



## Rural health clinics

*Authors: Kelly Braun, Trent Bourland*

### Introduction

Rural health clinics (RHC) were established in 1977 by the Rural Health Clinic Service Act to improve access to primary medical care for rural residents. In response to the challenges of recruiting and retaining physicians in rural areas, RHCs were designed to increase the utilization of nurse practitioners (NP) and physician assistants (PA). To be designated as an RHC, the clinic must be in an area considered non-urban as defined by the U.S. Census Bureau. In addition, a site seeking RHC designation must be in an area designated as either a Primary Care Geographic Health Professional Shortage Area (HPSA), Primary Care Population-Group HPSA, or a Medically Underserved Area (MUA) by the Health Resources and Services Administration within the past four years. Exceptions may be made by an individual state where the governor may designate a shortage area.<sup>i</sup>

RHCs must be under the medical direction of a physician (MD or DO). They are required to employ (W2 employee) a PA or NP, and this provider must be present in the clinic at least 50 percent of the time that the clinic is open. Operating hours must be posted. In addition, the RHC must have the capacity to complete six laboratory tests on site, including:

- stick or tablet chemical urine exam
- hemoglobin or hematocrit
- blood sugar
- occult blood stool specimen exam
- pregnancy test
- primary culturing to send to a certified laboratory<sup>i</sup>

The main function of RHCs is to provide primary care services. At least 51 percent of the services provided in an RHC must be considered primary care. This leaves room for specialty services to be included based on the needs of the community. While RHCs are expected to have an emergency kit stocked with medication and equipment, they are also required to have an arrangement with a hospital so patients can access medical services that might not be available at the RHC. RHCs are subject to a state certification or accreditation organization survey to ensure that they meet all requirements of the program. Initial surveys are completed prior to designation and are updated every three years or according to the state's survey agency schedule.

RHCs differ from Federally Qualified Health Centers. Two significant differences include that they are not required to have a majority patient board of directors or a sliding fee scale. Some RHCs may choose to offer a sliding fee scale to assist patients, in which case their clinicians may qualify for loan repayment from the National Health Service Corps. Communities may be served by both a FQHC and RHC, and collaboration between sites can positively influence the health of a community.

According to CMS, as of April 2021, there are approximately 4,500 RHCs in the United States.<sup>i</sup> RHCs may be either independent or provider-based. Provider-based RHCs are owned and operated by a hospital, skilled nursing facility, or home health agency that serves as a parent facility and provides operational and administrative oversight to the clinic. Independent RHCs are often clinician-owned. In some instances, they may be owned by a hospital or health system, but they are free-standing and are not considered a department of the hospital.



A distinguishing factor of RHCs is they are reimbursed using an encounter-based payment for Medicare beneficiaries at an all-inclusive rate. In many states, the same methodology is utilized to reimburse Medicaid beneficiaries and those with Medicaid MCO plans. The Consolidated Appropriations Act of 2021 (CAA) changed the RHC reimbursement methodology for all RHCs. For independent RHCs and any new provider-based RHCs, the reimbursement limit was increased to \$100 as of April 1, 2021.<sup>1</sup> The upper payment limit will continue to increase until it reaches \$190 in 2028, and then it will increase by the Medicare Economic Index thereafter. Prior to the CAA, RHCs that were provider-based to a hospital with fewer than 50 beds were paid using a cost-based methodology with no limit. The CAA created a grandfathered RHC, which are those RHCs owned and operated by a hospital with fewer than 50 beds prior to December 31, 2020<sup>2</sup>. With the new rules, all new RHCs enrolling in the program on or after Dec. 31, 2020, will be paid under a cost-based methodology subject to the new upper payment limit. Grandfathered RHCs will continue to be paid using a cost-based methodology, however, they will be subject to a new cap increased by the Medicare Economic Index.

RHCs are required to meet minimum productivity standards. Currently, RHC physicians must see 4,200 patients per full-time equivalent and 2,100 patients per full-time equivalent for non-physician advanced practitioners. If more than one provider is in the RHC, patient visits can be averaged to reach the minimum productivity standard. If the RHC does not meet the minimum productivity standard, they can request an exception from their Medicare Administrative Contractor. If the exception is granted, the RHC's all-inclusive encounter rates will remain. If the exception is not granted, the RHC's all-inclusive encounter rate will be determined using a higher number of visits than they performed, which will negatively impact their reimbursement. For example, if the number of patient visits falls below the minimum productivity standard per FTE, the total expenses of the RHC will be divided by a number higher than the actual patient visits, resulting in a lower reimbursement rate per patient visit.

## Policy recommendations

### *Access to care*

RHCs provide essential access to care in rural areas. A primary care workforce is required to keep the doors of RHCs open. Creating a workforce pipeline is necessary to ensure the availability of health care providers in rural areas. Access to telehealth services can also improve the availability of specialty care in rural areas. For telehealth to be feasible, adequate broadband access and reimbursement for telehealth services must be in place. As telehealth encounters are typically still face-to-face in a virtual fashion, they should be considered visits and eligible for reimbursement.

### *Reimbursement*

The CAA made significant changes to the RHC payment methodology for both independent and provider-based RHCs.<sup>3</sup> These payment changes will result in significant consequences for the viability of the provider-based RHC program. Consideration should be given to continue cost-based reimbursement without a per-visit cap in exchange for allowing provider-based RHCs to voluntarily report quality measures. Provider-based RHCs owned and operated by hospitals with fewer than 50 beds would use the higher payment rate to support involvement in a quality reporting program. RHCs have not typically been

---

<sup>1</sup> The previous rate for independent RHCs and RHCs that are provider-based to a hospital with more than fifty beds was \$87.52.

<sup>2</sup> For RHCs enrolled in the program or that had applied to the program prior to 12/31/2020.

<sup>3</sup> Refer to Table 1 below for the RHC Payment Limits per year.



involved in quality reporting programs on a large scale. Technical assistance should be provided to RHCs to help implement, maintain, and strategically plan for technological advancements that would improve the quality of health care in the local community. Additionally, critical data on the RHC program, which has been historically unavailable, would be provided and assessed at a national level. Most importantly, this payment policy change will keep the provider-based RHC program stable, allowing for the creation of new clinics to support future needs in rural communities.<sup>ii</sup>

Prior to March 31, 2021	\$87.52
April 1, 2021	\$100
January 1, 2022	\$113
2023	\$126
2024	\$139
2025	\$152
2026	\$165
2027	\$178
2028	\$190

*Programmatic updates*

The Consolidated Appropriations Act of 2021 updated payment methodologies, but other aspects of RHC modernization were not included. There are currently six laboratory tests RHCs must be able to provide. Medicine has evolved since the RHC program was created in 1977, and at that time, lab services were not as readily available as they are now. RHCs should be able to select the laboratory tests to be performed on-site based on the needs of their patient population and the services that may be available nearby.

RHCs must employ at least one advanced practice provider. This can be challenging given current health care staffing shortages. To increase flexibility and

help staff RHCs, the requirement of employing an advanced practice provider should be modified so contracted providers can be utilized. Additionally, federal supervision requirements take precedence over state and local rules in RHCs. These federal regulations should be loosened so RHCs can practice consistently with state and local regulations. This could reduce the administrative burden and allow providers to practice at the top of their scope of licensure, increasing access to care for rural communities.

Further consideration should be given to include behavioral and oral health as Rural Health Clinic services that must be rendered 51 percent of the time the clinic is operating. Both services are integral to overall health; however, they are currently considered specialty services. Therefore, RHCs must not provide such services more than 49 percent of the time, preventing patients from accessing needed care and services. Rural primary care providers are providing basic behavioral health services daily. Still, the provision of more specialized services, such as substance use disorder counseling, may fall outside the definition of primary care. Further, RHCs cannot furnish services in K-12 schools, Head Start locations, or community colleges, unlike FQHCs. Adding the provision of services to students and families at K-12 schools and Head Start locations will help increase access to care for rural families.

**Recommended action**

- Reinstitute cost-based reimbursement without a per-visit cap in exchange for requiring provider-based RHCs owned and operated by hospitals with fewer than 50 beds to report quality measures as outlined in the reimbursement section of this document.



- Permanently enable all RHCs to serve as distant-site providers for all covered RHC services for purposes of Medicare telehealth reimbursement. Additionally, allow telehealth visits to be defined as face-to-face encounters and be reimbursed at the AIR.
- Modernize physician, physician assistant, and nurse practitioner utilization requirements to allow for arrangements consistent with state and local laws relative to practice, performance, and delivery of health services by allowing RHCs the flexibility to contract with all physician assistants and nurse practitioners, rather than requiring one employed non-physician provider.
- Revise outdated laboratory requirements to consider readily available services in each region. Clinics should have the flexibility to determine which lab services should be on-site to best meet the needs of their patients.
- Expand and provide a standardized definition of primary care – which currently includes primary care, pediatrics, and women’s health – to include additional services such as mental health and preventive dental services.
- Update allowable service locations to include Head Start programs, K-12 schools, and community colleges.

## Conclusion

RHCs are vital to ensure rural residents have access to quality primary care services close to home. Since the RHC program’s inception in 1977, health care and the needs of rural residents have evolved. It is vital the RHC program must be updated to respond to these needs and ensure its stability for years to come.

---

<sup>i</sup> Medicare Learning Network. 2021. *Rural Health Clinic*. Centers for Medicare and Medicaid Services. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctshst.pdf>.

<sup>ii</sup> National Rural Health Association. Accessed November 2021. *Rural Health Clinic Program Modernization*. <https://www.ruralhealth.us/getmedia/d3b74a44-59a6-46e3-8084-5863f41382ac/NRHA-Rural-Health-Clinic-Program-Modernization-Summary.aspx>

<sup>iii</sup> Centers for Medicare and Medicaid Services. Accessed January 2022. *Update to Rural Health Clinic (RHC) Payment Limits*. <https://www.cms.gov/files/document/mm12185.pdf>