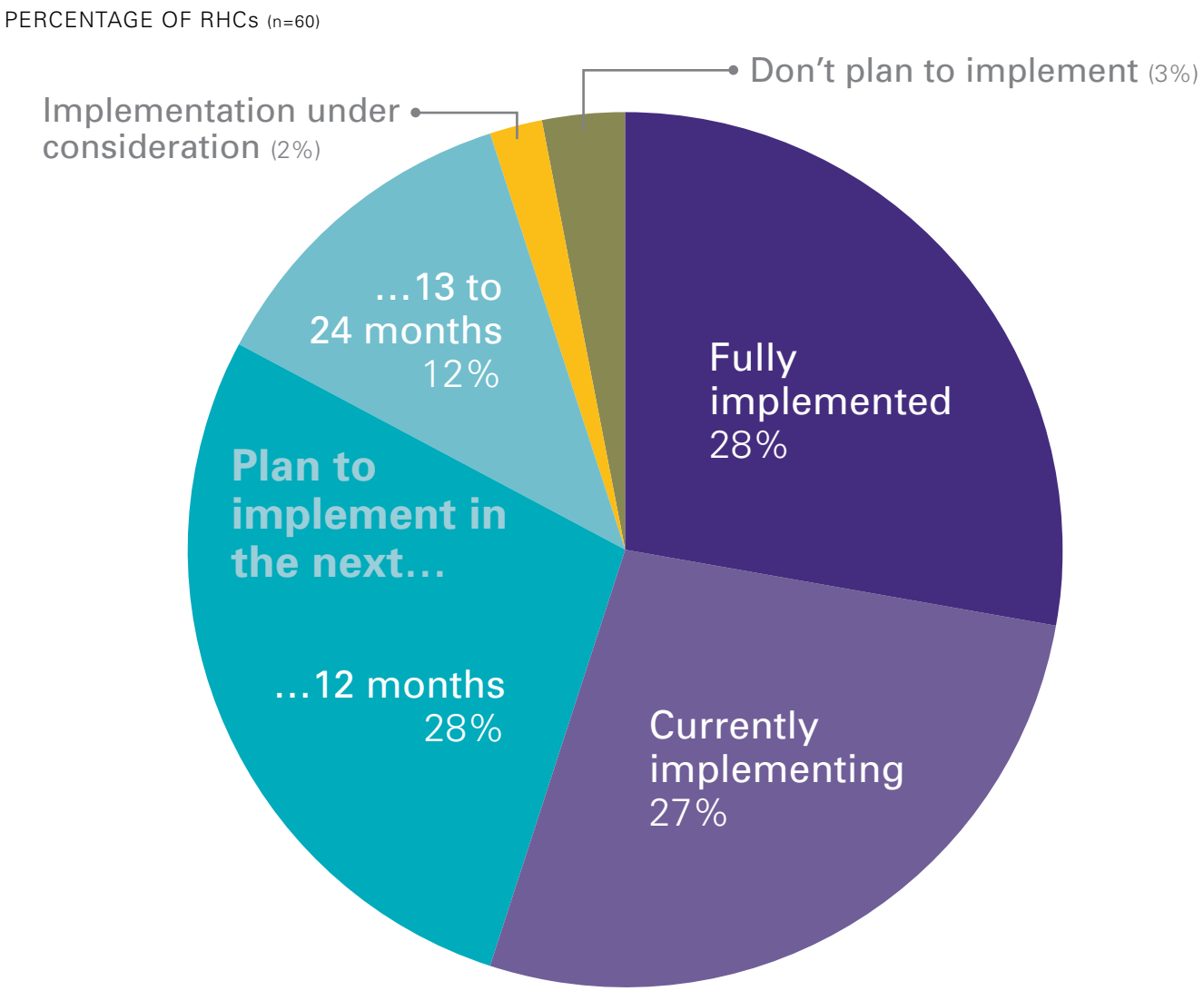
RHC Internet Use, by Activity, 2011



Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

RHCs reported using the Internet for many purposes, particularly clinic-centered activities such as insurance eligibility determinations and research. Less common uses were interacting directly with other providers and patients. About half of RHCs used the Internet to contact other providers, but just 12% did so to contact patients.

RHC Implementation of EHRs, 2011



Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

EHRs allow practices to track patient information digitally and to interact with outside providers and institutions such as public health agencies. Half of RHCs reported they already had or were currently implementing EHRs, with another one-third planning implementation within the next year. Only 5% of RHCs were not planning to implement EHRs within the next two years.

RHC Uses of EHRs, 2011

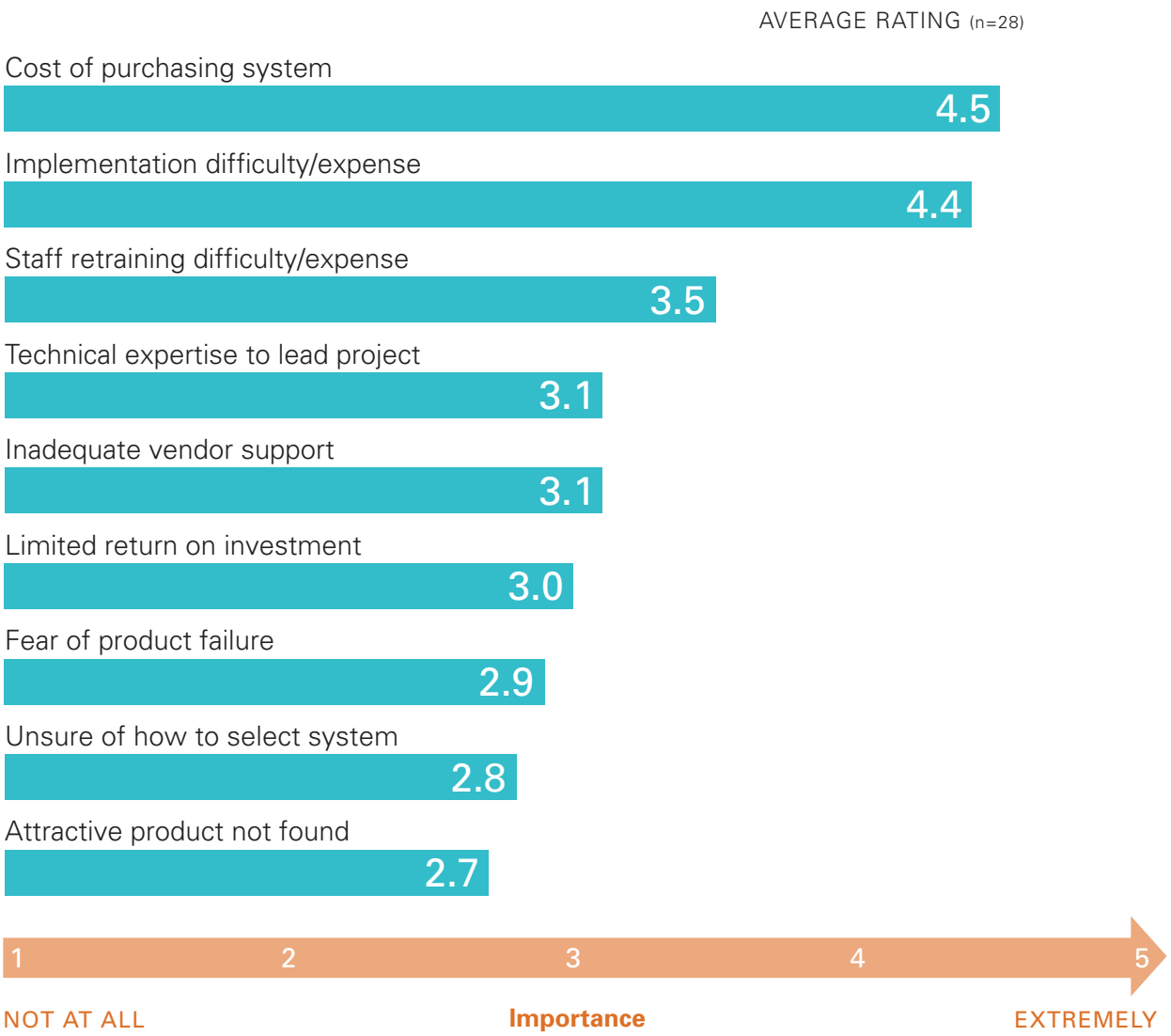
PERCENTAGE OF RHCs WITH AN EHR USING THE FOLLOWING CAPABILITIES (n=31)

87%	Recording demographics, vital signs, or smoking status
84%	Maintaining active medication, medication allergy, or diagnoses lists
71%	Drug/drug and drug/allergy interaction checks
68%	Computerized Physician Order Entry for medications, laboratory, and radiology/imaging
68%	Providing patients an electronic copy of their health information
58%	Submitting data to immunization registries
58%	Generating patient lists by specific conditions
48%	Exchanging key clinical information between care providers
48%	Drug formulary checks
45%	Clinical decision support
45%	Sending reminders to patients for preventive/follow-up care
13%	Submitting syndromic surveillance data to public health agencies

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

Most RHCs with EHRs used them to help providers record and track patient information. More than half of EHR users also used the technology to order and track prescriptions and laboratory tests. The least used functions involved sharing information with patients and public health agencies.

RHC Rating of Importance, Selected EHR Obstacles, 2011



Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

For those RHCs that did not have an EHR system, the most important obstacles in delaying or deterring adoption were the cost and difficulty of purchase and implementation. The least important obstacles centered around concerns about the EHR system itself.

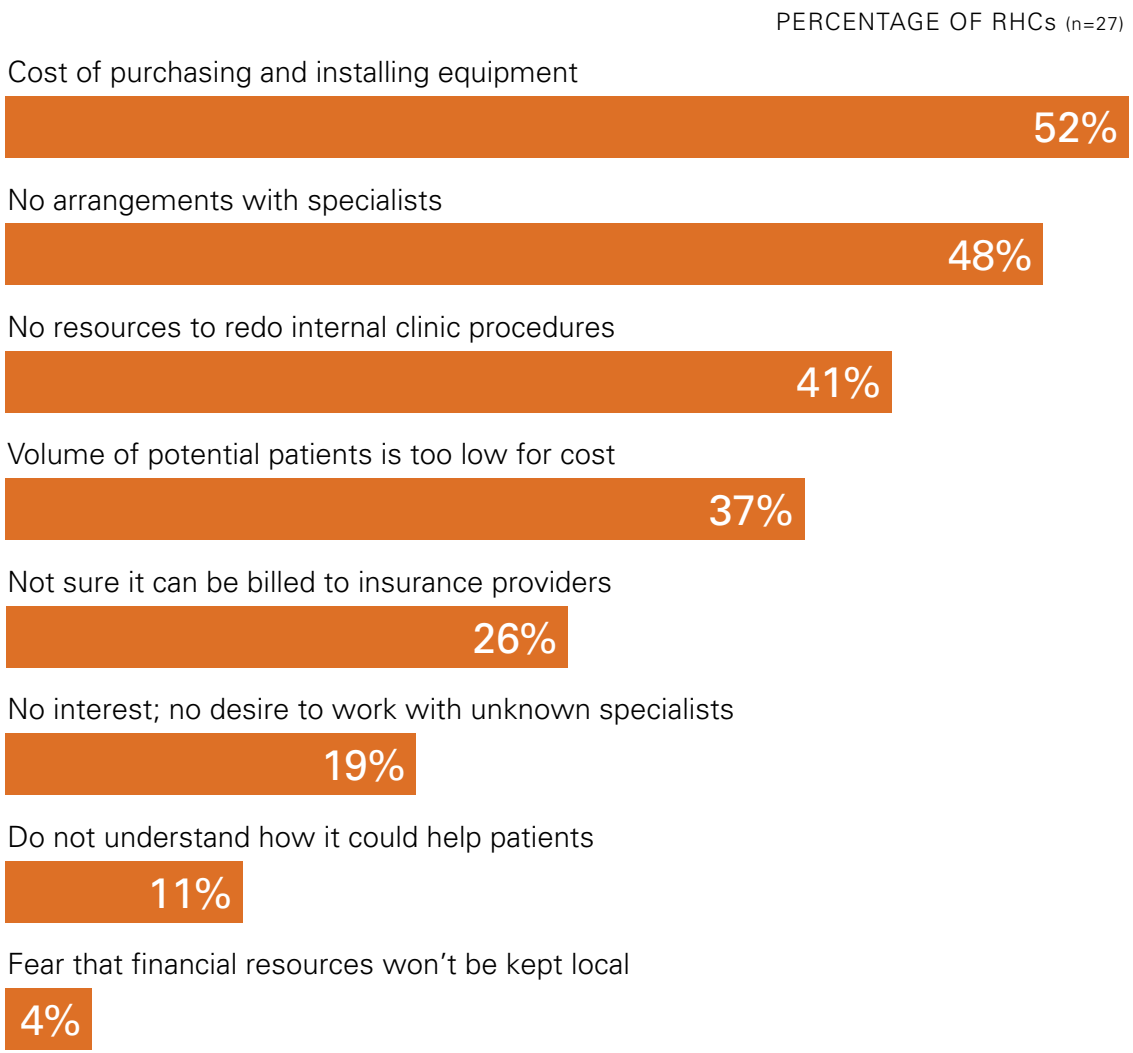
RHC Participation in Selected Telehealth Activities, 2011

PERCENTAGE OF RHCs (n=60)

*Store-and-forward refers to the practice of capturing digital still images and clinical information, and transmitting this information to other care providers for asynchronous review.
Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for data from the last 12 months.

Telehealth allows patients at RHCs or in their homes to receive care from distant providers. It has the potential to increase access to care for rural patients — especially to specialists — but obstacles to adoption must be overcome. This survey found that while almost half of RHCs had engaged in videoconferencing in the last year, the majority of clinics had not participated in any telehealth activities.

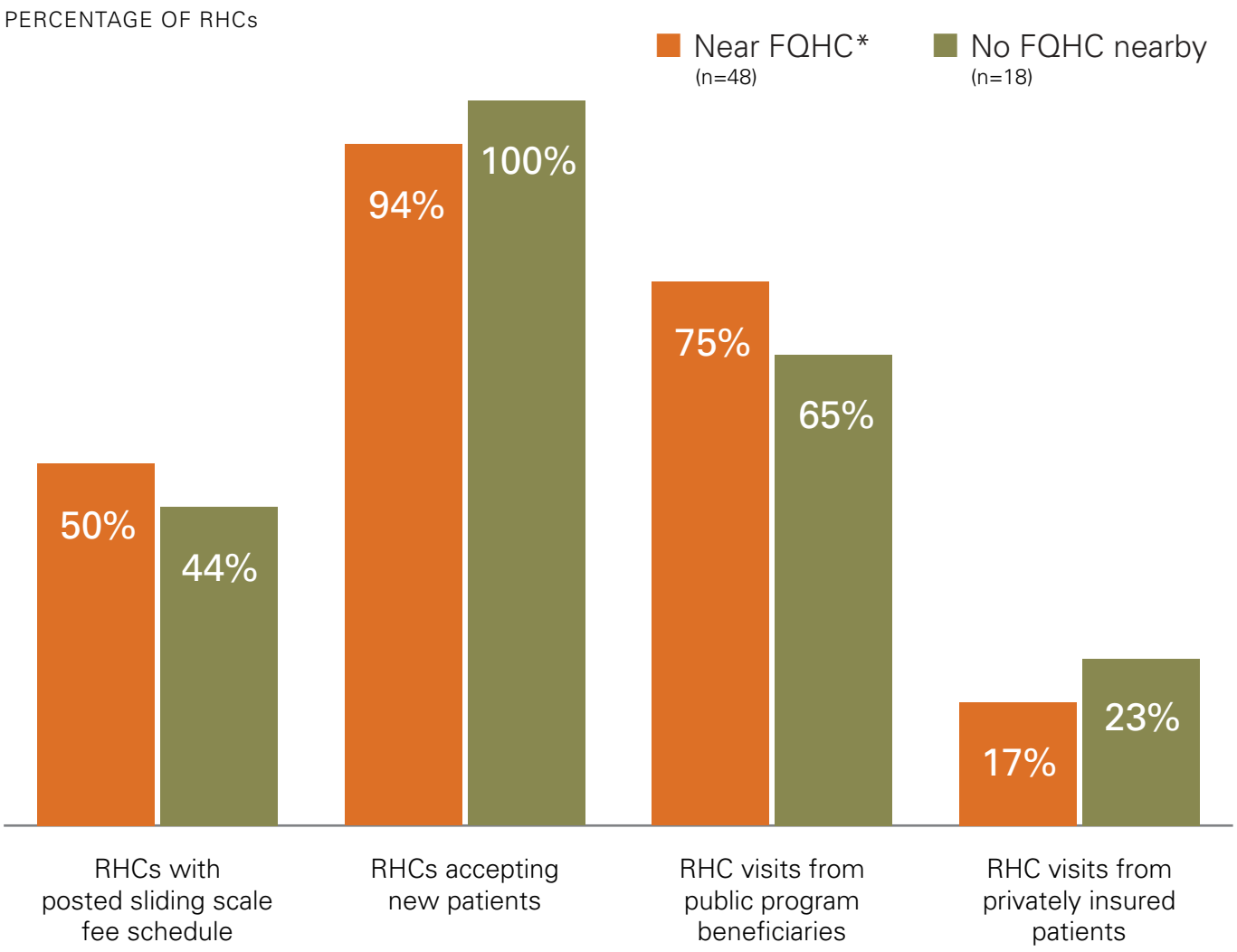
RHCs Reporting Selected Telehealth Obstacles, 2011



Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

For the RHCs that did not participate in telehealth activities in 2011, many obstacles were cited as the reason. The most prevalent obstacles involved telehealth infrastructure: the cost of purchasing and installing the equipment, the lack of a network of specialists with whom to work, and insufficient resources for adoption.

Impact of FQHC in the Same Community



*RHCs self-reported the existence of an FQHC within 30 miles of their clinic.

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data on sliding scale fee schedules and accepting new patients, and for last fiscal year data on public program and private insurance visits.

The proximity of an FQHC can affect RHC services and utilization as the two institutions have overlapping roles in serving the underserved. RHCs near FQHCs were more likely to have a posted sliding fee schedule. RHCs that operated without FQHCs nearby were more likely to accept new patients, and had proportionally more privately insured patients and fewer public program beneficiaries.

RHC Rating of Importance, Selected Challenges, 2011

AVERAGE RATING OF IMPORTANCE OF SELECTED RHC CHALLENGES (n=59)
(5 = EXTREMELY IMPORTANT AND 1 = NOT AT ALL IMPORTANT)

4.69	Maintaining financial stability
4.63	Achieving break-even or better financial performance
4.46	Complying with legal and regulatory requirements
4.42	Low reimbursement rates from public payers
4.42	Low reimbursement from third-party payers (Blue Cross, Blue Shield, etc.)
4.36	Managing increased documentation requirements of insurance companies
4.19	Staff recruitment
4.19	Patient health issues
4.14	Staff retention
4.14	Increase in/extent of uninsured patients
3.92	Managing day-to-day clinic operations
3.83	Implementing federal health care reform
3.69	Billing Medicare and Medicaid
3.66	Cost of medical liability insurance
3.61	Billing private insurance
3.51	Lack of clinic space or exam rooms
3.47	Decrease in/limited number of patients
3.34	Lack of staff technological expertise or desire
3.29	Lack of staff training
3.20	Lack of technological/IT support

Source: Rural health clinic survey conducted by Blue Sky Consulting Group in Fall 2011; survey asked for current data.

When asked to rate the importance of various challenges, RHCs cited financial concerns such as maintaining financial stability, making a profit, and low reimbursement rates from both public and private payers as the most important. Also important were operational issues such as recruiting and retaining staff, complying with legal and regulatory requirements, and managing day-to-day operations.

Methodology

The information presented in this snapshot is based on an analysis of administrative and survey data from a variety of sources. Administrative data include Medi-Cal FFS paid claims data collected by the California Department of Health Care Services, and cost reports filed by RHCs under Centers for Medicare and Medicaid Services (CMS) rules. Medi-Cal FFS paid claims data reflect FY 2010 (July 2009 to June 2010). RHC cost reports to CMS are based on each RHC's fiscal years, which vary; the span of fiscal years reflected in the reports analyzed for this snapshot is from late 2007 to the end of 2009.

Survey data include analysis of the 2009 California Health Interview Survey conducted by the University of California Los Angeles, as well as a project-specific survey of rural health clinics conducted by Blue Sky Consulting Group in November 2011.

The project-specific survey was conducted because the publicly available administrative data for RHCs is not comprehensive. For example, a statewide Office of Statewide Health Planning and Development dataset on primary care clinics offers fairly comprehensive patient and financial data, but it does not include all RHCs. This is because practices run by private physician groups, government agencies, and hospitals are not legally required to report their data. On the other hand, two administrative datasets do require active RHCs to report information, but they collect only a limited amount of data (on Medi-Cal visits and Medicare costs, respectively).

Blue Sky Consulting Group conducted its survey of California's RHCs in the fall of 2011. Fifty-eight clinics that are members of the California Association of Rural Health Clinics (CARHC) were invited via email by CARHC to participate in an online survey. The remaining 253 clinics listed on the CMS list of California RHCs (accessed June 2011) were sent a letter that explained the project, and were invited to respond online. In addition, the California Hospital Association sent an email to its outpatient-clinic listserv inviting certified RHCs to participate in the survey. All clinics received at least one follow-up request for participation. The second mailing included paper surveys and pre-stamped return envelopes as an alternative to online completion. A random sample of clinics was contacted by phone in order to increase the survey response rate. Sixty-seven clinics completed the survey.

Questions in the survey asked clinics to report current data, data for the last 12 months, or data for their last fiscal year, which varied by clinic.

Term Definition

Outpatient providers included physicians, physician groups, hospital outpatient departments, and primary care clinics that had ZIP codes with a Rural Urban Community Area (RUCA) code of four or greater, as determined by the WWAMI Rural Health Research Center. RUCAs are a Census tract-based classification scheme that utilizes the standard Bureau of Census Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize all of the nation's Census tracts regarding their rural and urban status and relationships. WWAMI developed a ZIP code approximation that was used for this project.

FOR MORE INFORMATION

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