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THE NEED FOR BETTER FOCUS IN THE RURAL HEALTH CLINIC PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

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THE NEED FOR BETTER FOCUS IN THE RURAL HEALTH CLINIC PROGRAM

THURSDAY, FEBRUARY 13, 1997

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:15 p.m., in room 2203, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, Souder, Pappas, Towns, and Kucinich.

Staff present: Lawrence J. Halloran, staff director and counsel; Doris F. Jacobs, associate counsel; Robert Newman, and Marcia Sayer, professional staff members; R. Jared Carpenter, clerk; Ron Stroman, minority professional staff; and Jean Gosa, minority staff assistant.

Mr. SHAYS. I will call this hearing to order.

The Rural Health Clinic Program is adrift. Drawn off course by financial cross-currents and a weak hand at the helm, the program lost sight of its core mission: improved access to primary health care by Medicare and Medicaid beneficiaries in rural areas. Today, the subcommittee asks how the Rural Health Clinic Program lost its focus and grew dramatically away from truly underserved areas into less rural and suburban locations.

The rapid growth in the number of rural health clinics since 1990 caught the attention of both the General Accounting Office, GAO, and the Health and Human Services Department, HHS, Inspector General, the IG. Through separate investigations, the two reached strikingly similar conclusions: rural health clinics are growing for the wrong reasons, in the wrong places, and at substantial cost to Medicare and Medicaid programs. Their testimony today will describe a program distorted by a focus on money rather than medicine.

In launching the program in 1977, Congress permitted cost-based reimbursement of primary care doctors as well as mid-level practitioners, physician assistants, nurse practitioners, and nurse midwives, to induce the expansion of health care delivery into rural areas. The higher reimbursement rates made rural Medicare practices financially viable.

In later years, as Medicare and Medicaid moved away from cost-based reimbursement to lower, fixed fee schedules in other areas, rural health clinics became one of the last opportunities for doctors and hospitals to get the higher payments.

It appears this financial incentive, more than any other factor, drove the growth of rural health clinics after 1990 and tilted that growth away from independent clinics toward those owned and operated as part of a hospital or nursing home. In 1990, less than 10 percent of the 600 rural health clinics nationwide were provider or facility based. Today, they represent almost half the Nation's 3,000 rural health care clinics, and their growth continues.

The GAO also found many rural health clinics were formed through the purchase or conversion of existing medical practices, rather than through the extension of care to those without adequate access. In many instances, the rural health clinics designation became little more than an accounting gimmick. The result was not better rural health care, just a healthier bottom line for some suburban doctors and hospitals.

Different program management and broad eligibility criteria also facilitated, perhaps even accelerated, this costly form of growth.

The Health Care Financing Administration, HCFA, decided it would be easier to reimburse facility-based rural health clinics the same way Medicare pays for other outpatient departments. That decision proved very costly. Unlike payments to independent rural health clinics, reimbursement to provider-based clinics are not capped, not reviewed for reasonableness, and may include institutional overhead costs shifted from a facility's other operations. We asked the agency to address this policy and their plans to control Rural Health Clinic Program costs in testimony today.

At the same time, the Health Resources and Services Administration, charged with the designation of medically underserved areas and health professional shortage areas, where rural health clinics may locate, failed to update those key indicators to reflect current areas of need. Certification of one, or two, or any number of clinics in an area has little or no impact on its designation status. The availability of mid-level practitioners, the very heart of the Rural Health Clinic Program, has never been factored into the designation formula.

As a result, we have no way of knowing where the Rural Health Clinic Program is succeeding or where it needs to go next to meet real needs. Testimony from the agency today will address how rural health care access can be measured more accurately and more often.

Finally, we will hear from rural health clinic association representatives and testimony from an independent clinic operator on how to extend the reach of Medicare and Medicaid into isolated rural areas more efficiently and effectively.

For me, this type of hearing epitomizes good, constructive oversight. A 20-year-old program, targeted to meet rural health care needs, is found to be missing its mark. Through the process of thorough investigation, open public discussion, and the cooperation of the executive and legislative branches, we can recalibrate the program's trajectory and put it back on course.

It may take additional hearings to clarify the administrative and legislative actions needed to focus the Rural Health Clinic Program on the rural elderly, the poor, and the children who truly need better access to Medicare and Medicaid. We are committed to the task,

and I am grateful to all our witnesses today for their help in this effort.

I welcome all of you.

At this time, I would turn to the gentleman from Cleveland, if he has a statement he would like to make, and then I will turn to my colleague, the vice chairman.

Mr. KUCINICH. I just want to say, Mr. Chairman and members of the committee, what a pleasure it is to be on this subcommittee with the Chair. I look forward to a productive relationship, and I certainly appreciate the chance to be here. Thank you.

Mr. SHAYS. I thank the gentleman.

Mr. SNOWBARGER. I will forego any opening remarks.

Mr. SHAYS. Well, we are eager to begin. We have a great committee, some wonderful new Members. This subcommittee, in the last session, had 52 hearings, and I felt that we not only had hearings, but we acted on what we learned. So we're going to learn a lot today, and we look forward to what we learn. Hopefully, we can all, collectively, make a contribution.

Before actually calling on you, Mr. Towns is the ranking member of this committee and, frankly, an equal partner in this process. So, at this time, if he can catch his breath, we are going to call on you, if you'd like to make a statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Access to adequate primary health care is a critical need in rural America. While I represent an urban district in Brooklyn, NY, I was born in a rural community in North Carolina, so I know personally the importance of this issue. I also know that the lack of primary health care in rural communities is also faced every day in inner city areas like Brooklyn. In both cases, there is a dangerous shortage of trained primary health care professionals, and we should never lose sight of that. That is why I support the goals of the Rural Health Clinic Program.

This program was designed to attract and retain primary care providers and assistants to rural communities around the country. Unfortunately, as GAO has discovered, there appears to be widespread waste and abuse within this program. Even more disturbing to me is the fact that Medicare and Medicaid payments to rural health clinics are increasingly benefiting well-staffed, financially well off clinics in suburban areas that already have extensive health care delivery systems in place. That is a real concern.

As the GAO points out, there are numerous rural underserved communities which desperately need the rural health clinics, but there are virtually no efforts being made to locate rural health clinics in these areas. Instead, more populated suburban areas are taking advantage of the large financial incentives in the program. This abuse must be stopped, and it must be stopped now.

I am pleased to note, Mr. Chairman, that the Department of Health and Human Services appears to be moving in the right direction to correct some of these abuses. For example, it is my understanding that HHS will soon hold facility-based rural health clinics to the same payment limits and cost reporting requirements as independent rural health clinics. This would be a good first step, but more needs to be done, and that's what we have to talk about even further.

As the GAO report makes clear, this problem will only be fixed if both the Congress and the administration work together to solve these problems. As a member of both this subcommittee and the Health and Environment Subcommittee of the Commerce Committee, I look forward to working with you, Mr. Chairman, and the administration to correct the problems that we know exist.

I would like to yield back. Thank you for holding this hearing. I look forward to working with you in bringing about some solutions. Thank you very, very much. I yield back.

Mr. SHAYS. I thank the gentleman.

Before I swear in our panel, I would ask unanimous consent that all members of the subcommittee be permitted to place any opening statement in the record and that the record remain open for 3 days for that purpose. Without objection, so ordered.

I also ask unanimous consent that our witnesses be permitted to include their written statements in the record. Without objection, so ordered.

We have today Bernice Steinhardt, Director, Health Service Quality and Public Health, General Accounting Office; accompanied by Frank Pasquier, Assistant Director, Health Issues, Seattle Office; and Lacinda Baumgartner, Evaluator, Health Issues, Seattle Office; then George Grob, who is the Deputy, Office of Inspector General, Department of Health and Human Services. It is wonderful to have all of you here.

At this time, if you would rise, we will swear you in. We swear in all our witnesses, including Members of Congress.

[Witnesses sworn.]

Mr. SHAYS. For the record, all four of our witnesses have responded in the affirmative.

We basically have two statements, but all can participate in responding to questions.

So we will start with you, Ms. Steinhardt.

STATEMENTS OF BERNICE STEINHARDT, DIRECTOR, HEALTH SERVICE QUALITY AND PUBLIC HEALTH, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY FRANK PASQUIER, ASSISTANT DIRECTOR, HEALTH ISSUES, SEATTLE OFFICE; LACINDA BAUMGARTNER, EVALUATOR, HEALTH ISSUES, SEATTLE OFFICE; AND GEORGE GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, GENERAL ACCOUNTING OFFICE

Ms. STEINHARDT. Thanks very much for having us at this hearing today to talk about our report on rural health clinics.

As you pointed out, Mr. Chairman, this is a program that has grown very rapidly. We brought a couple of charts along with us, and, as you can see from the bar chart, the program started out relatively modestly, from about 100 or so clinics in its early days, to about 500 clinics a decade later. But in the early 1990's, for reasons that I know the Inspector General's Office will talk about in testimony, the number of clinics began to grow dramatically, and today, as the chairman pointed out, there are about 3,000 rural health clinics across the country.

I wanted to add, though, that the growth in rural health clinic costs has also been dramatic, with Medicare and Medicaid expendi-

tures growing at two to three times the rate of the Medicare and Medicaid programs overall. Currently, annual expenditures for rural health clinics total about $760 million, but by the year 2000, they could exceed $1 billion a year.

When we started our study of the program for the subcommittee, we asked two broad questions. We asked first whether the program is serving a population that would otherwise have difficulty obtaining primary care. In other words, is this program improving access to care? And second, are there adequate controls in place to ensure that Medicare and Medicaid payments to the clinics are reasonable and necessary? The answer to both questions, simply put, is "no."

Let me take a few minutes to elaborate. Returning to the first question of improving access, I think it's fair to say that some rural health clinics do, in fact, benefit their rural communities. These clinics are generally in sparsely populated areas with fewer than 5,000 people, that couldn't support a primary care practice otherwise, and which, by their presence, have made it possible to reduce by many miles the distance they have to travel for care.

But while these types of rural health clinics can be found, as the pie chart shows there on the left, many of the areas in which clinics are being certified, and that's 19 percent of the pie there, are in well populated areas, sometimes with extensive primary health care systems. This has increasingly become the case among the clinics that have been certified in the last couple of years.

What is more, in many of the locations that we looked at in depth, primary care was already available to the Medicare and Medicaid populations. We looked at care patterns for a sample of over 42,000 Medicare and Medicaid beneficiaries, and we found that before they became rural health clinic patients, about three out of four of these people had been seeing a primary care provider in the same city in which they lived or in which the clinic was located.

Overall, in fact, we found that the availability of care didn't change very much for about 90 percent of these 42,000 people after their rural health clinics were certified. As you pointed out, Mr. Chairman, this really isn't surprising, given that 68 percent of the clinics were simply conversions of existing physician practices, practices that, in many cases, had been in existence for 12 to 18 years before they became rural health clinics.

Apart from the Medicare and Medicaid populations, the certification of rural health clinics seems to have little or no effect on the availability of care for any other underserved segments of the population. Even though many of these clinics qualify for the program because the overall population is designated as underserved, less than half of a group of clinics we surveyed said that they used the program to expand their staff or to increase the number of patients that they actually see. In fact, some of them told us they were seeing fewer patients after they became rural health clinics.

Turning to the question of cost controls, we found that the Rural Health Clinic Program does not have adequate controls in place to ensure reasonable costs. These clinics, you will recall, are generally reimbursed by Medicare and Medicaid for the costs that they claim in providing services, rather than according to the lower set fees for these services that would otherwise apply.

So, under this system, we estimate that, in 1993, rural health clinics were paid at least 43 percent more by Medicare and at least 86 percent more by Medicaid than they would have been paid under a fee schedule system. In 1996, we estimate this amounted to an additional $100 million for Medicare and close to an additional $200 million in Medicaid reimbursement. This differential we found is particularly great among those rural health clinics that are operated by a hospital or other facility.

As you can see—once again, I will turn your attention to the bar chart—about half of all rural health clinics are made up of facility operated clinics, which are the white portion of the bar. And their portion, as you can also see from the chart, has increased dramatically over the last few years. You can only see a white bar there beginning in 1990.

Unlike the independently operated clinics, the facility operated clinics are not subject to any limits on payments for visits. In one case we came across, a clinic received over $200 for a visit, or about four times the maximum $55 or $56 paid for a visit to an independent clinic. While independent clinics have a maximum reimbursement per visit, neither they nor the facility based clinics have any apparent limits on the amount or types of costs that they can claim.

In a sample of independent clinics, we found that a quarter were paying physician salaries of up to 50 percent or more than the national mean of $127,000. These are rural health clinics, mind you. In looking at facility based clinics we found hospitals sometimes claiming overhead costs that were more than 100 percent of the direct costs of operating the clinic.

Finally, under current law, rural health clinics receive this extra Medicare or Medicaid reimbursement indefinitely, even if the area in which they are located is no longer rural or underserved, and even if the clinics don't depend on it for financial viability.

So what does the program need to do to address these findings. Our report made several recommendations. First, we recommended that HCFA revise its Medicare payment policy to hold all rural health clinics to payment limits and to reimburse them for only the reasonable costs incurred in providing care. HHS has actually agreed with our recommendations and has said that it would begin to take actions to implement them.

We also believe that the Congress needs to develop a more precise definition for the types of areas that are eligible for these higher Medicare and Medicaid payments, so that the program is more clearly targeted to increasing access to care. This wouldn't necessarily require redoing the existing criteria, only adding another screen that would be targeted to communities where access is a problem.

We therefore recommended that the Congress restrict this higher Medicare and Medicaid reimbursement to rural health clinics in areas that have no other Medicare or Medicaid providers, or to clinics that can demonstrate that the existing providers, the existing capacity, if you will, is not great enough to accept new Medicare or Medicaid patients, and that that funding will be used to expand access to them.

We also recommended that the Congress require periodic recertification to make sure that the financial assistance given to clinics is still appropriate.

This concludes my remarks, and we would certainly be happy to answer any questions.

[The prepared statement of Ms. Steinhardt follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources, Committee on Government Reform and Oversight, House of Representatives

For Release on Delivery
Expected at 1:00 p.m.,
Thursday, February 13, 1997

RURAL HEALTH CLINICS

Rising Program Expenditures Not Focused on Improving Care in Isolated Areas

Statement of Bernice Steinhardt, Director,
Health Service Quality and Public Health Issues

GAO/T-HEHS-97-65

Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our recent report on the Rural Health Clinic (RHC) program.[1] This program, established two decades ago, allows higher Medicare and Medicaid reimbursement as a way to support health care professionals, including nurse practitioners and physician assistants, in underserved areas that may be too sparsely populated to normally sustain a physician practice. The RHC program is one of the few federal programs that addresses underservice in small communities that do not have a traditional health care system in place.

The program is administered by the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which must certify as RHCs all Medicare-certified primary care providers requesting such status if they practice in a rural and underserved area. At the time of our review, there were nearly 3,000 RHCs in the program and their numbers were growing by more than 30 percent a year. At this rate of growth, Medicare and Medicaid will pay RHCs more than $1 billion a year by 2000. This rapid growth has raised concerns about the benefits that program expenditures are providing.

At this Subcommittee's request, we undertook our review, which used available national statistics that we supplemented with a detailed review of 144 RHCs in four states—Alabama, Kansas, New Hampshire, and Washington. We focused our review on two main questions:

- Is the program serving a Medicare and Medicaid population that would otherwise have difficulty obtaining primary care?
- Are adequate controls in place to ensure that Medicare and Medicaid payments to RHCs are reasonable and necessary?

In brief, the answer to both questions is no. The program needs to be refocused. While some clinics clearly meet the program's initial focus of serving Medicare and Medicaid populations having difficulty obtaining primary care in isolated rural areas, most clinics are in fairly well-populated areas that already have extensive health care delivery systems in place. Controls over the amounts that these clinics receive from Medicare and Medicaid are weak or nonexistent, resulting in reimbursements that are in some cases over five times higher than those

[1] Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996).

paid to other providers. These financial benefits are provided indefinitely, even after an area may no longer be rural or underserved.

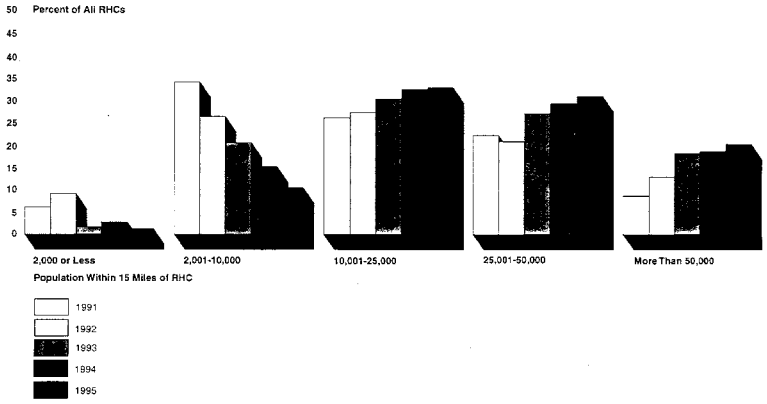
Program Often Is Not Targeting Underserved Populations

Some RHCs clearly provide benefit to rural communities. Such RHCs were generally those in communities without Medicare or Medicaid providers or in sparsely populated areas such as those with fewer than 5,000 people. For example, 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. Nearly 40 percent of the clinic's Medicare patients reduced their distance to care by a median of 18 miles. Similarly, a hospital district in eastern Washington uses three family physicians and two physician assistants to operate an RHC and two satellite clinics 15 to 30 miles away, reducing distance to care for at least 80 of the 507 Medicare patients by a median of 48 miles.

We did not find much evidence of efforts to establish RHCs in such locations, however. In the four states we reviewed, neither HCFA nor the state rural health offices were aware of any efforts to actively target and establish RHCs in areas with 5,000 people or less, though many of these areas had no Medicare or Medicaid primary care provider.

While sparsely populated areas of the country may be underserved, as shown in figure 1, RHCs are increasingly being certified in larger communities, many with 50,000 or more people living within 15 miles of the clinic.

Figure 1: RHCs by Population and Year Certified, 1991-95



We found that these larger communities already have a number of health care providers and facilities in place. For example, one clinic we reviewed was recently certified in a location that had 25,000 people, 17 practices with primary care providers, a number of specialty practices, a hospital, two skilled nursing facilities, a mental health facility, a hospice, and a home health agency.

Also, RHCs generally do not appear to enhance the availability of health care in these larger communities. In the four states where we reviewed clinics, the availability of health care did not change appreciably for at least 90 percent of the Medicare and Medicaid patients using them. A significant reason was that two-thirds of the RHCs were simply conversions of existing physician practices. For most clinics, the primary change was

the higher level of Medicare and Medicaid payments that they received, and not the number and mix of patients treated.

Broad Eligibility Criteria Allow Growth in Areas Where Need Is Minimal

Why are many RHCs being approved in areas where they are unlikely to improve access to care? One reason is the broad criteria used for defining rural. While the Bureau of the Census generally defines rural areas as those with fewer than 2,500 people, the law authorizing the program allows for including areas with up to 50,000. However, the census boundaries may not account for all the people living within 15 miles of the RHC, which HHS has defined as the maximum distance people should have to travel for care under the worst road conditions. Therefore, the law allows RHCs to be near other cities that constitute an even larger patient base, as many as 1 million or more.

A second reason, that we have pointed out in other recent work,[2] is that the definitions of underserved areas results in an undercount of the number of medical providers already present. To become certified, an RHC must be located in an area that HHS has determined to have health care shortages. However, we found that more than half the underservice designations may be invalid because they are outdated or do not count a significant number of primary care providers, such as nurse practitioners or physician assistants.

A third reason is that there is no requirement to use the benefits of the RHC program to expand services to whoever is underserved in the community. While HHS often designates an entire community as underserved, most RHCs said that the uninsured poor make up the majority of underserved people in their community. Nevertheless, only 16 of 73 RHCs we contacted said that they offered services on a sliding fee scale, based on the patient's ability to pay for care. Similarly, over 85 percent of RHCs said that the program had no influence on the number or type of patients they serve, even when located in areas with specified underserved population groups such as migrant farmworkers or Medicaid patients.

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

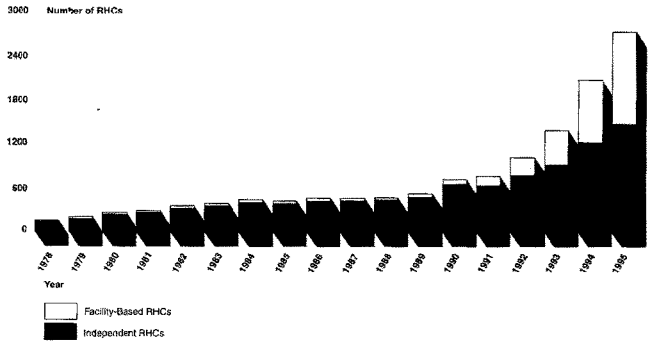
Controls Are Not in Place to Ensure Reasonable Costs and Effective Targeting of Funds

Despite the fact that many RHCs provide little additional benefit to Medicare and Medicaid patients, these RHCs continue to receive significant financial benefits from these programs. RHCs are generally reimbursed by Medicare and Medicaid for the costs they claim in providing services, rather than by the lower set fees for these services that would otherwise apply. Using 1993 claims data, we estimate that Medicare paid at least 43 percent more for services at RHCs than it paid to other providers, while Medicaid paid at least 86 percent more. Assuming that this same percentage held true in following years, the RHC program cost Medicare an additional $100 million and Medicaid about $195 million in 1996.

Because the RHC program is more generous, adequate controls over claimed costs are particularly important to safeguard Medicare and Medicaid expenditures. However, such controls are not in place to do so. RHCs that are independently operated are limited to an annually adjusted amount currently set at $56 per Medicare or Medicaid visit.[3] However, there are no limits on payments to RHCs operated as part of a hospital or other facility, even though almost half the RHCs are operated by such facilities, and this percentage is rapidly increasing (see fig. 2).

[3]This amount is still substantially higher than the average payment providers received for similar services on the Medicare fee schedules.

Figure 2: RHCs by Ownership Type, 1978-95



HCFA has not determined how much more Medicare and Medicaid pay for services at facility-operated RHCs as a result, but indications are that the costs are sometimes substantially higher. For example, our review of cost reports for 28 of these RHCs shows that they received up to $214 per visit, or four times the maximum amount paid for a visit to an independent RHC. HCFA has established a working group that is addressing the issue of payment limits for facility-operated RHCs, but had no estimate of when regulations will be issued.

Second, HCFA has not implemented screening guidelines to assess whether claimed costs are reasonable. Because such guidelines were never implemented, RHCs have no apparent limits on the amount or type of costs they claim for Medicare and Medicaid reimbursement. Our review of 228 cost reports for independent RHCs found that one-fourth were paying physician salaries of up to 50 percent or more than the national mean of $127,000. Our review of 28 cost reports at facility-operated RHCs shows

that hospitals sometimes claimed overhead costs that were more than 100 percent of the direct costs of operating the clinic.

Third, under current law the RHCs receive the extra Medicare or Medicaid reimbursement indefinitely, even if the area is no longer rural or underserved. Many areas of the United States that were considered rural in 1978 are now part of an urbanized area, and areas considered underserved 15 years ago may now have an adequate number of primary care physicians. This aspect of the program—the lack of recertification—means that the program cannot effectively target reimbursement only to the clinics that need it. Most of the clinics we called said that they were financially viable without the added reimbursement, while some said that it was only needed in their first few years as a new clinic until an adequate patient base was established. Most clinics, however, thought that the higher reimbursement should continue because it helped them to compete for patients with other providers moving into the area and assisted in offsetting the negative effects of Medicare and Medicaid reimbursement reform.

Conclusions and Recommendations

Our work clearly demonstrates that the RHC program is adrift. It lacks a clear focus on its original goal of assisting underserved rural communities and also lacks controls over costs to the Medicare and Medicaid programs. As it continues to grow—often in 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 and Medicaid beneficiaries or other underserved segments of the population.

What does the program need? One thing is a new definition for the types of areas that are eligible for the higher Medicare and Medicaid payments. The rural and underserved criteria by themselves are insufficient to ensure that its most attractive feature for providers—cost reimbursement—is used by clinics needing it to meet a clear program goal, rather than obtaining a competitive advantage or avoiding the effects of Medicare and Medicaid payment reforms. A second need is for controls over the reimbursement costs claimed by clinics to ensure that they are reasonable. 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.

Accordingly, our report contains recommendations for both the Secretary of Health and Human Services and the Congress to accomplish these needed improvements.

First, for those RHCs that continue to receive higher Medicare and Medicaid reimbursement, the Secretary of HHS should direct the Administrator of HCFA to revise Medicare payment policy to hold all RHCs to the same payment limits and reporting requirements and reimburse them for only the reasonable costs incurred in providing care to Medicare and Medicaid beneficiaries. HHS agreed with our recommendations and stated that it would begin to take actions to implement them.

In addition, we recommend that the Congress assist in refocusing the RHC program to meet its original purpose by

- restricting higher Medicare and Medicaid reimbursement 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
- requiring periodic recertification to continue higher payments only to the clinics that need it for this purpose.

This concludes my statement. I would be happy to answer any questions you have.

Contributors

This testimony was prepared under the direction of Bernice Steinhardt, Director, Health Service Quality and Public Health Issues, who may be reached at (202) 512-7119 if there are any questions. Other key contributors include Frank Pasquier, Assistant Director, and Lacinda Baumgartner and Stan Stenersen, Evaluators.

Mr. SHAYS. Thank you.

We will hear from Mr. Grob and then we will start our questioning. I like this era of charts. They one-upped you; they've got color.

Mr. GROB. Mr. Chairman, it's 1997, and it's the 20th anniversary of this program. Like a birthday that ends in zero, it's probably a good time to take stock and see where we've been and where we're going.

When we began this evaluation, we found that the General Accounting Office was also beginning work on this subject, so we began to collaborate with them early on in the project to divide the work up. We took somewhat different approaches to the study. Our approach was based very much on onsite reviews. We sent inspectors out into the countryside to locate the rural health clinics that were there, to see what they were like, to talk to the people who were there, and things of this nature. We did some other larger analysis of national data.

What is good about the fact that we took these two different approaches is two things. One is, I think if you put the two reports together, you get a pretty full picture of what's happening. The second is a remark you made in introducing this, which is, the results were identical. For all practical purposes, the findings and the recommendations were the same. So it seems that no matter what direction you look at this thing from, you get the same answers, which gives you even more confidence about the results.

Briefly, we found that the rural health clinics are important to people who live in rural areas and who need access to primary care. But the program is vulnerable to waste because of the placement of the centers and because of weak cost controls or unsatisfactory reimbursement systems.

Rather than repeat all of the details of those findings, which you have just heard from the representative from GAO, let me concentrate instead on talking about the growth and the nature of the growth. I've got a growth chart here that is similar to GAO's, and, frankly, I did it so that the line would appear to be a bit steeper, because I wanted very much to illustrate the rapid rate of growth of this program.

From 1990 to the end of 1996, the number of centers has increased tenfold. In the last year alone, the increase in the number of centers was 30 percent. When we calculated it, there were more than 250 applications still pending at the end of that year. In some of the States that we went to and asked them questions, they expected growth rates of 50 percent in 1 year, not a small number of States.

As far as the dollars are concerned, as was mentioned, we are now at about three quarters of a billion dollars. The growth began to accelerate in recent years. It wasn't so heavy in the beginning years. The remark that by the year 2000 we would be at $1 billion actually may come true sooner than that. In the last year alone, the growth rate was 48 percent in the dollars. So if we have the same growth rate next year, we will be at $1 billion just next year.

Now, why is this growth occurring? And a good question that might be asked, is anything different today than was the case 20 years ago when the program was first started? Well, some things are still the same. One thing pushing the growth is the need. About

a quarter of the population of the country still lives in rural areas, and they are going to continue to need access to primary care. Hopefully, that will become the driving force for any growth in this program.

Another big part of it, though, is the incentive funding. And to make it simple, I have just included a chart here that shows what the funding levels are in just a few States, and these are typical of what you will see. Basically speaking, the reimbursement rates for the rural health clinics are about twice what they would be for clinics that don't receive this incentive. And if they are provider based, because that cap is not on them, they can even be considerably more than that, perhaps two or three times that amount. So that chart there just illustrates that fact.

Now, where health care is missing, where people have trouble with the financial base, that might be just what the doctor ordered, financially. But in places where there are lots of services—for example, in one area we visited, we found 10 pages in the Yellow Pages, 10 Yellow Pages full of health care providers in a location where a health clinic was located.

Mr. SHAYS. Just to clarify that, you mean like the big ad?

Mr. GROB. Well, I was just saying, we sent our inspectors out to actually see these things.

Mr. SHAYS. I just want to understand 10 pages.

Mr. GROB. Ten pages in the Yellow Pages.

Mr. SHAYS. Was it lines?

Mr. GROB. Well, it was the usual mixture of ads and lines, typical Yellow Pages full of health care providers, as an example, just to give you a sense of how rural it was or how needy it was.

So the incentive funding no doubt is a big cause for the growth. Now, in fairness to the Health Care Financing Administration, the last time this Congress took a look at this program, there was a concern that there wasn't enough growth in the program, and HCFA was instructed to notify various providers of the availability of this program, and they did so. That might have had a hand in spurring the growth of some of the provider-based rural health clinics.

We found a reason that we didn't expect, and that was managed care. What's happening here is that there are unspecified fears of the coming of managed care in rural areas, and the large providers are basically trying to get a foothold in the area before other managed care organizers come into the area. They are trying to establish a foothold, a very common thing that we heard over and over again.

A lot of those provider-based rural health centers are very small, one practitioner. They may even be claiming to lose money, but what they are saying is, they want to be there so that they have a stake in it before someone else comes in and organizes the area.

Another thing is the business organization. Initially, a lot of these clinics were just small operations, one or two doctors, and things like this. Now, with the providers becoming heavily involved in it, we have the basis of a large organization behind them, some chains are cropping up here and there, as well. So that accounts for it.

Finally, as far as the dollars are concerned, there is the problem of tenure that was alluded to earlier. Once you have the incentive funding, you have it; it never goes away. There is no recertification of these programs periodically.

The reason that I mention these areas of growth is that all of them are still there. In fact, the forces behind some of them are growing, and the forces for some are such that they will spur the growth even faster. For example, where we had the centers opening up, initially their costs were not high because they were new businesses. Now they are maturing, so their cost is going to be even greater. They are going to be doing more and more business as time goes on.

The tenure never goes away, so it keeps accumulating. We keep getting more and more growth that way. And certainly the concerns for managed care will be increasing and not decreasing in the near future.

For all these reasons, we feel that what is important to consider now is the rate of growth that is occurring and also the notion that someone iterated earlier, that if we do want to do something about this program, we need to do it now, because there are large dollar amounts looming right behind that curve. Even without the reasons, I think any analyst would put a ruler in that curve and guess where that curve is going to end up next year.

Our recommendations are similar to GAO's, and I won't repeat them. We think a control can be placed on the location and the cost. There are numerous ways to do this that are spelled out in both of our reports and in our written testimony.

Thank you very much.

[The prepared statement of Mr. Grob follows:]

Testimony
Before the Committee on Government Reform and Oversight
Subcommittee on Human Resources and Intergovernmental Relations

Rural Health Clinics

Statement of
George Grob,
Deputy Inspector General for Evaluation and Inspections

February 13, 1997

Office of Inspector General
Department of Health and Human Services

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Good morning. My name is George Grob and I am Deputy Inspector General, Office for Evaluation and Inspections, U.S. Department of Health and Human Services. I am pleased to be here today to discuss our national inspection on the rural health clinic program.

When we began our study in 1995, the rural health clinic program had never been formally evaluated and reliable information was lacking on its impact. Only anecdotal information was available. We heard that the number of rural health clinics was growing rapidly, yet no one seemed to know much about them: were they being established in medically underserved areas; who was creating them; what they were costing Medicare and Medicaid; and what impact they were having on access to health care for people living in rural areas. The purpose of our study was to analyze this growth more systematically and identify its implications for the Federal and State governments.

I believe that our study tells us two things. The first is that the rural health clinic program remains important today to people living in rural, medically underserved areas. The second is that it is vulnerable to waste and abuse - particularly with regard to the placement of clinics and the controls over cost and reimbursement. Fortunately, certain changes, which are easy to make, can protect the integrity of the program and thus its long-term viability as well.

Background

As you are aware, the Rural Health Clinic (rural health clinic) program was created in 1977 by Public Law 95-210. It provides enhanced cost-based Medicare and Medicaid reimbursement to primary care clinics in medically underserved rural areas. Cost reimbursement was provided as an incentive to attract or retain primary care providers in these areas. The law allows reimbursement to mid-level practitioners as well as physicians. The Health Care Financing Administration (HCFA) is responsible for the certification and oversight of rural health clinics.

A rural health clinic may be an independent clinic or provider-based, that is, part of a larger facility such as a hospital, nursing home, or home health agency. To date, almost all provider-based rural health clinics are owned by hospitals. Independent clinics are reimbursed on the basis of costs, with a Federally-established annual cap of $56.64 per visit, and are required to provide a minimum number of visits per year. Provider-based rural health clinics are reimbursed based on the lower of costs or charges, with no reimbursement cap; they are not subject to a minimum number of visits.

Growth in Rural Health Clinics

Our study documented a seven fold increase in the number of rural health clinics from 1990 to 1995 - from 314 to 2,530. We also projected, based on a count of applications on hand in each state as of December 1995, that the number of rural health clinics could double in as many as 30 states between 1994 and 1995 alone. HCFA data show there are now 3,272

rural health clinics nationally, up 30 percent from October 1995, with an additional 235 applications pending.

Expenditures for this program have also increased rapidly. From 1992 to 1995, Medicare expenditures on rural health clinics doubled (to $125 million) and Medicaid expenditures tripled (to $314 million). Thus, the total was $439 million in 1995. About half of this is the additional amounts that Medicare and Medicaid paid above and beyond their normal rates. Forty states submitted data to us showing that their Medicaid spending on rural health clinics had increased 50 percent or more in just one year. This pace continues. Total spending increased by 48 percent in 1996 bringing Medicare up to $182 million and Medicaid to at least $468 million, for a total of $650 million. The General Accounting Office estimates in its report that expenditures for rural health clinics will exceed $1 billion for the year 2000.

Access to Care

The numbers alone do not tell the whole story. We also attempted to analyze whether these clinics were indeed making primary care more available to people in underserved rural areas, as the law intended.

To get a handle on this, we complemented our review of national data with detailed case studies. Our inspectors visited 27 rural health clinics in 3 states (Illinois, Texas, and Mississippi) where rural health clinics had increased significantly. Within these States we

focused on counties where rural health clinics had also proliferated. They systematically gathered information about each clinic we visited. This included clinic tours, discussions with clinic owners and administrators, physicians, mid-level practitioners and others, and review of data - especially cost reports and billing records, statistics on types of patients and number of visits, written guidelines or protocols. Inspectors asked staff to walk them through a "typical" visit. We observed the geographic and demographic characteristics of each area, including the prevalence of health care providers generally. We viewed every rural health clinic in each county in the study, even those clinics that we did not actually visit.

In all three states, we found clinics which we believe have retained or expanded care in rural areas. But, we also visited others that made us question why they had been established, who they served, and whether they were truly needed in their communities. Let me illustrate our concerns by describing two clinics in our study: one that we believe is operating as the law intended, and another which raises important issues.

Clinic A is in a town of 1,400. The area is sparsely populated, consisting of arid farmland and small rundown or abandoned houses. There is one other physician in this town and no hospital. Health care providers (including a large rural health clinic), and commercial development, are concentrated in the county seat (population 23,000) 20 miles away, off the interstate that bisects the county. The rural health clinic was established in 1992 by a physician who graduated from medical school at the age of 40. The clinic was "going

under;" she said, with two-thirds of her patients on Medicare or Medicaid, and she needed higher reimbursement. She paid a consultant $24,000 to help with the conversion to a rural health clinic.

The clinic is in a tiny shopping center at the intersection of two 2-lane highways. To save money, the physician's husband and son built out the clinic from the bare walls. The physician supervises the one mid-level practitioner from another rural health clinic 10 miles away. Over 2 years, she paid thousands of dollars in finder's fees to a search firm for 3 mid-level practitioners who left after a few months for higher paying jobs at city hospitals miles away. The clinic sees 25 to 30 patients a day, who live from 15 to 25 miles away.

The physician has resisted buy-out offers from hospitals who are building managed care networks. She wants to remain independent and says that the hospitals "won't take care of my patients the way I do."

Clinic B is one of three independent rural health clinics owned by a group practice in the next county. Created in 1985, it became a rural health clinic in 1993, seeking higher reimbursement. It is in a city of 44,000, in an area designated medically underserved years ago by the governor. The city has four other rural health clinics, two hospitals, and enough other practices, including specialty practices, to fill 10 yellow pages in the telephone book. There are 5 other rural health clinics in the surrounding county to serve the remaining 35,000 residents.

Located in a large, modern building on the main highway through the city, the clinic is staffed by 12 physicians and 4 mid-level practitioners who specialize in family practice, OB-GYN, or pediatrics. The clinic reports 79,000 visits a year, some from the adjoining state. An estimated 25 to 33 percent are eligible for Medicare or Medicaid. The administrator told us that the clinic's costs are much higher than the Medicare and Medicaid reimbursement cap established for independent rural health clinics.

This second case scenario also illustrates the findings of our study--findings which we believe need to be addressed in order to protect the integrity of the Rural Health Clinic Program and ensure its continued viability for future generations.

Medically underserved designations are outdated: The "medically underserved" designation of the area where this second clinic is located, and of many other counties we visited, has not been updated for years and may no longer be a valid designation. Recertification is not routinely required. Rural health clinics thus may retain their status indefinitely in areas where there may no longer be a need.

Providers already serving the medically underserved population may simply convert to rural health clinic status when no additional incentives were needed to retain them. Most (14 of 16) independent rural health clinics we visited, like our second example, had operated in their communities for many years before converting to rural health clinic status. When asked why they became a rural health clinic, respondents said it was for the enhanced

revenue.

Rural health clinics are concentrated together or with other primary care providers. The Congress intended these clinics to serve rural communities that had few or no other primary health care providers. In our second example, however, there are 10 rural health clinics in the county of 79,000, five of them in the city. While the city officially qualifies as "rural," with a population under 50,000, the number and types of medical practices and facilities there seem inconsistent with a "rural" designation. We found similar concentrations in other places. Concentrations of these clinics with other providers can duplicate services rather than create new ones.

Rural health clinics may drive other providers out of an area. In areas with more than one primary care provider, enhanced reimbursement can give a rural health clinic a competitive advantage over non-rural health clinic practices in the area. Provider-based clinics are capable of absorbing increased costs since they are not subject to any reimbursement cap. If this type of competition leads existing primary care practices to close, are the best interests of the community being served?

Clinic owners did not name "increasing access" first as the reason they created a rural health clinic. As noted, some independent clinics sought enhanced revenue by converting to rural health clinic status. Those at hospital-run clinics said that enhanced reimbursement helped position them for managed care by creating a network of clinics to establish a

market share, create a referral base, and enhance community visibility.

We found no reliable evidence about access to care. Most people we talked to contend that their clinics are improving access to care. In some cases, we think they probably are, in some small way at least. However, almost no one had any reliable data to show how, or how much, they have increased access. State officials also had no such data, and at the time we did our work, no national evaluations or studies existed documenting the impact of the program nationally.

Costs

As I noted earlier in my testimony, the costs of this program continue to increase dramatically in tandem with the increase in the number of clinics. Some State officials have expressed concern about the large increases in their Medicaid reimbursement for rural health clinics due to the enhanced payment rate. The enhanced payment for rural health clinics is in some cases almost double what is paid to a typical physician practicing in his/her office. The payment can almost triple when compared to reimbursement for a provider-based rural health clinic. In one State, for example, the regular Medicaid rate was $26.33 per visit. The enhanced rate for rural health clinics was $51.99 per visit, and provider-based clinics received $76.84 per visit.

We continue to have concerns about the amount of payment received by provider-based clinics and about other possible vulnerabilities in the cost reimbursement mechanism used to

pay rural health clinics. These, along with a lack of State and Federal oversight, may result in inflated or even inappropriate payments to rural health clinics in the millions of dollars.

Cost reimbursement creates little incentive for cost control and also may lead to inappropriate or inflated billing. Almost all the cost reports for the clinics we visited showed costs higher than the capped rate for independent clinics and higher than charges for provider-based clinics. However, the lack of a cap for provider-based clinics was of particular concern to people from some national organizations, state officials, and owners of independent rural health clinics. They expressed concerns that shaky hospitals were creating rural health clinics to shift costs to these clinics in order to stay financially afloat, sometimes offering to buy individual practices by offering the physician higher reimbursement as a hospital-based rural health clinic.

In regard to the issue of inappropriate or inflated billing, some of the clinics we visited reported billing on occasion for just handing out prescription refills or test results. They could do this because the definition of an "encounter" is so broad and vague. State officials raised concerns about the potential for padding bills, shifting costs, double-billing, billing for unnecessary or unlimited visits, or duplicate billing - both the encounter rate and fee for service for a single visit. Cost reports are complex and the reporting process is cumbersome.

State and Federal oversight is minimal. Oversight at rural health clinics is minimal -- they are not visited routinely by state or federal officials. The clinics cost reports are rarely, if ever, thoroughly audited by Medicare and States rely heavily on Medicare's determination of the reimbursement rate, rarely reviewing cost reports themselves. Thus we have no complete, accurate, or coherent picture of what we are getting for our money.

Recommendations

Mr. Chairman, the rural health clinic program provides needed incentives for primary care providers in medically underserved rural areas. However, based on this study, we believe that program requirements need to be reviewed by policy makers in order to tighten them up -- particularly with respect to the location of the clinics and the reimbursement system. Following are some specific actions which the Health Care Financing Administration and the Congress could consider as a plan is being developed to address these issues.

Location of Rural Health Clinics

- Create specific underserved designation criteria for this program. Or refine the existing system.

- Establish new criteria, in addition to rural, underserved designations, that will document need and impact on access of new rural health clinics.

- Require recertification of rural health clinics within a specific time limit (for example, 5 years).

- Expand the involvement of State officials in the certification process.

Cost Control and Reimbursement

- Require itemized Medicare billing for independent clinics and encourage States to do the same for Medicaid billing.

- Require rural clinics to provide certified financial statements.

- Respond to State requests for guidance in matters such as commingling and provider-based reimbursement.

- Require provider-based clinics to submit cost report work sheets providing the same data now required of independent clinics.

- Implement controls such as a clearer definition of an encounter, itemized billing and limits on visits per patient per year. Remind States that they may take such measures to do so.

- Once itemized billing is instituted, conduct focused audits of clinics to identify true costs as a basis for developing a new reimbursement mechanism.

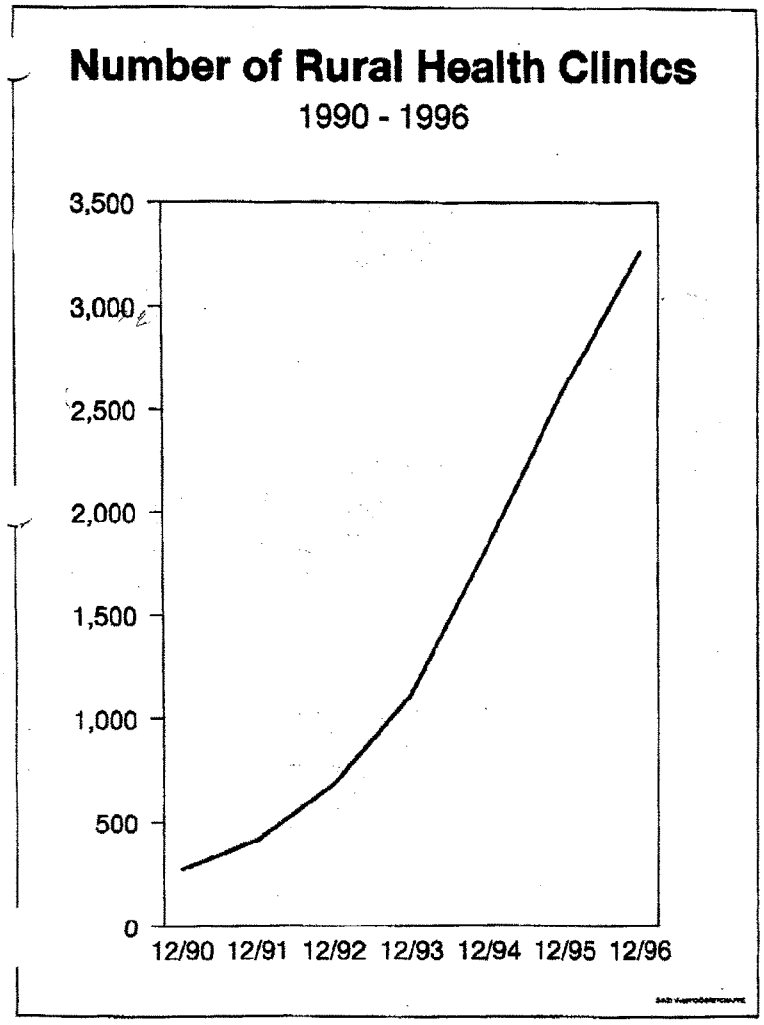
- Establish a cap for provider-based clinics, similar to that used for independent clinics.

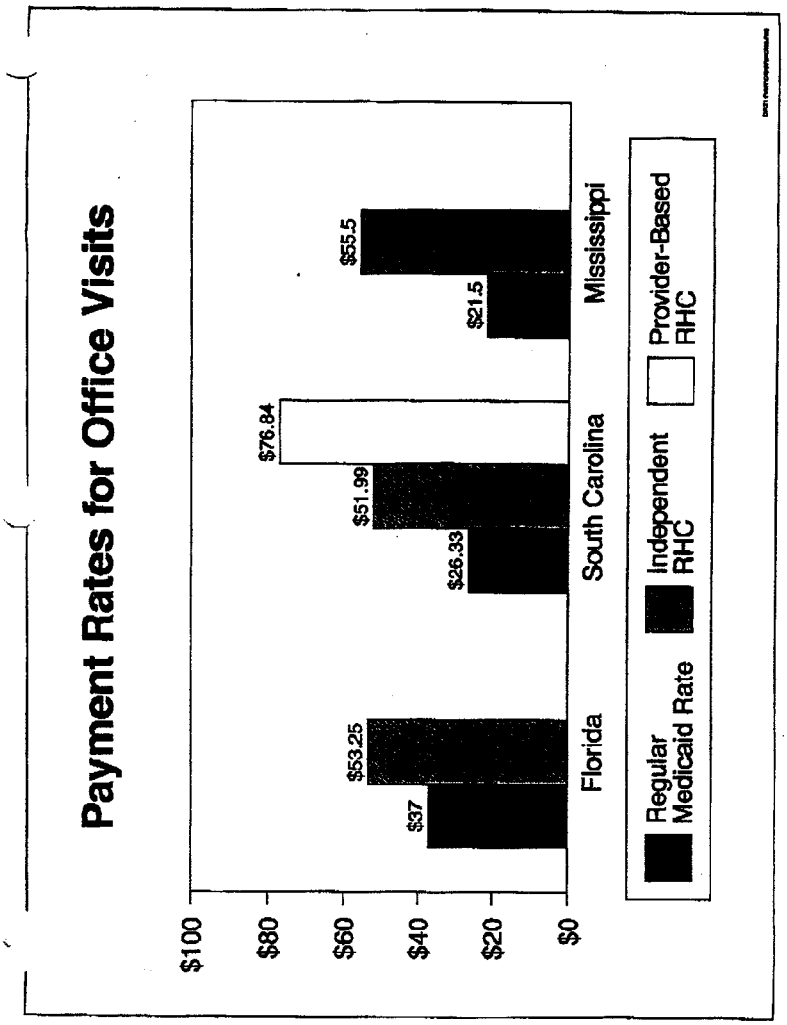
- Develop a new reimbursement system for rural health clinics that is not cost based.

We cannot precisely estimate the savings that would result from these measures. But, given the rapid growth of the program, combined with the weak oversight, savings would probably be substantial -- without jeopardizing access to care in rural areas. Even a 10 percent reduction of misdirected payments could save $25 to $50 million per year.

Closing Statement

Our findings and recommendations are documented in our report entitled "Rural Health Clinics: Growth, Access, and Payment" (OEI-05-94-00040). Mr. Chairman, thank you for the opportunity to testify today; and I will be happy to answer any questions you may have.


Number of Rural Health Clinics
1990 - 1996
3,500
3,000
2,500
2,000
1,500
1,000
500
0
12/90 12/91 12/92 12/93 12/94 12/95 12/96


Payment Rates for Office Visits
$100
$80
$60
$40
$20
$0
$37
$53.25
$26.33
$51.99
$76.84
$21.5
$55.5
Florida
South Carolina
Mississippi
Regular Medicaid Rate
Independent RHC
Provider-Based RHC

Mr. SHAYS. Mr. Towns, you have the floor.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Mr. SHAYS. Let me just say, Mr. Grob and Ms. Steinhardt, both reports were very well-written, well-organized, and I think fairly clear, not oversensationalized. I thought they were both excellent reports. In some sense, I almost feel we don't have to issue a report; we just submit yours to the Congress.

We hope, very shortly, to respond to what you all have written. Before I do give the floor to Mr. Towns, I want to be clear on one thing. When we're asking HCFA to make a change in the process—I guess what I really want to know is, I feel a number of people have gained the system and are making a gigantic windfall. Do we have the ability quickly, through regulation, to change, or is it going to be a long, laborious process?

Mr. GROB. I could give an opinion on that. I think that some of the change that needs to be made can indeed be made through the regulatory process, but the regulatory process is never quick. The rules for public rulemaking generally take a year or more because of the requirement for the opportunity for the public to comment, and dealing with those comments, and things of this nature.

Mr. SHAYS. And there is no shortcut, Ms. Steinhardt?

Ms. STEINHARDT. Well, there is no shortcut to the rulemaking process. But I think the point here is, if we have the will to take action here, there are things we can do to make sure that this program is back on track. It had a purpose. It has lost focus and lost track of that purpose. I think both the Congress and HCFA need to take action.

Mr. SHAYS. By the time it comes to my questioning, because I will go to Mr. Snowbarger after Mr. Towns, I would love you to just articulate what changes are really rulemaking changes and what can be done more quickly. That will be something I will ask.

Ms. STEINHARDT. Sure.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin with you, Ms. Steinhardt. You mentioned recertification more than once. In order to do that, how much money are we talking about? Have you thought about it in dollars and cents?

Ms. STEINHARDT. What it takes to actually recertify?

Mr. TOWNS. Yes, the costs. Yes, the costs involved, that process.

Ms. STEINHARDT. We didn't calculate the cost, but this is not something that needs to involve onsite field visits or anything. This is something that HCFA can do, or HRSA could do, with a data base, just knowing who these clinics are and where they are located. This is a data base search.

Mr. TOWNS. Right. And I guess it would not take too much to put that equipment in place.

Ms. STEINHARDT. They ought to know where all these clinics are.

Mr. TOWNS. As you know, Congress established the Rural Health Clinic Program because many rural communities were having difficulties attracting and retaining primary care providers. In your review, did you come across sparsely populated rural areas that lacked primary care providers?

Ms. STEINHARDT. Yes. We found that there were some areas that met the general criteria that would qualify them for rural health

clinics that were still without a rural health clinic. Maybe Mr. Pasquier wants to add some details to that.

Mr. TOWNS. Sure.

Mr. PASQUIER. Yes. I think the real contrast that we say was, when we took our sample of beneficiaries, the ones where access has improved, we noticed in the smaller communities where there were these clinics that the program really did make a big difference. In the larger communities, there really wasn't much of a change in access. The patients were going to the same providers or providers in that same community.

So I think the benefits of the program are much more pronounced and easier to see when they are restricted to the smaller community. That's what we found.

Mr. TOWNS. In your judgment, why aren't those communities using the Rural Health Clinic Program? Do you have any reason as to why they were not using it?

Ms. STEINHARDT. They may not be aware of it, that they qualify for it. I know, just anecdotally, some of the rural health clinics that we spoke with became aware that they were eligible for certification because financial consultants contacted them and told them that they had an opportunity to increase their reimbursements if they applied for designation as a rural health clinic. So not every community is aware of the benefit available to them.

Mr. TOWNS. Do you have any suggestions as to how HHS might be able to target these communities to be able to get this information?

Ms. STEINHARDT. Well, I think the recommendations we make would certainly help the program be focused on those places where there are no Medicare or Medicaid providers or where the providers can't accommodate any more Medicare or Medicaid patients. That's where we think this program was intended—those are the communities we think were the intended beneficiaries of this program, and we think that's how the criteria ought to be targeted.

Mr. TOWNS. Let me ask a question I think the chairman sort of alluded to, but I want to turn it around, maybe, to a degree. Once a rural health clinic is designated, that designation cannot be removed, even if the area has developed into a well financed and viable health care delivery system, if it has it in place. Once that designation is there, it is there. How would you recommend fixing it?

Ms. STEINHARDT. We would revisit that. It's not that it can't be dedesignated. In fact, there were some clinics that, during the 1980's, I guess, the sort of earlier years of the program, that were dedesignated.

Mr. TOWNS. How did that come about, do you know?

Ms. STEINHARDT. I think they asked for it, or the definitions changed.

Mr. SHAYS. Excuse me. Could you be clear as to whom "they" are? Did the rural health clinic ask, or did HCFA ask for it? Where is it coming from?

Mr. TOWNS. The "who," yes.

Mr. SHAYS. If you don't know, I would just as soon not speculate. I want us to be very clear on this.

Ms. BAUMGARTNER. They are dedesignated—if there is a change of ownership, they have to reapply for certification, or if they lose

their status as a Medicare provider, they would be dedesignated. There was some movement to dedesignate some of the shortage areas, I think, in the 1980's.

Ms. STEINHARDT. Right. My point is simply that it is possible to dedesignate; it's just that, by and large, no one has ever gone back to take another look at the clinics to see whether they still met the original criteria that qualified them. And that's our recommendation—that such a review take place to see whether they still meet the original criteria, and we would add our additional screening criteria.

Mr. GROB. That would require a statutory change, that review.

Ms. STEINHARDT. Right. The recertification requirement would require Congress to act.

Mr. TOWNS. You know, I agree with you that there should be a review, but I think the point I want to make is, how often should this review take place?

Ms. STEINHARDT. Good question. We didn't specify the frequency of the review. One thought that came to our minds was every 3 years, which is the frequency with which the health professional shortage areas are reviewed to see whether they still qualify as health professional shortage areas, but we have no set feelings about it.

Mr. TOWNS. Any other comments?

[No response.]

Mr. TOWNS. Your report suggests restricting the cost-based reimbursement benefit of the program. What impact will this have on the financial viability of rural health clinics in truly underserved areas?

Ms. STEINHARDT. Good question. From our review, we found that most of the clinics don't depend on their rural health clinic status or cost reimbursement status for financial viability. It's just not the case. And these clinics, unlike, say, federally qualified health centers, are not required to serve underserved populations. They don't have to see uninsured populations, for example, as a condition of their being a rural health clinic.

So this is not as though they need their rural health clinic status in order to make sure that they are able to care for the uninsured, because they don't have to see them if they can't afford to.

Mr. TOWNS. I know you made some recommendations. Is there anything else, now that you've had an opportunity to look further, that you would like to recommend that we might be able to do on this side?

Ms. STEINHARDT. Well, as far as the Rural Health Clinic Program, I think the recommendations we've made in this report would take care of the two big areas that we are concerned with, which is improving access for the intended beneficiaries of this program, and establishing better cost controls.

There are things, I think—and this is something we intend to do some more work on—we think that there are issues related to the whole area of how we deal with increasing access to communities that are regarded as underserved. There are a whole variety of programs that are intended to help these communities. They are not well coordinated; they are not really well related to one another. We think there are opportunities to improve, overall, how we, as

the Federal Government, support access to these communities by doing a better job with those programs.

We have done some work in this area in the past. We have recommendations on the whole medically underserved health professional shortage area system. We have looked at the J–1 visa waiver program that allows foreign physicians to serve in underserved areas. We have looked at the National Health Service Corps. There are common themes that run across all these programs, and I think there is certainly room for improvement in how we put all these programs together to deal with improving access.

Mr. TOWNS. Thank you very much. I yield back, Mr. Chairman.

Mr. SHAYS. Thank you.

Mr. Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

I apologize for the simplicity of these questions. You all are out there sitting there as experts, and the chairman is probably an expert on this, and the audience is probably expert on this. I want to go back just to some very basic things.

Mr. Grob, if you can help with your chart, your South Carolina line. If you can just explain to me the differences there in the reimbursement, it would be helpful.

Mr. GROB. OK. First of all, let me tell you that there is no central data bank of Federal data for what happens in every State. Whenever we look at the Medicaid program, we really have to hustle after the data and get it State by State, and we don't always get uniformly comparable data when we do so.

But just to give you an example, there is a rate that each State sets for reimbursement of primary care. Health care providers, they have the option to set whatever rate they want. So for each of those three States, I have shown what rate those States have set on their own.

For a freestanding rural health clinic, they are allowed to receive reimbursement based on the costs that they incur, but it is subjected to a limit, and the limit is imposed by HCFA, by the Health Care Financing Administration, which basically certifies the centers. That's what you see there for the independent rural health centers. You notice they are all about the same. The rate now is about $56.65, something like that, but, again, it's a cost limit, so there might be a few that are below that.

Mr. SHAYS. If I could just interrupt you, I would just point out to the gentleman that the questions can be simple, but the answers are never.

Mr. SNOWBARGER. I suspected that.

Mr. SHAYS. I thought I understand this, and I'm getting a little confused. I want you to speak a little more slowly and define the difference between Medicaid and Medicare. I just think it would be helpful. And I just want to say to you that we learn more from the simple questions, so that's the way we proceed.

Mr. SNOWBARGER. Prepare to learn.

Mr. SHAYS. Yes. So I'm going to ask you, if you don't mind, to answer the vice chairman's question by just starting over again, giving a different framework. You've got independents, you've got the provider-based, you've got the independent doctors, and you've got Medicare and Medicaid. If you could kind of sort all this out,

because this is going to be the base from which we ask other questions.

Mr. GROB. OK. Let me start out, first of all, there are both Medicare and Medicaid program. The Medicare program is administered by HCFA. The Medicaid programs, of course, are administered by each State. Each of those programs sets their own rates. There are rates that HCFA sets for the Medicare program, and each State sets its own rate for the Medicaid programs.

If a center, physicians' office, or any group would like to become a rural health clinic under the Medicare and Medicaid Rural Health Clinic Program, they apply to the Health Care Financing Administration for a certification to that effect. If they pass certain criteria, which includes providing certain primary care services, having the assistance of mid-level providers, and things of this nature, and if they live in an underserved rural area, then the Health Care Financing Administration will certify them as being one of these centers.

Now, if they are certified, they get more money, under both the Medicare program and the Medicaid program. The money that they get is based on the cost that they incur. So instead of getting money for a certain fee, they are basically allowed to charge what it costs them to do business.

However, that cost reimbursement is limited by a cap which the Health Care Financing Administration has set. That cap is updated every year, and it applies to the freestanding clinics. Whether they be under the Medicare program or the Medicaid program, they are subject to that cap. Right now it's about $56 or $57. OK?

Other clinics, of course, get paid by a fee, are on a basis other than that. However, if they are not freestanding, if they are basically owned by a hospital, then the Health Care Financing Administration has construed that they are part of the hospital, and they are reimbursed the way that, say, the outpatient department of a hospital or another ancillary unit of a hospital would be reimbursed.

That reimbursement system under Medicare does not have a cap placed on it. It is based on reasonable costs. The result of that is that if you are a clinic that is owned by a hospital, the cap doesn't apply to you.

So this chart that I have prepared here illustrates how this would work under the Medicaid program. It shows the fact that those rates would vary from State to State, because the underlying Medicaid rates would vary from State to State. A similar thing would happen, however, under the Medicare program.

Basically speaking, in these rural areas, the independent clinical labs are receiving about twice as much money as a clinic would receive under the Medicaid program. For those that are owned by providers, it could be a lot more.

Mr. SNOWBARGER. Could I follow through with a few definitional things here?

Mr. SHAYS. Yes.

Mr. SNOWBARGER. I understand that Medicare and Medicaid are different programs, and you have indicated that both of those programs have some kind of rural health clinic designation.

Mr. GROB. Yes.

Mr. SNOWBARGER. Are they definitionally the same?

Mr. GROB. They are.

Mr. SNOWBARGER. Wow, we finally coordinated something.

Mr. GROB. Yes, we did. However, I will tell you—and you didn't ask me this, but I think it's worth laying on the table.

Mr. SNOWBARGER. Well, I'll ask it.

Mr. GROB. OK. Another issue is, different people would represent the interest of the States. You each represent the interest of the States that you come from, to some extent. So would the people running the Medicaid program or the Governors.

It is the Health Care Financing Administration that certifies these clinics. So if they certify them, then the Medicaid program must pay the higher rates. Not all the people who run the Medicaid programs are happy about the fact that they have to pay higher rates because the Health Care Financing Administration certifies the clinics.

So there is a single certification, which is unusual, and it applies, for this program, to both Medicare and Medicaid. The State officials don't have any control, or very little control, over that certification process. Some wish they did have more control. To change that, by the way, I believe that would be a statutory matter.

Mr. SNOWBARGER. Again, coming out of HCFA, Medicare makes the designation?

Mr. GROB. In essence, yes. The Health Care Financing Administration speaks on behalf of both.

Ms. STEINHARDT. One thing that I think might be important to keep in mind, just in sort of a historical context about this program, when the Rural Health Clinic Program was established, Congress' concern was that there were parts of the country, rural areas in the country, which depended for primary care on people other than physicians—nurse practitioners, physician assistants—and they were not being reimbursed under Medicare.

So the initial thrust of this program was to provide reimbursement to nonphysician providers of primary care, to make sure that those areas of the country were not penalized, you might say, for depending on nonphysicians for their care. Everybody was under a cost reimbursement system then. So it wasn't cost reimbursement that was the sort of benefit, by itself, to these rural health clinics; it was coverage of nonphysician providers that was the benefit then.

As we moved to a prospective payment system, where we moved to a fee schedule, and under this sort of managed care—the whole restructuring of the health care system, in which suddenly there were concerns about managed care and establishing market share, and so on. The whole flavor of the program really changed dramatically, so that it's now operating really in a very different environment and with different kinds of concerns than it did back in 1977 when it was established. And that's important to remember.

Mr. SNOWBARGER. One other question, and I want to just make sure that the reference over here to provider base is the same as reference to facility base here?

Mr. GROB. Yes, it is. Yes, thank you.

Mr. SNOWBARGER. A phenomenon I've seen occur in our area is for, say, a metropolitan hospital—it comes from a large area—

would not qualify, I presume, as a rural health provider. As is common with a lot of hospitals, both buying and creating family practice clinics, and some of those clinics end up in areas that now qualify for the higher reimbursement.

Is that the kind of thing we're talking about?

Mr. GROB. Yes.

Mr. SNOWBARGER. What is the rationale used by these agencies that this perhaps even transplanted clinic from an urban area to a rural area, frankly, operated under a separate structure even, now qualifies?

Mr. GROB. I think I can address that, if you wish, sir. It gets to say that I still live in a rural area and have been following these developments very carefully in the area that I live.

What you see happening there is that there is quite a concern among various organizers of health care. They may be the large hospitals, they may be HMOs that are associated with hospitals or freestanding, they may be groups of physicians who want to band together to have their own health maintenance organizations, or whatever, but they are all quite concerned about organizing the medical care in the areas where it is unorganized right now. Those areas may be rural areas.

So exactly what you are saying is happening. Hospitals and others are, as I said earlier, trying to gain a foothold so they have a stake in everything that happens and that they are basically in the game. We were surprised about this. When our inspectors went out and talked to the people as to what was happening, they started coming back with these reasons, which are somewhat nebulous, but very commonly given.

I know I, myself, have seen it firsthand where I live. It is a consideration, and it's exactly what you are describing. That's starting to fuel this instead of the original purpose of the program.

Mr. SNOWBARGER. Again, Mr. Chairman, what is the rationale for the higher reimbursement for the provider-based and facility-based, in the circumstances that I was saying.

Mr. GROB. OK. What happened here was that, when the Health Care Financing Administration had to establish what the limits on cost-based reimbursement were, it had a harder time, administratively, dealing with how we pay hospitals. Since they were controlled by the hospitals, they had to be paid for as part of the system for paying hospitals, which is a different system entirely.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. SHAYS. You're welcome. I would love to just get a much clearer sense of what is rural. Define for me "rural."

Ms. STEINHARDT. Under 50,000. The definition now is non-urbanized areas, and for the purposes of this program it's non-urbanized areas of less than 50,000 population.

Mr. SHAYS. In a 15-mile square?

Ms. STEINHARDT. No, that's it. That is the definition with no other qualifications around it. It could be only a few miles away from a larger area.

Mr. SHAYS. That's just too absurd to contemplate. If you had a 10-mile-square area, and you said there were less than 50,000, and right next to it you had even a larger area, you are saying that would be defined as rural?

Ms. STEINHARDT. Yes.

Mr. SHAYS. OK. That doesn't take a rocket scientist to know that's the first thing we change. Except, politically.

Ms. STEINHARDT. Yes. Go ahead.

Mr. SHAYS. No, I'm happy to have both of you participate in this dialog. Do you have something to add to it?

Mr. PASQUIER. No, the definition in this program uses the Bureau of the Census definition, which is "non-urbanized," and it depends on the city. If the city has an under–50,000 population, then it is considered rural.

Now, looking at solutions to the program, we think, if you establish additional criteria rather than try to redefine what is rural, if you establish additional criteria that is trying to target funds to those beneficiaries that are experiencing problems with access, you can avoid having to redefine "rural" in the statute, which is a problem.

Mr. SHAYS. I hear what you are saying. There must be another reason why I can't do it. Are you saying that a Ridgefield, CT, that maybe has a population of 10,000 people, or 12,000, or 15,000 people, could be designated as rural under our system? There must be other factors.

Mr. GROB. These would be areas that are outside the large metropolitan statistical areas.

Mr. SHAYS. It's not logical to me, so there is something I'm not getting.

Ms. STEINHARDT. There are lots of problems with trying to define "rural," just as there are lots of problems with trying to define "medically underserved" and "shortage areas."

Mr. SHAYS. Let me just say that what this committee, I am almost certain, is going to do: we're going to recommend that we do a better job serving people in rural areas. And what I'm getting a sense of is, I'm not sure that your reports are going to really help us get to that, if I'm not able to see a little more definition to this issue.

Ms. STEINHARDT. I think, though, the way we tried to get at it was to focus on the problem of access. If the people in the community are not well served, if they have no Medicare or Medicaid providers, or the ones they have can't see any more patients, that, to us, gets at the problem of access most directly.

So, while I think it may be very important to take on the issues of defining "rural," and defining "medically underserved," these are very thorny problems.

Mr. SHAYS. Is that a thorny problem politically, or statistically is it a problem?

Ms. STEINHARDT. Maybe both.

Mr. SHAYS. The other two who are going to follow afterwards maybe can answer some of these questions. Where I get concerned is when you basically tell me that the new people who have gained access, basically about 90 percent of them didn't need it, and that tells me that we're building this gigantically expensive system that is going to have a constituency. When you get into the billions of dollars, you are going to have a hard time changing it. So I feel there is a tremendous sense of urgency to get at that problem.

So you, basically, in your chart over there against the wall, when you say 27 percent are in areas that are 25,000 to 50,000, that is even a misstatement, in some ways, because they could be right next door to a community with a lot more.

I mean, I have a friend who lives in Montana, who thinks nothing of going shopping 5 hours away, or going, literally, to a movie that is 3 hours away. But to my suburban mind, if it's 10 miles away, that's a distance. There's a mind-set here that we just have a big disconnect.

Ms. STEINHARDT. Well, every 3 years, HCFA does a survey of Medicare beneficiaries. When they ask Medicare beneficiaries how they feel about their access to care, 97 percent of Medicare beneficiaries feel they have adequate access to care. It's an important reminder.

Mr. SHAYS. OK. Let me just say, from my standpoint, I'm going to investigate this with the panels that will follow. You have kind of thrown the ball into play and have provided a tremendously useful effort for us.

Mr. Souder, do you have some questions you would like to ask?

Mr. SOUDER. Just a couple of clarifications. I apologize; I missed the original testimony. I tried to look through some last night and some here while we were talking through. I'm a bit confused on a couple of terms in Mr. Grob's testimony.

You have a statement that rural health clinics converted to rural health clinic status—in other words, they were already rural health clinics—when you say independent rural health clinics, do you mean those are the ones that haven't converted to status yet.

Mr. GROB. No. You may be running a clinic in a rural area, but you may not be receiving the benefit of any special funding from either the Medicare or the Medicaid program.

Mr. SOUDER. So you would be the blue on your chart?

Mr. GROB. Yes, the regular rate. So, if you wanted to receive that funding, then you would have to apply for certification to get into the Medicare and Medicaid Rural Health Clinic Program. Then, if certified, you could receive the higher rates of pay.

Mr. SOUDER. So, then, if you are independent, you move to the red; and if you work with a facility, you are in the green.

Mr. GROB. Yes, that's right.

Mr. SOUDER. And your chart over there is, the gray is, in effect, the red; and the white is the green?

Mr. GROB. That's correct.

Ms. STEINHARDT. Yes.

Mr. SOUDER. The increase in the amount of independents, you are arguing, was due to the financial incentives; both of those groups, the white and the gray?

Mr. GROB. That's correct.

Mr. SOUDER. There is some implication in the testimony that some of these places might have closed if they weren't able to convert. How do we sort that out?

Mr. GROB. I really don't think anybody knows that, to be honest with you. I certainly don't think we would have any way of telling. I can tell you that our inspectors, in reviewing the facilities, didn't see very many that they felt were really in jeopardy. In fact, the opposite may be the case. Because of the special rates that these

facilities receive, they may actually be making it more difficult for nonsubsidized enterprises to come into existence, because they have an advantage in these heavily populated areas.

It is possible, though, I think in the rural areas, that are truly rural and truly underserved, I do think the financial thing could make a difference. And I don't think that any of us are advocating that we eliminate that financial benefit for those in the rural areas where you need the money for financial stability or because you might want to attract providers in the area that aren't there now. I think it does turn more on what is truly rural, what it truly underserved.

Ms. STEINHARDT. In our survey—if I might just add—in our survey we found that, while some may depend on this designation, many don't depend on it for financial viability. Even if they were not to have that designation, they would remain financially viable.

Mr. SOUDER. The other question I have is that—anybody here can answer the questions; I was picking on Mr. Grob—obviously, the group of the facility-based has exploded, proportionally, yet there has been a steady growth of the other as well.

My understanding is, you were having independents also convert to facility-based, so it means there has been a fairly substantial percentage converting from nothing into the independent. Then there also is probably some resistance—I certainly hear this in Indiana—the resentment of doctors and independent clinics having to go with facilities. There is somewhat of a rivalry.

So on what grounds—is this being facility-driven, trying to come in, is that part of your argument, as opposed to—are the independents that associate with a facility actually struggling financially?

Mr. GROB. No, I think you stated it exactly right. Again, now, this is not hard; this is what people were telling us. What I think we are seeing is that, on the provider side, on the facility-based, it's the facility that is bankrolling the center, to get it established, to kind of extend themselves out. Whereas, for the independent practitioner, they are the ones who want to convert over because the funding is more favorable.

I don't think that the facilities are necessarily establishing these centers because they expect to make a lot of money in them, initially. I think they are simply trying to position themselves. In fact, a lot of them told us that they weren't making money. Of the facility-based centers that we saw, a lot of them were very small: one doctor, a few visits. The independent ones were the large ones, because they were behaving much more as the program was intended to behave.

Again, we can't prove this, and I'm sure that representatives of the industry might deny that it's the case, and perhaps on good basis. I am simply trying to tell you what our inspectors saw and what people told them when they were there.

Mr. SOUDER. How much of this may be caused by the fact that the hospitals in towns 5,000 to 10,000 are in relatively deep trouble?

For example, in my district, which is centered by Fort Wayne and has nine rural counties around it, what has happened is with the access of the interstates and the commuting, and so on, the Fort Wayne hospitals are in heavy competition to get the feeder

system that, on almost anything major, they are drawing in the patients from the rural areas, leaving substantial empty beds in the rural hospitals, then starting to set up this outreach to feed in and through system.

Are they using this heavily to do that? Is that partly what is going on?

Mr. GROB. I believe that, in a general manner, they are using the ability to sponsor these centers as a way to reach out and fill those areas with things less than hospitals.

Mr. SOUDER. Thank you for helping clarify.

Mr. TOWNS [presiding]. Thank you very much.

Any other questions from any Members?

[No response.]

Mr. TOWNS. Let me thank the members of the panel for enlightening testimony. Also, you have pointed out that we still have a lot of work to do in order to make certain that we are not wasting resources. I think that is a real concern. I think that when we get involved in the checking and the rechecking, we don't want to spend all of our money checking and rechecking either. We also want to be able to have some resources to spend in terms of getting rid of the problems in terms of the patients.

So thank you very, very much.

The second panel: Kathy Buto; Dr. Gaston; Dr. Puskin.

We swear in all of our witnesses. If you would just please stand.

[Witnesses sworn.]

Mr. TOWNS. Let the record reflect that all of them answered in the affirmative.

Why don't we start with you, Ms. Buto.

STATEMENTS OF KATHLEEN BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; MARILYN H. GASTON, M.D., DIRECTOR, BUREAU OF PRIMARY HEALTH CARE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DENA PUSKIN, ACTING DIRECTOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Ms. BUTO. Mr. Chairman, members of the subcommittee, I am very pleased to be here. I am Kathleen Buto, the associate administrator for policy at the Health Care Financing Administration, HCFA.

I am pleased to have the opportunity to address rural health clinics and to respond to the concerns raised by the Inspector General's report and the GAO about the program not improving access to primary care services in underserved areas.

The GAO and IG reports indicate that while the number of rural health clinics has grown rapidly in recent years, their proliferation has not necessarily been in areas where Medicare and Medicaid beneficiaries face access problems. Rather, many clinics are being certified in areas where other clinics, RHCs, already exist or where beneficiaries have other sources of medical care. The process does not adequately identify underserved areas, and Medicare's current

cost base payment methodology encourages providers to seek RHC status.

HCFA generally agrees with the findings of the reports and is working with the Public Health Service to correct these problems. Before discussing how we are addressing these issues, I would like briefly to touch on some background of the Rural Health Clinic Program.

The Rural Health Clinics Act was enacted in 1977 by Congress and implemented by us in 1978, to increase access to primary health care services for Medicare and Medicaid beneficiaries living in rural areas. To be classified as an RHC by HCFA, clinics must be located in a rural area and a shortage area. I would emphasize that, because there was a lot of focus on the rural designation in the last panel. The shortage area designation is equally if not more important in this program, as designated by the Public Health Service or by a Governor, and approved by the Public Health Service.

In addition, an entity applying for RHC designation under Medicare must meet specific conditions of participation set out in the Medicare statute, including staffing requirements, lab requirements, and other criteria appropriate to a setting for primary health care.

Under the Medicare statute, HCFA must continue to designate existing clinics as RHCs, even if the area in which they are located is no longer considered a shortage or rural area. This is a statutory provision. Certification by Medicare as an RHC leads to corresponding RHC status under Medicaid, if the clinic elects to serve Medicaid beneficiaries.

The scope of services furnished by these clinics is comparable to services provided in a physician's office. These services may be provided by physicians and mid-level practitioners, including physician assistants, nurse practitioners, and certified nurse midwives. Services provided by RHCs also include outpatient mental health services furnished by clinical psychologists and clinical social workers.

Medicare regulations for this program distinguish between two types of rural health clinics: independent and provider-based. Independent clinics are freestanding practices that are not part of the hospital, skilled nursing facility, or home health agency. Provider-based clinics are integral and subordinate parts of hospitals, skilled nursing facilities, or home health agencies, under common licensure, governance, and professional supervision.

The rural health clinic benefit has allowed many communities in rural America to establish and maintain rural health clinics. Communities located primarily in the western United States rely heavily on Medicare and Medicaid support to provide primary and emergency care to beneficiaries living in remote and mountainous areas.

While some rural clinics serve primarily Medicaid beneficiaries, most rural health clinics are an essential source of care for the entire community, including patients with Medicare, Medicaid, private insurance, as well as the uninsured, even though they are not required to cover the uninsured. Rural health clinics often provide care free of charge to patients who are unable to pay.

When the act was passed in 1977, projections of participation were optimistic. By October 1990, only 581 clinics around the country participated in the Rural Health Clinic Program. Recognizing the importance of rural health clinics in improving access to vital health services, Congress enacted several amendments to the original law to encourage participation of providers.

For example, in OBRA 1987, there was a mandated increase in the payment caps applied to this program and annual updates to the caps based on the Medicare economic index. Prior to that, we didn't have any indexing or increases in the cap. OBRA 1989 provided Governors the option of designating health care shortage areas within the States, thereby increasing the number of areas where RHCs could potentially locate.

This law also required that HCFA disseminate rural health clinic application materials—I think as alluded to by the previous panel—to all Medicare providers, including hospitals, skilled nursing facilities, and home health agencies, as a way of promoting participation in the program. The legislation also required us to expedite the approval time for rural health clinic certification.

In part due to these changes instituted by Congress, the number of rural health clinics has grown significantly, as pointed out. Much of the growth in rural health clinics has occurred in States where there are large rural areas that for many years had few or no clinics. The GAO and IG are concerned, however, that while increases in the number of rural health clinics may approve access in certain geographic areas, these clinics are also locating in areas where Medicare and Medicaid beneficiaries have adequate access to other primary care.

Let me now address some of the initiatives HCFA and the Department are pursuing to address the concerns raised in the two reports. First, a HCFA work group charged with monitoring the growth in rural health clinics; second, the Public Health Service's plans to reevaluate the shortage area designation process, which I will pretty much defer to the other panelists here; a proposed regulation that would consider a new payment methodology for rural health clinics; a study underway to evaluate access to clinic services; and legislative proposals that would give States flexibility in establishing new Medicaid rural health clinic rates that are in the President's 1998 budget.

We are concerned about the inappropriate proliferation of rural health clinics in recent years. The agency first received reports from State Medicaid agencies about the number of rural health clinics growing rapidly in 1994, and we moved to convene a working group in October 1994 to analyze and propose solutions related to this proliferation and other issues impacting the Rural Health Clinic Program.

Although we certainly agree with the GAO and IG reports, I would point out that we began to work on payment limits and payment reforms 2 or 3 years ago, and think that, basically, we are ready to go forward with rules.

Representatives from the Health Resources and Services Administration have also participated with us as partners, and our work group meets periodically with representatives from the rural health

care clinic community to solicit input and gauge industry reaction to some of our proposals.

One of the first issues addressed by the group, also identified by GAO as an area of concern, is the method by which the Department designates clinics. HCFA is concerned about the current method to establish areas and the fact that it only measures the number of primary care physicians to the population base.

In fairness to HRSA, HRSA is also concerned and is looking at the issue of whether mid-level practitioners, who typically provide the majority of services in rural health clinics, should be included in that calculation. So they are beginning to look at that, as well.

HCFA is concerned that all shortage area designations are not periodically updated, and, as such, a rural health clinic may be established in an area that was designated years ago but would no longer meet the criteria for shortage area. We are also sensitive to the fact, however, that the shortage area designations are used for a wide variety of governmental purposes. So any changes that need to be made to it need to take those broader purposes into account.

Given that scenario, we in HCFA believe we need to take a look at additional tests of need beyond the two that are set out in the statute already, the rural provision and also the medically underserved. So we are looking at a variety of other factors that could be put into place to add criteria in selecting rural health clinics, in addition to the two that exist.

We would consider the fact that rural health clinics currently, a number of them, are already located in areas, but that we ought to maybe take a look at nonphysician personnel, such as physician assistants and nurse practitioners, in considering future designations. We believe that additional tests and better measures of need will limit RHC growth to areas that are truly underserved, and we are working with a work group to develop specific proposals in this area.

The GAO and IG reports identified the currently statutorily mandated cost-based payment system as another factor contributing to the rapid growth of these clinics, particularly of the provider-based variety. We believe that a significant reason for this growth is the differential between independent and provider-based. We are preparing regulations to eliminate the difference in payment levels and apply a payment cap to the provider-based rural health clinics, or at least to seek comment on the application of a payment cap through regulations.

We are looking to get additional information about the relationship between RHCs and the access to care through an evaluation that our Office of Research and Demonstrations is sponsoring. Some of the questions that came up in the last panel about access to care issues in relation to costs that are rising are among the things that we will be looking at there.

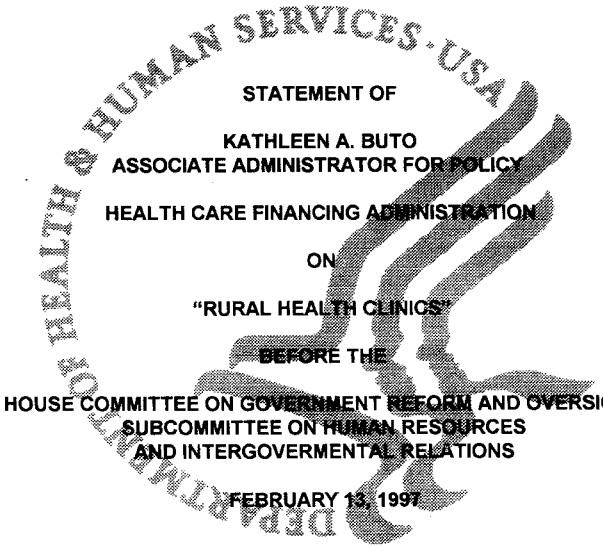
Let me mention a budget proposal in the 1998 budget that deals with the Medicaid provision, that would phaseout cost-based reimbursement. Right now, as you heard, Medicaid is required to pay the Medicare rates. This would phaseout that cost-based reimbursement. In place of that, our proposal would provide some supplemental payments during a transition period, both for rural

health clinics and FQHCs, as States move away from that to a more competitive basis.

Just in conclusion, as you know, we agree with many of the conclusions of the IG and GAO reports. We recognize that changes need to be made. We are working on some regulations to make those changes and to look at other criteria that ought to be applied.

I will end my statement there.

[The prepared statement of Ms. Buto follows:]



STATEMENT OF

KATHLEEN A. BUTO
ASSOCIATE ADMINISTRATOR FOR POLICY

HEALTH CARE FINANCING ADMINISTRATION

ON

"RURAL HEALTH CLINICS"

BEFORE THE

HOUSE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERMENTAL RELATIONS

FEBRUARY 13, 1997

HCFA
MEDICARE • MEDICAID
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Mr. Chairman and Members of the Subcommittee:

INTRODUCTION

Good morning. I am Kathleen Buto, the Associate Administrator for Policy at the Health Care Financing Administration (HCFA). I am pleased to have the opportunity today to discuss rural health clinics (RHCs) and to respond to the concern raised by the General Accounting Office (GAO) and the Office of the Inspector General (OIG) that the RHC program is not improving access to primary care services in underserved areas.

The GAO and OIG reports indicate that while the number of RHCs has grown rapidly in recent years, their proliferation has not necessarily been in areas where Medicare and Medicaid beneficiaries face access problems. Rather, many clinics are being certified as RHCs in areas where other RHCs already exist or where beneficiaries have other sources of medical care. The reports cite two primary reasons for this--the current shortage area designation process does not adequately identify underserved areas; and Medicare's current cost-based payment methodology encourages providers to seek RHC status. HCFA generally agrees with the findings of the reports and is working with the Public Health Service (PHS) to correct these problems. Before discussing how we are addressing these issues, I would like to provide some background information on the RHC program.

BACKGROUND

The Rural Health Clinics Act (RHCA) (P.L. 95-210) was enacted by Congress in 1977 and implemented in 1978 to increase access to primary health care services for Medicare and Medicaid beneficiaries living in rural areas. The RHCA also created a cost-based payment mechanism to ensure the financial viability of RHCs and encouraged the utilization of mid-level practitioners by providing payment for their services, even in the absence of a full-time physician.

To be classified as an RHC by HCFA, clinics must be located in a rural area <u>and</u> a shortage area as designated by the Public Health Service or by a Governor and approved by PHS. In addition, an entity applying for RHC designation under Medicare must meet specific conditions of participation set out in the Medicare statute, including staffing requirements, laboratory requirements and other criteria appropriate to a setting for primary health care. Under the Medicare statute, HCFA must continue to designate existing clinics as RHCs even if the area in which they are located is no longer considered a shortage or rural area. Certification by Medicare as an RHC leads to corresponding RHC status under Medicaid if the clinic elects to serve Medicaid beneficiaries.

RHCs are required to provide a core set of services. The scope of the services furnished by RHCs is comparable to services provided in a physician's office. These services may be provided by physicians and mid-level practitioners, including physician assistants, nurse practitioners, and certified nurse midwives. Core services also include outpatient mental health services furnished by clinical psychologists and clinical social workers.

Medicare RHC regulations distinguish between two types of RHCs--independent and provider-based. Independent RHCs are freestanding practices that are not part of a hospital, skilled nursing facility (SNF) or home health agency (HHA). Provider-based RHCs are integral and subordinate parts of hospitals, SNFs, or HHAs, and under common licensure, governance and professional supervision.

The RHC benefit has allowed many communities in rural America to establish and maintain rural health clinics. Communities located primarily in the western United States, such as Idaho and Montana, rely heavily on Medicare and Medicaid support to provide primary and emergency care to beneficiaries living in remote and mountainous areas. While some RHCs serve primarily Medicaid beneficiaries, most RHCs are an essential source of care for the entire community--including patients with Medicare, Medicaid, private insurance, as well as the uninsured. RHCs often provide care free of charge to patients who are unable to pay.

When the RHCA was passed in 1977, projections of participation were optimistic. By October 1990, only 581 clinics participated in the RHC program. Recognizing the importance of RHCs in improving access to vital health services, Congress enacted several amendments to the original RHC law to encourage participation of providers in the program. For example, OBRA 1987 mandated increased payment caps and established annual updates to these caps based on the Medicare Economic Index. OBRA 1989 provided governors the option of designating health care shortage areas within the States, thereby increasing the number of areas where RHCs could potentially locate. This law also required that HCFA disseminate RHC application materials to all Medicare providers (hospitals, skilled nursing facilities, and home health agencies) as a way of promoting participation in the program. OBRA 1990 legislation required HCFA to expedite the approval time for RHC certification.

In part due to these changes instituted by Congress, the number of RHCs has grown significantly in recent years--947 in 1992 to 2,708 in early 1996. As of January 1997, HCFA counted 3,270. Much of the growth in RHCs has occurred in States with large rural areas that for many years had few or no RHCs, including Texas, Missouri, Kansas, Nebraska, Oklahoma, North Dakota, Michigan, and Mississippi. The GAO and OIG are concerned, however, that while increases in the number of RHCs may improve access to

health care in certain geographic areas, RHCs are also locating in areas where Medicare and Medicaid beneficiaries already have adequate access to primary care services.

HCFA INITIATIVES to CURB RHC GROWTH

Today I would like to discuss several activities HCFA and the Department are pursuing to address their concerns including:

- A HCFA workgroup charged with monitoring the growth in RHCs;
- The PHS' plans to reevaluate the shortage area designation process to better identify areas with primary care access problems;
- A proposed regulation that would consider a new payment methodology for RHCs;
- A study underway to evaluate access to RHC services; and
- A legislative proposal that would give States flexibility in establishing new Medicaid RHC rates.

Like the OIG and GAO, HCFA is concerned about the inappropriate proliferation of RHCs in recent years. The agency first received reports from State Medicaid agencies that the number of RHCs was growing rapidly in 1994 and was able to collect and analyze data to confirm the States' claims. As the dramatic increase in RHC certifications became apparent, HCFA staff responsible for RHC policy making established a workgroup to analyze and propose solutions related to proliferation and other issues impacting the RHC program. Representatives from PHS' Health Resources Services Administration also participate in this group. The RHC workgroup periodically meets with representatives from the RHC community to solicit input and to gauge industry reaction to HCFA's proposals to modify the RHC program.

One of the first issues addressed by the focus group, also identified by the GAO as an area of concern, is the method by which the Department designates clinics as RHCs. As indicated earlier, to be classified as an RHC, a clinic must be located in a rural area and a shortage area. The RHCA mandated the definition of "rural" as "an area that is not urbanized" as defined by the Bureau of the Census. Three types of shortage areas are relevant to RHCs--health professional shortage areas (HPSA), medically underserved areas (MUAs) and Governor-designated shortage areas. HRSA determines if an area is a HPSA or MUA based on information submitted by the States. Governor-designated shortage areas must also be approved by HRSA. The RHCA requires HCFA to use the

shortage area determinations made by HRSA in evaluating RHC applications.

HCFA is aware that the current process for determining shortage areas does not always result in increased access to care in those areas. HCFA is concerned that the current method to establish shortage areas measures only the number of primary care physicians to the population base. Mid-level practitioners who typically provide the majority of services in RHCs, however, are not included in this calculation. We understand that HRSA is investigating the possibility of counting mid-level practitioners in the shortage area designation calculation. This is important, particularly in light of recently-enacted State laws that broaden the scope of practice for non-physician practitioners.

HCFA is concerned that all shortage area designations are not periodically updated by HRSA and as such, an RHC may be established in an area that was designated years ago but would no longer meet the criteria for a shortage area. We understand that HRSA is considering revising the designation process to address this issue.

HCFA is evaluating whether to subject clinics and physician's offices to "additional tests of need" before granting RHC status. HCFA could consider a variety of other factors, in addition to the rural and underserved location, before approving a clinic's or physician's office RHC application. For example, HCFA could consider the number of RHCs already located in a given area, as well as the number of non-physician personnel, such as physician assistants and nurse practitioners practicing in that locality. We believe that additional tests and better measures of need will limit RHC growth to areas that are truly underserved.

The GAO and IG reports identified the current statutorily mandated cost-based payment system as another factor contributing to the rapid growth of RHCs in recent years. We agree that a significant reason for RHC growth is the reasonable cost-based payment method used to pay for RHC services, particularly for provider-based RHC services. As I mentioned earlier, HCFA's current payment methodology that allows for different payments for "free-standing" and "provider-based" entities, may be driving the increase in RHCs, particularly the provider-based type. Unlike independent RHCs, provider-based RHCs are not subject to a per visit payment cap. With the growth of integrated delivery systems, HCFA has received numerous requests from entities requesting provider-based status.

In August 1996, we issued guidance to our regional offices on determinations of "provider-based," reiterating various elements of our policy that have been issued in regulations and other program issuances. Our policy on "provider-based" designations applies across the board, to all Medicare participants, including physicians' practices or clinics that state they are part of a provider.

In addition, we are preparing a proposed regulation to address the issue of inequity of payment between provider-based and independent RHCs. We are considering several issues, including payment limitations for both independent and provider-based RHCs, and requiring physicians to separate RHC practices from private practices. Because we are aware of the impact any payment policy change may have on access to care, we are seeking input from the public about how payment rates should be established. In the development of this proposed regulation, HCFA is making every effort to ensure that a policy change does not impede beneficiaries' access to necessary medical care.

We are seeking to gain additional information about the relationship between RHCs and access to care from an evaluation of the RHC program sponsored by HCFA's Office of Research and Demonstrations. The evaluation, begun in September 1995, is being performed under contract with Mathematica Policy Research, Inc. A design report was submitted by Mathematica in June 1996, and we expect a final report by the end of the summer 1997. The goal of the study is to assess access to care through RHCs compared to increased costs arising from the higher payment rates mandated by the RHC legislation. The Mathematica study will also examine the integration of RHCs into managed care networks, a topic that was not addressed in either the OIG or GAO studies, which focused primarily on growth in numbers and the impact of program rules.

I have focused thus far on RHCs in the Medicare program. As you know, RHCs fill a critical void in the health delivery system for the Medicaid population as well. As with Medicare, the proliferation of RHCs has strained State Medicaid budgets. The rapid conversion of private physician offices to RHC status is creating large increases in Medicaid spending. Forty percent of States with RHCs reported increased expenditures of 50 percent or more in FY 1995. The cost increase associated with RHC status is more dramatic for Medicaid because the statute requires that Medicaid RHC payments be made at the Medicare rate along with costs incurred for ambulatory services required under the State Medicaid plan. The RHC Medicaid rate is considerably higher than most States pay for comparable physician or clinic services. Several States report dramatic increases in requests for RHC designation largely due to an influx of "physician-owned and operated clinics." These private doctors can avoid the State's physician fee schedule, which is typically less than cost reimbursement, by becoming an RHC.

The President's 1998 Budget includes a Medicaid provision that would phase-out cost reimbursement for RHCs in one year. In place of reasonable cost reimbursement, we are developing a proposal to provide supplemental payments to RHCs to ease the transition. We believe that these proposals, if enacted, would reduce the incentive of some clinics to convert to RHC status while continuing our support of these critical providers.

CONCLUSION

HCFA agrees with the conclusions of the OIG and GAO reports. The increase in the number of RHCs has not always resulted in improved access to care because many new RHCs are not located in areas where beneficiaries are experiencing access problems. We are working with our colleagues in PHS to eliminate unnecessary growth in the RHC program while continuing to provide critical support to providers located in isolated and underserved areas. Revisions to the shortage area designation process, along with additional tests of need should limit the growth of RHCs to areas where their presence is justified. Results from the evaluation project being conducted by Mathematica should help us in this effort. In addition, the proposed Medicare payment regulations we are developing should eliminate financial incentives for some providers to convert to RHC status. Finally, our Medicaid RHC proposal, if enacted, will reduce expenditures for RHC services provided to Medicaid beneficiaries. These initiatives will improve our ability to limit RHC proliferation to truly rural and underserved areas, thereby slowing expenditure growth.

Mr. Chairman, thank you for allowing me to explain our activities concerning RHCs. I would be pleased to answer any questions.

Mr. TOWNS. Thank you very much.

Dr. Gaston.

Dr. GASTON. Thank you very much, Mr. Chairman, members of the committee. I am Dr. Marilyn Gaston, director of the Bureau of Primary Health Care within the Health Resources and Services Administration. I am pleased to be accompanied by Ms. Dena Puskin, acting director of HRSA's Office of Rural Health Policy.

We implement safety net programs which provide primary health care services to underserved populations. In the Bureau, these include the National Health Service Corps and the federally qualified health centers, FQHCs, including community health centers, migrant health centers, health care for the homeless programs, and health care for public housing residents, and the FQHC look-alikes. In connection with these programs, we also manage the underserved area designation processes.

Safety net programs are a critical part of the health care delivery system in the Nation today. As you know, that system is being challenged rapidly and dramatically, with profound effects upon these programs and, most of all, upon the people that they are trying to serve.

In the last 5 years, the numbers of uninsured persons increased nationally by 15 percent, but the number of uninsured increased by 34 percent within our safety net programs, clearly double. These programs are also affected by decreasing revenues, as managed care is implemented, and by loss of capacity caused by closures of other safety net providers. Yet these programs are more essential than ever to assure access to health services for uninsured and other underserved populations.

RHC's and FQHCs are both intended to enhance access in underserved areas. However, FQHCs serve as safety net providers, as they must provide care to all patients in their target populations who seek their services regardless of their ability to pay. This is an essential feature of safety net providers. As GAO points out, some RHCs are serving as safety net providers and providing care to the underserved populations on which their certification is based, including not only Medicaid and Medicare patients but also the uninsured and underinsured.

HRSA agrees with the GAO finding that many RHCs are located in areas of highest need. This is occurring, in part, because their location is a designated underserved area alone is not sufficient to ensure that Federal resources are targeted to areas of highest need.

In HRSA Bureau of Primary Health Care, we use the designations as only one aspect of determining need for Federal resources and funding of FQHCs. For example, the National Health Service Corps uses a HPSA designation as a first screen in determining where a provider should be placed. Other scoring mechanisms are then used to determine priorities among HPSAs and among primary care delivery sites in HPSAs, before available providers are allocated to those HPSAs of greatest need.

Similarly, the MUAMUP designation is the first screen in determining potential need for a health center grant. Then a grant application for a health center is also required to confirm that unmet need in the designated community and how they intend to increase

access. Throughout all of these determinations, we routinely gain invaluable input from States regarding the need and required intervention.

Like health center grantees and National Health Service Corps placements, applicants for FQHC look-alike status must also provide information on additional aspects of need. So we use designations as a first screen and other measures of need as additional considerations. Most of all, we continuously monitor our programs for need, access, quality, and community impact.

To assure adherence to the mission, we require annual grant or recertification applications from grantees and FQHC look-alikes, respectively. In addition, for grantees we conduct monitoring activities beyond the annual applications, which include regularly scheduled onsite reviews.

Finally, we agree with the GAO that MUAs be updated regularly. HRSA has developed a new approach to improve the existing designation process for HPSAs and MUAs. The new approach will consolidate the two existing procedures, thereby eliminating two overlapping lists of designations and additional data burdens for States and communities.

As a result, in the future, both MUAs, MUPs, and HPSAs will be updated simultaneously, on a regular schedule, the one we are using for HPSAs at this point. We would ask States to review their designations annually and require States to submit new data for those designations every 3 years. With the new designation process, we also plan to begin counting nurse practitioners, physician assistants, and certified nurse midwives.

We also agree with the GAO that the current RHC eligibility criterion of location in an underserved area does not go far enough to ensure that the program is directed and maintained in needed communities with critical shortages of primary care providers. As has been stated, additional assessments of need are required.

Before an entity is certified as an FQHC or RHC, it is important that it documents the lack of sufficient health care resources in the service area and how it intends to increase access to health care for a substantial number of underserved persons. We in HRSA support HCFA's efforts to explore additional tests of need for RHCs, and have been working with them in their efforts.

I would also like to note that just last week the Secretary's Advisory Committee on Rural Health adopted a position which supports certification of new RHC sites based on additional program-specific needs assessment. Clearly, HRSA considers State involvement in the certification process as critical. We have also been collaborating with HCFA in determining how to increase State involvement. HRSA also agrees with the GAO recommendation to require periodic recertification of RHCs to ensure that clinics continue to meet eligibility and need requirements.

In conclusion, we believe all of these changes will greatly improve decisions around the location of RHCs and will help ensure that they are strategically placed. A recertification process will ensure whether they should be maintained in underserved communities.

Provider types that are reimbursed by higher Medicaid and Medicare rates than others, because of their safety net nature,

which includes FQHCs and RHCs, should be held accountable for receiving the special subsidy. It is imperative that FQHC or RHC provide increased access to health care for a substantial number of underserved persons.

Given the changing health care environment and budgetary pressures at both the Federal and State levels, it is critical that Federal grant programs and financing mechanisms for health care services maximize their contribution to the safety net and increase access for the many underserved citizens in our country.

Thank you very much for the opportunity to testify. We will be glad to answer any questions.

[The prepared statement of Dr. Gaston follows:]

Testimony Statement

MARILYN H. GASTON, M.D.

DIRECTOR, BUREAU OF PRIMARY HEALTH CARE

HEALTH RESOURCES AND SERVICES ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Before the
Committee on Government Reform and Oversight
Subcommittee on Human Resources

February 13, 1997

Mr. Chairman:

I am Dr. Marilyn Gaston, Director of the Bureau of Primary Health Care, the organization within the Health Resources and Services Administration (HRSA) that implements safety net health care programs providing primary health care services to underserved populations. These include the National Health Service Corps (NHSC) and the Federally Qualified Health Centers (FQHCs), including community and migrant health centers, health care for the homeless programs, health care for public housing residents, and the FQHC "Look-Alike" certification. In connection with these programs, we also manage the underserved area designation processes, which I will discuss. I will also address HRSA's views on some of the issues raised by the General Accounting Office (GAO) report on the Rural Health Clinic (RHC) program.

THE SAFETY NET

Safety net programs are a critical part of the health care delivery system in the Nation. That system is now changing rapidly and dramatically. Safety net providers are more essential than ever to assure access to health services for uninsured and other underserved populations. The safety net is

severely strained by massive changes as insurance coverage erodes, resources shrink and the marketplace is transformed by managed care and competitive forces. We must act now to strengthen these programs and their ability to care for those otherwise without access to care.

In 1995, 40 million persons, 10 million of them children, lacked health insurance and presumably lacked access to a primary care provider. Furthermore, the number of uninsured persons in the Nation has been growing steadily since 1990 and the increase is expected to continue to between 45 and 53 million within the next five years, depending on the changes made in Medicaid. Safety net providers are especially vulnerable as they are less able to care for the poor; they have smaller proportions of paying patients to begin with and they can no longer shift costs due to decreased payment rates. Existing access problems, especially in isolated rural areas and among vulnerable and hard to serve populations, are being exacerbated by changes in the health care infrastructure and reductions in safety net capacity.

RHCs and FQHCs are both intended to be safety net providers which enhance access in underserved areas, and both receive cost-based

reimbursement through Medicaid and Medicare all-inclusive per-visit rates. As GAO points out, it is important to recognize that some RHCs are true safety net providers. These RHCs are providing care to the underserved populations on which their certification is based, including not only Medicaid and Medicare patients but also the special populations that are the basis of some underservice designations. Furthermore, some of them also provide care for the uninsured and underinsured to the best of their abilities.

Many factors influence the extent to which access to care is actually increased by an entity, including but not limited to committment to the underserved, provider capacity, and finances available to provide access to needed care. It is important to keep in mind that the requirements for RHCs and FQHCs are markedly different, both in terms of what is required of them and how their applications are processed.

DISCUSSION OF THE DESIGNATION PROCESSES

The portion of the RHC effort that HRSA clearly has responsibility for is the shortage area/underserved population

designation process, so let me address this in some detail.

Two types of designations are required by the PHS Act: Medically Underserved Areas and Populations (MUA/Ps) and Health Professional Shortage Areas (HPSAs). Both were developed for PHS safety net programs prior to their use for other programs such as Rural Health Clinics.

The MUA/P designations are intended to identify areas and population groups with a shortage of primary care health services; this type of designation has been required for grant funding as a health center under section 330 of the PHS Act since 1975. The criteria for these designations are required to include indicators of health status, ability to pay for and access to health services, and availability of health professionals. Historically, MUA/P designation has used an index approach; the variables currently included in the index are infant mortality rate, percentage of the population below the poverty level, percentage of population over 65, and primary care physician to population ratio.

The HPSA designations are intended to identify areas that have a

shortage of primary care health professionals. A HPSA designation (under section 332 of the PHS Act, as amended in 1976), allows a community to request National Health Service Corps health professionals. Historically, HPSA designation has primarily emphasized the primary care physician to population ratio, with high poverty and/or infant mortality used to indicate areas and populations of unusually high need, requiring a lower population-to-primary care physician ratio for designation.

A third type of designation used by the Rural Health Clinics program is Governor's designations. These are made by State Governors using State criteria and data, after the criteria are first reviewed by HRSA.

DESIGNATION AS A FIRST NEED SCREEN

I want to emphasize that underservice designations are designed as the first screen in determining need for health resources and services. For example, HPSA designation is the first screen in determining need for providers placed by the National Health

Service Corps, but other scoring mechanisms are then used to determine priorities among HPSAs and among primary care delivery sites in HPSAs before available NHSC assignees (scholars or loan repayors) are allocated to the HPSAs of greatest need.

Similarly, MUA/P designation is the first screen in determining potential need for a health center grant. However, an application is also required that confirms the need in the designated community and allows relative scoring of the need of the community as compared to other applicants.

Candidates for Federally Qualified Health Center (FQHC) Look-Alike status, which HRSA is responsible for reviewing and recommending to HCFA for certification, are also required to provide additional information on need beyond serving an MUA or MUP. They are asked to identify existing resources in the community that provide primary health care to the underserved. Also, they must document the lack of sufficient health care resources in the service area to meet the primary health care needs of the target population.

UPDATE OF DESIGNATIONS

There is a statutory requirement that the list of federally designated HPSAs be annually reviewed, revised as necessary, and published. To continuously update the HPSA list, each year States are requested to submit current data, with emphasis on those HPSAs whose designations are older than 3 years. For health center programs, updates regarding the need of the area or population group for health services are presented in the continuation applications of grant funded centers and re-certification applications of FQHC Look-Alikes.

COUNTING OF FEDERAL PROVIDERS IN THE DESIGNATION PROCESS

The NHSC and other Federal providers are not included in practitioner counts in designating HPSAs, and for MUA/P designation purposes providers at FQHCs are also excluded. Therefore, these designations reflect the situation in the absence of Federal resources. To do otherwise would result in a "Catch-22" situation, where placement of a Federal or federally-funded clinician might require dedesignation of the area, in turn requiring removal of the clinician.

Because the federal providers are not included at the designation stage, it is critically important that they be included at a subsequent stage of the allocation process. For example, the NHSC placement process considers the NHSC clinicians already placed in a HPSA in determining the number of new NHSC assignees that can be added; the Health Center grant process takes into consideration the locations and service areas of other FQHCs.

COUNTING NONPHYSICIAN PROVIDERS

At the present time, we do not include nonphysician providers (nurse practitioners, physician assistants and certified nurse midwives) in the counts of primary care providers for designation purposes. We have not done so up to now for several reasons.

When the Rural Health Clinics Act was first passed, there was a concern that counting nurse practitioners and physician assistants for designation purposes would prevent designation of rural areas where they practiced, thus precluding their eligibility for RHC certification.

At this time, a major concern is that the use of nonphysician

providers varies widely from State to State. In States whose laws permit them to practice relatively independently, it is appropriate to count these providers.

There has also been a lack of data on the location and practice patterns of nonphysician providers. We understand that these data may now be more readily available allowing a reasonable estimate of FTEs available for primary care in the future.

OTHER USES OF DESIGNATIONS

The original statutory intent of the MUA/P and HPSA designations was to identify communities in need of community health center development or National Health Service Corps assistance. However, over 25 other Federal programs, as well as some State programs, also use the MUA/P and/or HPSA designation in screening for need and allocation of resources. These include certification of rural health clinics (RHCs) which must be located in either MUAs, HPSAs, or Governor-designated areas; the 10 percent Medicare incentive payment to physicians practicing in geographic HPSAs; the placement of foreign trained physicians through the J1 visa waiver program; and a number of Bureau of

Health Professions grant programs that offer preference for applicants that have some involvement with a designated community. The fact that these other programs use these designations to guide allocation of their resources can be considered in revising the designation process, but should not obscure the original purposes of this process.

On the other hand, HRSA would not support the creation of separate underserved designation criteria specifically for the RHC program. The MUA/HPSA designation criteria, particularly with the revisions and updates we plan, can work for the RHC program as well as other programs.

RESPONSE TO GAO REPORT

MAXIMIZING CONTRIBUTION TO THE SAFETY NET

Given the changing health care market and budgetary pressures at the Federal and State levels, it is critical that Federal grant programs and financing mechanisms for health care services maximize their contribution to the

safety net for underserved populations. Those providers types that are reimbursed at higher Medicaid and Medicare rates than others because of their safety net nature, which includes FQHCs and RHCs, should be held accountable for receiving the special subsidy. It is imperative that the FQHC or RHC provide increased access to health care for a substantial number of underserved persons in the target population.

REVISIONS TO THE DESIGNATION PROCESS

While there is no statutory requirement to periodically review MUA/P designations, we have undertaken the task of combining and improving the existing processes for designation of HPSAs and MUA/Ps. As part of this effort, over the past few years we have convened two panels of outside experts to obtain their views on needed changes and later to react to our proposals. In addition, we have shared our proposed revised approaches with numerous interested groups, including our State partners in the designation process.

Our revision is intended to accomplish a number of goals simultaneously. The new approach would consolidate the two existing procedures and sets of criteria, which currently result in two overlapping lists of designations. In their place, we will have one procedure with consistent criteria that generates an integrated list, with primary care HPSAs as a subset of MUA/Ps. As a result, in the future the MUA/Ps and HPSAs will be updated simultaneously. The schedule will be like that used now for HPSAs, where each year those designations more than three years old must be updated.

The revised process is designed to make maximum use of data available nationally and reduce the effort at State and community levels associated with information gathering for designation and updating; to expand the State role in the designation process, especially in defining rational service areas; and to incorporate better measures of or proxies for health status and additional indicators of access barriers.

With respect to counting mid-level providers, we plan to begin counting nurse practitioners, physician assistants and

certified nurse midwives, once a determination is made that a sufficient number of States have adequate data. We will count these practitioners in those States whose laws permit them to independently provide services traditionally considered to be physicians' services.

ASSESSMENT OF NEED

The HRSA believes that the effectiveness of RHCs in fulfilling the goals of the program would be improved by 1) requiring, within the RHC certification process, additional assessments of need beyond the underservice designation and 2) implementing a recertification process for RHCs that includes assessment of need. These changes would ensure more rational and strategic placement of RHCs.

HRSA is supportive of the GAO conclusion that the current RHC eligibility criterion of location in an underserved area does not go far enough to ensure that the program is directed and maintained in needy communities with critical shortages of primary care providers. HRSA recognizes that some of the issues raised in the report will be remedied by

a revised designation process.

We support HCFA's efforts to explore additional tests of need for RHCs beyond presence in a designated area and have been working with them in their efforts.

Before an entity is given the FQHC or RHC status, we must require documentation of the lack of sufficient health care resources in the service area to meet the primary health care needs of the target population. The FQHCs and RHCs should not be excluded from serving overlapping service areas, but they as applicant should be required to demonstrate that there is need for another provider with that status.

RHC RECERTIFICATION

HRSA also agrees with the GAO recommendation to require periodic recertification of RHCs to ensure that clinics continue to meet eligibility and need requirements. Currently, there is no recertification requirement based on need for RHCs. If a recertification process is not a viable

alternative, other ways to monitor RHCs could be examined.

STATE INVOLVEMENT

HRSA has been collaborating with HCFA in determining how to increase State involvement in the RHC and FQHC Look-Alike certification processes. Our objective is to obtain information from key State stakeholders at the appropriate time in the certification processes.

COSTS AND PAYMENTS

As GAO identified, the costs of facility-based RHCs are often higher than those for independent RHCs. Given that finding, it may make sense to also implement payment limits and cost-reporting requirements for facility-based RHCs. HRSA believes that steps should be taken to improve the current cost reimbursement system. These steps should include an examination of the current cap for reimbursement

of visits to independent RHCs to determine if the cap is reasonable.

We believe that consideration of any change from cost reimbursement should include a thorough analysis of potential effects on the RHCs' ability to remain in operation, and the impact on access to primary health care in underserved rural communities.

CONCLUSION

HRSA believes there is room for improvement in designations of underservice and in the RHC program. We also believe that RHCs, like health centers, are critical participants in maintaining the fragile safety net of providers who serve underserved populations. We must continue to work together to ensure that appropriate providers are able to deliver needed care to underserved populations.

Thank you for the opportunity to present today.

Mr. TOWNS. Thank you very much, Dr. Gaston. I understand that Dr. Puskin will not be testifying, so we will move forward.

Let me just move to you, Mr. Snowbarger, and let you open up.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

I have just a couple of questions. I guess I didn't realize until your testimony, Dr. Gaston, that we've got two different kinds of certifications: one is medically underserved; the other one is, what, health professional shortage?

Dr. GASTON. Shortage area.

Mr. SNOWBARGER. OK. I looked on the map for my State, and where I see these RHCs going in, there may be some areas where they are medically underserved or there would be a shortage; I see other areas of the State where there definitely is, but there aren't any RHCs out there. So if we are trying to target this relief—or maybe incentive, I ought to say—if we are trying to target this incentive to places where there really is a medically underserved or health shortage area, how do we change the definitions to get them focused in the right way?

Dr. GASTON. As I mentioned, one of the things that is important to remember is that the HPSA—let me talk about them in a little more detail. The HPSA, the health professional shortage area, is to really look at those areas that need providers. The medically underserved areas are looking at services. Now, you can't separate providers from services, but that is the main intent.

The HPSAs are published annually, and they are updated every 3 years. OK. The first screen for the HPSA relates to—it's focused on providers—it relates to the physician to population ratio in that area, in a rational service area.

Mr. SNOWBARGER. So "provider" refers specifically to a physician?

Dr. GASTON. It does. Right. We are going to begin counting other providers, the mid-levels; we have not done that in the past. So it's talking about mainly the physician to population ratio, starting at a 1 to 3,500 ratio. After that, though, before we put any core providers in an area, we look at the poverty of that area, we look at the infant mortality rate, we look at the access barriers as it relates to distance, we look at low birth weight.

So there are many other criteria that go into the determination, and then we take those HPSAs and score them and prioritize them. Then we also score the sites in those prioritized HPSAs. So it's a three-stage process. I think that is the point that we want to make.

And we do this in conjunction with the States. So if we want to target certain areas, first of all, those communities have to ask for those designations. We don't designate them from the Federal Government. This is a ground-up process. So the communities and the States decide what areas they want to be designated, and then they send them to us for that. I think that's an important distinction, too.

So the targeting of those areas first starts with the local concern, and then to get resources, to have Federal interventions put into those areas, we really have to look at a major series of steps that determine need further than just the HPSA or the MUA.

Mr. SNOWBARGER. The statute that talks about HPSAs indicates that they are to be reviewed annually and, if necessary, revised. Have we been revising those?

Dr. GASTON. Yes, they are reviewed.

Mr. SNOWBARGER. Well, what are we revising? What do you interpret that statute to mean? The reason I ask is, apparently, it looks to me like we need to be revising the designation or the definition of where there is a shortage.

Dr. GASTON. What gets revised are the resources in areas. OK. And this is happening very rapidly now, as you might expect. But what changes could be the level of poverty, it could be, certainly, the physician to population ratio. So all those criteria are subject to changes based on the environment.

Mr. SNOWBARGER. But they are measured against some kind of standard? Let me try to do it a different way. I see a problem happening here. When I measure these bar graphs with, again, the map of my State, where these RHCs are located. I see a mismatch. And with the pie chart over here, I see a mismatch.

Has there been any attempt to try to change that mismatch, to try to get RHCs into areas that are medically underserved and the health professional shortage?

Dr. GASTON. Let me mention something very important. We in HRSA do not administer the RHCs. We don't know when they get certified. We don't know where some of them are. This is administered by HCFA.

Mr. SNOWBARGER. OK. I'm asking the wrong person.

Ms. Buto, same question.

Ms. BUTO. Any attempt to try to target the areas that are—that's the issue of further additional criteria for targeting. We have set up this group of folks to look at those criteria. Some of the issues would be, can you come up with a way to target frontier areas, for instance, areas which are really underserved, that really aren't able to get professionals in there? That's one of the things we're looking at.

Another thing we're looking at is, there might be different purchasing strategies that you need to take. For instance, in the budget this year, we are asking for authority so that Medicare can go in.

Where we have a need and we're not able to use a major statutory framework to get at the need, maybe we ought to go in and say, we need to purchase special services in a really underserved area; let's see what kind of bidding we can set up to get interested parties into this area. That might be a more effective way to get at those really hard to get at areas, by figuring out what you need in that area to get people into it.

So I think we've got to use more than one strategy to get at this issue.

Mr. SNOWBARGER. Mr. Chairman, just two more short questions. The question may not be short, but the answer is expected to be. Let's put it that way.

Have we decertified any of these areas since 1977?

Ms. BUTO. The law does not allow us to—there is an actual provision that grandfathers in existing rural health clinics. So one of the issues that I think the GAO and IG both raised is, if we really want to put teeth in decertification, if you will, there probably has to be a change in the law. That's one of the things we've looked at, as well.

One issue that has to be dealt with in any provision in that grandfather clause would be, you know, you want to be sure you are not just decertifying in an area and then it becomes medically underserved again and you recertify. You want to be sure that you have criteria that get at the problem rather than create a churning in the system that actually disadvantages the people being served.

Mr. SNOWBARGER. It looks like we've given an awful lot of incentive for some areas that may have been medically underserved in the past to be fully served, maybe excessively served at this point in time.

Dr. GASTON. May I make one point?

Mr. SNOWBARGER. Sure.

Dr. GASTON. Just to clarify the decertification versus dedesignation.

Mr. SNOWBARGER. OK.

Dr. GASTON. The designation process relates to what we do in HRSA, MUAs, OK. There has not been a decertification, as far as I know, or very few, in terms of the RHCs, the clinics themselves. There's a constant process where we are dedesignating areas all the time. They lose their HPSAs, and then new HPSAs are designed. So that process is very fluid.

Ms. BUTO. The problem—just to get back to the connection to the grandfather issue—is that even after that has occurred, if there is one designated in that area right now, the law says they continue.

And the reason, I think, originally, for that was, there was a lot of concern, especially as the program was getting started, that by the time you invested the capital and actually set up a clinic, that if the designation was lost, you would have really deterred people from getting into the program. That was, obviously, a long time ago.

Mr. SNOWBARGER. Since the answers don't appear to be short, the next question will be a rhetorical one. There's a statement in the report that concerns me greatly. Let me just read it quickly.

"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." Here's what bothers me: "And it was easier to reimburse these RHCs the same way as Medicare paid the facility's other outpatient departments, on the basis of lower costs or charges for services."

That may be easy, but the time has come to put a little hard work into it and figure out why we're paying at different rates for the same service.

Ms. BUTO. Yes. And I think I mentioned that we're going to that. I should just say that, at the beginning, there were only 10 hospitals. There was a real danger in double paying, because in a hospital accounting system, you would pay them for some of the overhead here, and then you would also pay in the clinic over here.

So the feeling at the time was, one accountant looking at all the books was better than paying them out of different pockets. Now, we feel that, you know, that's obviously out of control and we need to put limits on.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you.

We have a vote on, so what I would like to do is to finish with this panel and then bring the next panel up.

Let me begin by saying that GAO recommended four changes to the Rural Health Clinic Program. Which of those recommendations do you agree with, and which ones do you disagree with? Or if you want to add some more, fine.

Ms. BUTO. We basically agree with all of them. Two of them, I think, were legislative changes, and two were administrative changes. One of those, as I say, we're already planning to propose a cap on the provider-based. And the other was to apply some screens in terms of reasonable costs, if I recall. I may be getting IG and GAO mixed up. We are also doing the development of screens. So we're doing both of those administratively, and the legislative proposals we also agree needed to be addressed.

Dr. GASTON. We also agree that there need to be further determinants of need. There needs to be a recertification process and some monitoring.

Mr. TOWNS. In your testimony, Dr. Gaston, you used the term "periodic" recertification. What do you really mean by that, every 3 years, every 5 years, every 6 months? What do you really mean?

Dr. GASTON. OK. Again, we don't certify or recertify the RHCs. We are involved in that process as it relates to the FQHC look-alikes, which we also do conjointly with HCFA and really could serve as a model of how we could do the RHC program. But we designate areas of underservice. They are looked at annually by the States. We do this in conjunction with the States. Then their designation is either given to them, or they are dedesignated on a 3-year basis.

Mr. TOWNS. Right. That's the test for need.

Dr. GASTON. Yes.

Mr. TOWNS. OK. Can HHS meet the statutory 1-year requirement for updating the health professional shortage area list? If not, how long would it take you to do it?

Dr. GASTON. Well, we are assessing them annually. The States do that. We rely on the States to do that. And we do it every 3 years; we do a complete one. It's very labor intensive, in terms of finding the data. So to do it annually, when we are not convinced that the criteria need to be looked at that often, we have not considered moving to a complete assessment annually. We do that every 3 years, and that seems to work fine.

Mr. TOWNS. Let me ask a question, Ms. Buto. How much time and money is needed to conduct the type of periodic recertification recommended by GAO? How much money would be involved in doing that; do you have any idea?

Ms. BUTO. I don't. We have a general survey budget in Medicare. Unlike someone else's statement in the earlier panel, Medicare certifies hospitals and nursing homes, home health agencies, and many other providers, for Medicaid. So this is not the only instance in which we have the same standards. So we have to budget that. When the budget for the agency comes up, we usually line item how much we can allocate to each of the different categories.

I can't tell you specifically, if we were to go to recertification, how much it would cost. We would need to reshuffle some of our money,

because that hasn't been growing. We have had to reallocate and target that funding.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Mr. SHAYS [presiding]. I thank the gentleman.

Unfortunately, because I wasn't here during the previous questions and some of the statements, what I may do is cover a little bit of old ground, but I want to just establish a sense of what the obstacles are in this situation. Basically, the GAO is saying that 90 percent of the people who are being served would have been served anyway. So first I need to be clear with both of you whom you have your disputes with: the GAO or the Inspector General.

Ms. BUTO. I think we said earlier we really don't have disputes with the GAO and Inspector General around the recommendations. There are a number of areas where I would dispute or at least raise the question that I don't think that they had the time or the focus of their review was in the same direction.

The 90 percent is a good example. Ninety percent may have been served. I don't think we know many of those would actually have received the same range of services. They may have had a provider; it may have been an emergency room. Again, it depends how the question was asked and how extensive the services were that were available. It may be some smaller percentage, but the fact is, we all know that there are many of these rural health clinics that are in areas where there are plenty of other providers.

The issue of overpaying them is really, again, related very much to the managed care penetration, both in Medicaid and Medicare. Particularly where physicians are seeing themselves moving into managed care in Medicaid, the rural health clinic option has become more and more attractive, even more attractive because the fee schedules themselves are going away in Medicaid and being replaced by negotiated managed care arrangements.

In Medicare, it's more complicated. We actually have an abuse in the program where some physicians have actually picked and chosen between sometimes billing us as a physician and sometimes billing us as a rural health clinic. Our regulations are intending to address that issue, as well, because there are fees in the Medicare physician fee schedule that are higher than what you could get as an RHC.

We find that some billings are occurring for those fees. And then when the clinic rate is higher, billing is occurring there. This is not a widespread problem, but it is enough of an issue that we're going to draw some very clear lines about what an RHC is, and if it's an RHC service, you cannot bill the fee schedule.

So those are the kinds of things we're finding that I'm not sure GAO or IG went into, because that wasn't the line of inquiry. So the nature of service, if you will, and the reasons people are doing RHC billing may vary, and there actually may be worse abuses in some other areas related to lack of clarity here.

Generally, we agree with the recommendations.

Mr. SHAYS. Well, I think your key point is that, if it was even 70 percent of the problem, it would be bad. Now you are going to decide at what level people are being served. I have a sense that you might have a disagreement as to what level. So, in essence, you basically buy into the fact that this system is broken.

Ms. BUTO. That's right, that we need to fix—we either need to narrow those criteria to really get at the areas of need and change the payment limits to really discourage that proliferation on the provider-based side.

Mr. SHAYS. Usually, if there is 10 percent type of abuse in the other way, you would say we're starting to see a problem. So 10 percent may be working the way we want, and 90 percent not working the way we want raises some questions, obviously, that really make us wonder: are we approaching this in a quick enough manner? And I'm not getting a sense that that's happening.

Dr. Gaston, where do you agree or disagree with the general thrust of the Inspector General's or GAO's report?

Dr. GASTON. We agree that the determination around need and where they are placed really needs to be refined and looked at. The way we do it in the Bureau is the way we would recommend doing it, that the designations, as they are published, are only screens, first-level screens, and then, after that, you go through a whole list of other need determinants, along with access, other health services, the community impact.

So these entities really have to show that they are performing the mission, they are increasing access, and having an impact. That's the first thing. They certainly need to be recertified so that, over time, you do have to make decisions as to whether that is continuing. So the monitoring and the recertification is another key aspect.

We certainly agree that this has to be done in conjunction with the States. We cannot do that in isolation. So all these decisions, the States have to have input in terms of data, input in terms of their priorities, input into interventions they think should happen, et cetera.

Mr. SHAYS. One of the things that we determined in looking at other areas where we wanted to change rules, the rules are basically stacked against the people who have to pay the bills, because it takes us so long, in our regulations and rules, to change them.

So if the system favors the seller—and I consider the government the buyer; in other words, we are paying for it—if it favors the person who is providing the service, they are going to readily want to take advantage of it. If it doesn't favor them, they simply aren't players. So we only lose. In other words, we're just going to continue to pay out.

I need to get a sense of how we can move more quickly. I need some specific recommendations of what you suggest that we do, so that this committee staff can write a report soon, and I can go to the leadership on both sides of the aisle and say, we need to take action. So tell me some very real, specific things we can do right away.

Ms. BUTO. We're about to issue the rule on putting the payment limit on the provider-based side. Clearly, as you say, regulations take a while.

Mr. SHAYS. How long will it take? Just run me through that.

Ms. BUTO. The regulations take—a good estimate is a year from the time that they go out in proposed to the time they are actually finalized and implemented, because we give our intermediaries a chance to put them into place. If there were legislation, for in-

stance—and I think it's fair to say we would support legislation of this sort—that were to make the same change, we would still have to give our contractors time to make the change, but it would be quicker.

Rulemaking is important for another reason. I just have to say this. We often create unintended consequences, and we're concerned about that, and that's why we seek public comment. So there's a balance. But in terms of quickness, you know, legislation is quicker than regulations.

Mr. SHAYS. Do you both agree? I'm sorry. Dr. Gaston.

Dr. GASTON. Yes.

Mr. SHAYS. What could be done relatively quickly?

Dr. GASTON. Well, from our side, we already have revised regulations as it relates to the designation process that I described in my testimony, that would improve what we are doing in terms of MUA and HPSA designations. Hopefully, that will proceed. Again, we have to go through the same process that HCFA is having to do, in terms of rulemaking, et cetera. But certainly that will be on board very soon.

Mr. SHAYS. The GAO report came out in November 1996. Why do we not yet have suggested rule changes?

Ms. BUTO. The rule changes—and I mentioned a little of this before you came in—involve more than just the payment limit. They are going to address some commingling of funds between physicians who are billing us sometimes on the fee schedule, sometimes as RHCs. They are going to incorporate a number of other changes the law has made over time.

So it is a process that—by the way we do rulemaking, we try to involve interested parties, beneficiaries, then we clear them with our lawyers and issue them. That usually does take a few months. The IG's office has also been involved in looking at our rules in the Department. It just takes that long, quite frankly, to do.

Mr. SHAYS. Let me back up a second. Why did it take the GAO's report to get us to take some action? Why didn't we do this 5 years ago?

Ms. BUTO. And I disagree with that, because we started the rulemaking effort way before the GAO issued its report. We began working on the commingling issue a couple of years ago, just gathering the data on what was happening, because you can't assume it's happening everywhere until you look at what records are being billed, as well as the cap issue. We have been working sort of in tandem with the Inspector General and others on this, and gathering the information.

Part of it is, their information has helped us refine some of the policies in the regulation, but we did not start after they completed their report.

Mr. SHAYS. Either way, it's not a good commentary, frankly, on HCFA. If you started sooner, you should have been done sooner. And if you started later, you should have started sooner. So from my simple mind, you basically want people to go into rural areas, doctors; you want to provide health care in rural areas.

So my simple mind says, there are reasons why people don't do it. The reason they don't do it is, there is not a large population; therefore, they don't get enough traffic. And maybe they don't even

want the lifestyle of a rural area. So there has to be some inducement. So it seems logical that we should, in fact, pay more to serve a rural area.

My simple mind says, though, that if someone can go 10 or 15 or 20 miles away and get that same service, that maybe then you don't need to have a higher reimbursement rate. And it seems to me that that's a no-brainer. Tell me where I'm wrong.

Ms. BUTO. You're not.

Dr. GASTON. We agree with you.

Ms. BUTO. We agree with you. What we are doing is—because certification is still in our court, when new ones come in, we really are focusing on the areas where there aren't any, where we really, genuinely don't have providers, and we're giving those the highest priority. But right now, the way the law is structured, there is no ability, once you're certified, even if the designation changes, for you to be out of the program, nondesignated.

So we feel that, No. 1, we've got to move on that issue of adding more criteria.

Mr. SHAYS. You're talking about being designated as a rural health clinic.

Ms. BUTO. That's correct.

Mr. SHAYS. Let me ask you this: Why can't you have two levels of rural health clinics, those that are clearly isolated from other health care facilities, and those that aren't?

Ms. BUTO. You can. I mentioned also earlier that we're looking at the issue of frontier areas where there really is a dire need, where we can really focus this effort. And that's one of the things that we are likely to be having a proposal to address.

Mr. SHAYS. I guess the thing that concerns me is that there is a political problem. The political problem is that once you have allowed people to invest in these facilities and develop a political constituency, we're not going to change it. Yet if the number was 20 percent who really couldn't have gotten health care without this, but if we're looking at anything to more than 75 percent, it tells me that the system had to have been sick for a long time.

I don't mean to throw stones at HCFA or anyone else, because I know that politicians, of which I am one, sometimes come in and say, why didn't you do this or protect this person. I understand, but it strikes me that there is a tremendous imbalance at HCFA, where you are so sensitive to the criticism, to what doctors might say, and to what the politicians might say about you cutting off services or making it more difficult that we now end up with an abuse like this.

For me, recertification should be something that shouldn't take a long time. That's just a no-brainer that we would require recertification. Why do we have to compile all these different rules? I don't like to be in a large group sometimes, because you're only as quick as the slowest person in the group. I got that same image when you were talking about where you've got all these different rules you want to change.

So things that we know we can do now, we're waiting until we get some other things that we might want to do, and you want to package them all in one. Tell me why we have to package them all in one.

Ms. BUTO. They are done. They are very close to being issued, so I think, at this point, we ought to just proceed with those. They are related. The issue of a cap on provider-based entities and the commingling of funds, they are all related, because there are different ways to push the balloon, if you will.

Mr. SHAYS. And recertification?

Ms. BUTO. Recertification is in the statute. We cannot do it under the law. That's the problem.

Mr. SHAYS. OK. Have you asked anyone in Congress to recertify? Prior to this effort, have you made an effort, or anyone?

Ms. BUTO. We have not asked for legislative authority to repeal that or to change that, but it is one of the three or four things we are working on.

Mr. SHAYS. How long will it take you to do that?

Ms. BUTO. I think the next couple of months developing the proposal.

Mr. SHAYS. No, that takes us too long. We're not going to wait a couple of months. I mean, why would we have to wait a couple of months to have you write a letter to ask us to recertify?

Ms. BUTO. Oh, to ask for the authority?

Mr. SHAYS. Yes. In other words, why can't you all tell us? Put some of the burden on us. Why can't you tell us these are the things you want us to do, and we will work on them? I'll give you an example. In this very committee, we had the issue of people ripping off Medicare and Medicaid. It was not a Federal offense to commit fraud, except by wire or mail, and health care fraud was not a Federal offense.

We had a hearing like this, and it became evident to us, and the administration was asking us to change it. We went to our leadership, and we put it in the health care reform bill. But, I don't see why we would wait a day.

Ms. BUTO. We'll take it back and get back to you quicker.

Mr. SHAYS. OK. I would like to say that by the end of this month, if you could make some preliminary suggestions of things that you would like us to do statutorily. We need to get it in to start that process, and then, if you want to finalize it, or even if you want it to be oral in the next 2 weeks and then tell us in a month, but in the next 30 days. It seems to me that you have studied this long enough and you can ask us to do certain things.

Ms. Gaston, is there anything, statutorily, that you would like us to do?

Dr. GASTON. No. I would like to make a point, though, that you made, that was very important. We want people to go into underserved areas. What kind of incentives can we give them? As we look at cost-based reimbursement, that certainly has been an important one. We fully support those programs that are meeting the mission of seeing everybody, increasing access, everybody, regardless of ability to pay, do need cost-based reimbursement.

Also, the ones that are increasing access through enabling services, that are dealing with language barriers, et cetera, those kinds of incentives and those kinds of payments will keep them alive. So I want to make that as a point as that is being considered.

Mr. SHAYS. You are suggesting, then, you have a two-tiered billing.

Dr. GASTON. Yes.

Mr. SHAYS. Some rural health care clinics won't get that kind of reimbursement; some will.

Dr. GASTON. It has to be the ones that are meeting the mission of serving the underserved, increasing access, improving health outcomes, those are the ones that then get it.

Mr. SHAYS. Is there anything that you all wish we had asked or statements or comments you want to make?

Doctor, do you have any comment?

Ms. PUSKIN. The only clarification is, it's very important to understand what was said earlier about the very critical role of Medicare and Medicaid in assuring that services are available in rural areas. These are communities that often the providers have 60, 70 percent of their patient load is Medicare and Medicaid.

So the role of Medicare and Medicaid in stabilizing access to health services in those areas is very critical. Therefore, this program and its role in stabilizing the availability of services needs to be considered very, very carefully. So as we look at certification and recertification, we certainly feel that we need standards that are better than the current ones that we have.

As we look at it, it's very critical, as we look at underserved, the potential for communities to become underserved in the future is very critical to look at, particularly, I think, as we look at the history in the past. When we didn't have supportive services, special provisions for hospitals, for example, under Medicare, we saw that hospitals went under very quickly when we removed those underpinnings.

Mr. SHAYS. You are triggering a question that I do want to put on the record. In some of our urban areas we have community-based health care clinics that basically get reimbursement from Medicare and Medicaid, but also, frankly, provide health care services and aren't properly reimbursed. Will the rural health clinics come to me and say, you are seeing one part of the story; the other part of the story is that the extra money we get from the Federal Government has enabled us to serve other people who are the working poor? Will that be one of the claims that will be made?

What I'm trying to understand is, it seems so illogical that we could have allowed it to get to this point, there must be something I'm just not getting. For me, it should have been dealt with years ago, and I should have known about it years ago, and we should have dealt with it years ago, if it has gotten so bad. What am I missing here?

Ms. BUTO. I think what you are missing, what we all were missing for a while, is that a big part of this problem is in Medicaid, and it took us a while to understand the dimensions of what was going on in Medicaid. That is more than half of the growth issue. The other big part of this issue is provider-based clinics growing out of control, and that very much is related to the cap.

Were those two things really addressed—and, as I say, we have a legislative proposal on the Medicaid side and the cap on the Medicare side—then I think Dena is right. What we have to look at, and the tough thing about writing back to you in a month, is trying to develop the right criteria so that you're not putting every-

body at risk where you really need those critical clinics. That's the part we're really going to have to address.

Mr. SHAYS. Let me ask you this. Really what I would like is there to be some oral communication between this committee and your staff in the next 2 weeks, telling us where you think we could logically move and where the trouble points are, and that timeframe could obviously be adjusted then. It's just that I do think that we have to bring some kind of timeframe, some kind of deadline.

Given that I know the regulation process and the statutory process, I'm only here for, basically, 18 more months. That's the way I'm thinking. So I don't think I have that kind of timeframe to just go on indefinitely.

May I just clarify? Because HCFA focuses more on Medicare than Medicaid, obviously, you're saying that the Medicaid part you lost.

Ms. BUTO. The data we get from the States varies tremendously by State. So we have heard episodically about it, but until we had some of this very state-specific study that both GAO and IG have done, we haven't had that kind of detail in some of the State experience.

Mr. SHAYS. Doctor, do you have anything you want to add?

Ms. PUSKIN. One of the things is, you asked a question, if these clinics use the money to serve the uninsured, and I think that's a very important role. These clinics were designed, however, to ensure that there was access for the Medicare and Medicaid population. We did do a survey in 1994, when we had about 1,300 clinics, and we did find that about 16 percent of them had more than 25 percent of their volume in the uninsured.

We don't know exactly where that stands now. It is important to State, the mission for these clinics is to ensure—and we need to make sure that they do this—serve the Medicare and Medicaid population and ensure access for them. It is a much more complicated question when we get to the uninsured, because that is not necessarily part of their mission by statute.

Mr. SHAYS. It's not part of their mission, but they may have taken it on.

Ms. PUSKIN. In our survey, a significant percentage had a very high percentage of uninsured that they provided care to.

Mr. SHAYS. That is a good lead to the next panel. Let me just ask each of you, though, tell me the most difficult political obstacle. Clearly we have to define exactly what we want, but on merit, we need to make major changes and as quickly as possible. Define for me the political challenge that HCFA might have, HHS, in general, might have on this side. What are the political challenges?

Ms. BUTO. It's a very general one, and that is that we continue to see real problems in rural areas in terms of access, both in physician access and practitioner access. You will see we are proposing some greater access to nonphysician practitioner services. So there is this bigger problem. The problem in dealing with this one is not overdoing it in a way that we have done harm.

Mr. SHAYS. Let me put it in my words. Since it has the name "rural health clinic," just the name alone, if we make any changes in rural areas, people will say, what are doing changing a system

that is helping us? Even if they are only getting 10 percent of the benefit, they are fearful that some change could be harmful. Whereas, we've got to sell them on the fact that we really want to do a lot more in rural areas to meet their needs. But that would be one.

Ms. BUTO. I see that as the biggest one.

Mr. SHAYS. Any others?

Dr. GASTON. I would agree.

Mr. SHAYS. Is another obstacle that we have people entrenched in the system that are making a windfall; they have a collective mass that means that they will be able to prevent change?

Ms. BUTO. I may be naive on this, but I think there's enough concern from good rural health clinics and the legitimate providers that everyone wants to clean up that part of the problem where there are entrenched and undeserving, if you will, entities involved in the program.

Ms. PUSKIN. Can I just say, one thing that you need to recognize is, some people see rural health clinics and the toehold that some of the urban may have in it as actually a good thing, because what they are seeing is the need, using it as a tool to organize care in rural areas, and that what you're doing is creating the linkages that help to prepare those rural areas to become part of networks of care that are more effective.

Now, in fact, there is a lot of abuse, but I think, as you are looking at the system, rural health clinics have a reputation for both good and bad, for the good that they do in helping to maintain services out there. So the political problem you face is a concern of throwing the baby out with the bathwater.

Mr. SHAYS. One last question: The two-tier approach, will that encounter a lot of opposition?

Dr. GASTON. Yes, it will.

Mr. SHAYS. But that enables us to get around the whole issue of what is truly designated as a rural area. I mean, that's the way we can deal with that problem; correct?

Dr. GASTON. No. No, that's not going to deal with that problem.

Mr. SHAYS. Let me put it this way: An area that I might not consider rural, the census will call it rural—we're not going to change that. You are recommending that we not change that.

Dr. GASTON. No, the first thing we have to do is really define where they are, in terms of underserved areas.

Mr. SHAYS. Right.

Dr. GASTON. That has to be fixed right away, and I think that can be fixed right away.

Mr. SHAYS. OK. Thank you very much.

We will call our last panel. Bill Finerfrock, executive director, National Association of Rural Health Clinics; Tom Harward, physician assistant and executive director, in West Virginia; and Robert J. Tessen, co-founder and first president of the Texas Association of Rural Health Clinics.

If you would all remain standing.

[Witnesses sworn.]

Mr. SHAYS. Let me just say that you are free to read your statements, but sometimes, as the third panel, you can almost be more effective just responding to what you have heard. So I would en-

courage you to do that, but do whatever you are comfortable with. I want to address what you're hearing before we even start our questions.

We will just go down the line.

STATEMENTS OF BILL FINERFROCK, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS; TOM HARWARD, PHYSICIAN ASSISTANT AND EXECUTIVE DIRECTOR, BELINGTON CLINIC, BELINGTON, WV; AND ROBERT J. TESSEN, M.S., CO-FOUNDER AND FIRST PRESIDENT, TEXAS ASSOCIATION OF RURAL HEALTH CLINICS, NATIONAL RURAL HEALTH ASSOCIATION

Mr. FINERFROCK. Thank you, Mr. Chairman.

I think I would prefer to perhaps respond rather than recite what is in the testimony, because I think there are some important things that have been brought out here today and some things that perhaps need some clarification and explanation.

First, as was mentioned, this is the 20th anniversary of the Rural Health Clinic Program, 1997, and I think it's important that Congress take a look at the program at this time. What we're finding is that, while the Rural Health Clinic Program has not changed substantially over the last 20 years, the world in which rural health clinics operate has changed.

So while we didn't see tremendous growth in the early years, changes in Medicare, Medicaid, and other areas, managed care, as has been mentioned, has created perhaps an opportunity for folks to take a look at the Rural Health Clinic Program that didn't exist in the past.

I think it's important. We had the pie chart over there, and you focused somewhat on "rural" as part of what is the problem. The statute all along has defined "rural" as a non-urbanized area. So for the GAO report to say at the outset that the premise of the program was to put practitioners in underserved, low-density, low-populated areas is really an inaccurate reflection of the record.

In fact, at the time the Rural Health Clinic Program was created, there was very little discussion about the size of the community in which the clinic was located. In fact, the Carter administration had proposed that there be no restriction on the size of the community, that really what the focus was on was an underserved area, that what we were trying to do was provide access to underserved populations.

Congressman, in Brooklyn, you've got underserved populations even though you've got a million people who live in Brooklyn. So population is not your determiner of whether or not a community is underserved. So no one ever sat down and said, "Well, are you a population of 8,000 that is adjacent to another population," to a great degree; they said, "Are you underserved?" And therein lies the problem.

We have a situation that has evolved over the last almost 18 years where our definitions and what we define as "underserved" have really become outdated and inefficient. If you look, as has been mentioned, rural health clinics are supposed to be in underserved areas, defined as underserved areas or health professional shortage areas.

The MUA lists haven't been updated since 1981, which means that they were probably using data from the late 1970's to make those designations, if you look at the way we do data collection. So we're sitting here in 1997 certifying clinics in areas that were defined as underserved based on information from 1979. That doesn't make any sense. We have to update those medically underserved area lists, as has been mentioned by others.

In that regard, we would support an initiative to change the statute to put the words "currently certified" into the statute, with "currently" being defined as the area having been reviewed within the last 3 years. In other words, tomorrow, if that were to be in law, if someone were to seek certification as a rural health clinic and use the MUA list, we went to the MUA list and said, "Sorry, this designation was done in 1981. You can't have it until you come back to use with more accurate, up-to-date information."

We think that is absolutely critical, and we think the law needs to be changed to incorporate that into the statute, to give us that ability to have some degree of reliance that the information is at least timely and current.

We also believe that there is a problem with the cap that does not exist on provider-based, as you have heard, relative to the independent clinics. I would just say—and you started to get to this toward the end of your conversation with the previous panel—we've known about this problem for a long time.

The Health Care Financing Administration embarked—over 2 years ago, they announced in the Federal Register that they were going to develop regulations to address this particular problem. The rural health clinics community has been waiting for over 2 years for HCFA to publish regulations so that we could move ahead to begin to close what we see as a very serious gap in this process.

So we would encourage, as a community, the rural health clinics that I speak on behalf of, that we move ahead expeditiously in this area. That having been said, though, I think it's important, you had another chart up there, and I'm sorry it's no longer there, but it looked at the three different types of reimbursement. There was blue bar, a green bar, and a red bar.

The blue bar looked at what clinics get through traditional Medicaid. The green bar was what clinics get that are hospital-based. And the red bar was independent clinics. That's really not an accurate comparison or a fair comparison to make. In many respects, you are comparing apples to oranges.

Let me give you an example. Under the Medicaid program, as they mentioned, you had what was an office visit that might be charged at $25, and that was compared to a rural health clinic visit where the practice might get $56 or a provider-based clinic where they were going to get some higher amount. What that's not accurately reflecting is that the independent rural health clinic and the provider-based clinic are based on aggregate costs; it's an all-inclusive rate.

So if a Medicaid beneficiary under traditional Medicaid comes into a physician's office and has an ear infection, which is a fairly simply diagnosis to undertake and fairly simple prescription, it's a short visit, Medicaid pays that practice $25. That same patient

goes into a rural health clinic, they are going to get $56. Seems like a pretty good deal.

But 2 days later, that same patient, that same mother brings that child back, and she has fallen off her bike, she's got a wound that perhaps needs suturing, needs debridement, needs bandaging, may have a suspected broken bone. That clinic has to do an x-ray, has to suture the wound, has to bandage it, has to cast and set the fracture.

The clinic is only going to get $56 for that visit, even though, under traditional Medicaid, they might get $120, because an office visit is not just an office visit. Under fee-for-service, you have to add in all of the ancillary, additional costs that a practice can bill for. Rural health clinics don't do that. They look at the entire cost of operating that clinic on an annual basis and then aggregate that and bring it out to an average.

So some patients, as would be shown there, you're going to win on. But what that fails to show is that there are a lot of patients on which you're going to lose money on that particular encounter. So we need to really understand what cost-based reimbursement is.

Mr. SHAYS. Is that independent and provider both?

Mr. FINERFROCK. In provider-based clinics, it's a little bit different. In my testimony, I give you another example of where that somehow can be very misleading the way that is characterized.

A provider-based clinic is paid based on what is referred to as the lesser of cost or charges, and it's a step-down process in their accounting that is done through the hospital. So there is never a per-encounter rate that is done for a hospital-based rural health clinic.

The figure that you saw there is that GAO went in after the fact and looked at the aggregate that that hospital was reimbursed for its clinic, then looked at the number of patients they saw, and did a calculation. But that clinic was never reimbursed on a per-encounter basis.

Why that can be very misleading, in my testimony I give you an example. You have three clinics that all cost the same amount to operate, $250,000, let's say. They are identical in every way: overhead, services, the health professionals that they employ, the salaries that they pay each of those health professionals. The only difference is one is located in a community with 1,000 people; one with 3,000 people; and one with 5,000 people.

If, on average, every patient visits that clinic two times a year, you're going to have 10,000 visits, 6,000 visits, and 2,000 visits. What GAO has done is taken the $250,000, in the one case divided it by 10,000; in another case divided it by 6,000; in the other case divided it by 2,000, and come out and said, "Well, geez, in the community of 1,000, we're reimbursing these people $125 per encounter, and in the other community we're reimbursing them $25 per encounter."

The point is that in the low-density population, by virtue of the way they are doing their calculation, it's going to come out with a very high per-encounter rate. Now, we can argue whether or not that is fair or unfair, and so forth, but the point being that there is a volume factor here that comes into play. When you are talking about low-density areas, as they are, by definition you are going to

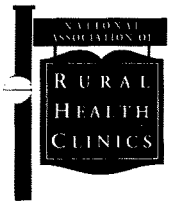
have a high per-encounter cost, because you have a low patient volume.

Mr. SHAYS. But they are not really talking about low density. In some areas, they aren't low-density at all.

Mr. FINERFROCK. They may not be. In some areas, they are not. I'm just saying that looking at a provider-based clinic and doing the calculations the way they do it can present a very misleading picture of what may or may not be occurring.

I will let it go on, and then we can answer questions.

[The prepared statement of Mr. Finerfrock follows:]



Testimony Of

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of

Rural Health Clinics

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Mr. Chairman, on behalf of the National Association of Rural Health Clinics, I want to thank you for this opportunity to express our views regarding the recent GAO report, "Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas."

Later this year, the Rural Health Clinics community will be celebrating the 20th Anniversary of the Rural Health Clinics program. We welcome this opportunity to talk about the positive contributions the majority of RHCs have made towards improving access to health care in underserved rural areas. In recognizing those accomplishments, however, we must also acknowledge that both the General Accounting Office and the HHS Inspector General's office have identified instances where RHCs are either not located in areas that are truly underserved or are being reimbursed at rates higher than what would be considered reasonable.

But before I address our reaction to the GAO report and their recommendations, I want to address a serious misperception the GAO report has created.

According to the General Accounting Office, "The program was designed to primarily benefit areas where population densities are insufficient to attract and support a physician-run clinic." This is not only incorrect, but in fact there is nothing in the hearing record to suggest that the population density of the community was a major consideration. In fact, if anything, the hearing record supports just the opposite conclusion - population size was not a consideration in designating clinic status. The primary consideration was then, and should be now, whether a community is truly underserved. In fact, the Carter Administration argued that there should be no limit on the size of the community or restrictions based on overall population. The only requirement should be that the clinic was located in an underserved area.

Unfortunately, because of the inaccuracy of this premise, it has been suggested by GAO that a majority of Rural Health Clinics are not in rural areas. This is simply not true. In fact, except for a very small percentage, Rural Health Clinics are in rural areas as defined by Public Law 95-210, The Rural Health Clinic Services Act of 1977. If GAO wants to challenge that definition or suggest a new definition of rural, that is their right. But to effectively create their own definition of "rural" and then seek to retrospectively criticize clinics that don't meet their definition is not only unfair but irresponsible.

Finally, I must also point out that the maps GAO created are extremely misleading. At the end of my testimony I have provided an example of how the GAO has completely misrepresented certain communities and the population that falls within the circles they created. Unfortunately, the example I have cited is not unique; although certainly dramatic.

In the event there are any questions about Congressional intent when the RHC program was created, Mr. Chairman, I have brought along a copy of the hearing record from 1977 and I would be happy have anyone go through this record and show me where Congress intended this program to be restricted to remote, isolated rural communities as GAO asserts.

That having been said, Mr. Chairman, we believe that GAO's criticisms, while overstated, deserve attention. We believe they fall into three categories:

1. We have Rural Health Clinics in areas that are not truly underserved;

2. We have Rural Health Clinics in areas that are not rural;

3. We are reimbursing some Rural Health Clinics at rates that are far higher than what would appear to be "reasonable".

In general, we believe the report correctly identifies the legitimate concerns that have been raised with regard to the Rural Health Clinics program.

Growth in the Rural Health Clinic Program

In order to be certified as a Rural Health Clinic, the clinic must be located in a non-urbanized area (population less than 50,000) that is also underserved. Underserved can be an area designated as a Health Professional Shortage Area (HPSA), an area designated as a Medically Underserved Area (MUA) or an area designated by the state's governor as being underserved for purposes of establishing a rural health clinic.

Legitimate questions have been raised by both GAO and the Inspector General's office as to whether all Rural Health Clinics are located in areas that are truly underserved. Any objective review of the data would lead to the conclusion that there are, in fact, clinics located in areas that are not truly underserved. In some cases, these clinics were designated at a time when the area was legitimately defined as underserved. In other instances, the designation was based on outdated or incomplete information thereby leading to an inappropriate RHC certification.

There are fundamentally two questions that arise from this situation.

First, what can be done to prevent this from continuing; and, second, what can be done about clinics that exist in areas no longer underserved?

The first problem has, we believe, both a short-term and long-term solution. We have discussed these with the Health Care Financing Administration and believe we are in general agreement on these points.

Short-term

1. One option Congress could consider would be to require that any new RHC certification be based on accurate and up-to-date information. While I am sure this is what Congress intended, the fact is that the data we use is often neither current nor accurate.

Congress could amend the statute to insert the words, "currently" in that section of the RHC law that talks about areas eligible for placement of RHCs. A definition of the term "currently" could be an area that has been reviewed within the past three years. What this would mean, Mr. Chairman, is that if an applicant sought to have a clinic designated as a Rural Health Clinic, HCFA would be able to deny that application if the HPSA/MUA had not been reviewed within the past three years.

2. Congress should also consider mandating that each time a new clinic is certified, a notice should be transmitted by the Health Care Financing Administration to the Office of Shortage Designation (OSD), alerting them to the certification. The Bureau, duly notified of a certification, could undertake a review of the area to determine if the shortage area designation continues to be valid. If, as a result of the RHC certification, health care access has been improved, the area could be removed from the shortage area list so that no additional RHCs would be certified for that community.

We believe the effect of these ideas would be significant.

First, the Health Professional Shortage Area lists are already under a federal mandate for review every three years. Consequently, this RHC mandate would be consistent with current law. However, it is not the HPSA lists that are the problem.

Instituting a "currently certified" standard would temporarily resolve a problem with the Medically Underserved Area lists.

Approximately 18 months ago, the General Accounting Office issued a report entitled, "Health Care Shortage Areas, Designations Not a Useful Tool for Directing Resources to the Underserved". According to this report, "The list of MUAs has gone substantially unchanged since it was established in 1976. Although new MUAs have been added, the overall list has not been reviewed systematically to update scores or to propose areas for dedesignation since 1981. GAO's review of current countywide MUAs showed that if the designations were to be reviewed using 1990 data, almost half would lose their designation."

By imposing a "currently designated" standard we would effectively eliminate the ability to designate a Rural Health Clinic using an outdated MUA designation until such time as that individual MUA was updated, or the entire list was scrubbed clean.

However, Mr. Chairman, even with a three year review, a lot can happen during that three-year period. Thus the need for better communication between HCFA and the Office of Shortage Designation.

By mandating a tie-in notice, you could accelerate the review process (i.e. not wait three years) in those areas where you have reason to believe that the workforce situation has been improved since the last time the area was reviewed.

Long-Term

Another problem identified by the earlier GAO report that bears significantly on the Rural Health Clinics program has to do with the completeness of the information being used to determine whether an area is underserved or not.

To varying degrees, both the HPSA and MUA lists use a primary care physician to population ratio as part of the designation process. Neither list factors in the availability of physician assistants, nurse practitioners nor nurse midwives. Again, according to the 1995 GAO report, "adding just physician assistants and nurse-midwives known to be practicing in countywide HPSAs would decrease the number of providers said to be needed in such HPSAs by at least 22 percent.

The failure of the shortage designation formulas to factor in the availability of PAs, NPs and CNMs has particular significance for the RHC program.

One of the principle objectives of the RHC program was to encourage utilization of PAs and NPs in the care of Medicare and Medicaid beneficiaries residing in rural areas. To achieve this objective, the law requires the use of PAs, NPs or CNMs as part of the health care delivery team. Failure to incorporate the availability of these health professionals into the designation equation results in some rather perverse situations.

Let us suppose, Mr. Chairman, that we are successful at amending

the law to mandate that an area be currently certified and the Office of Shortage Designation is vigilant in reviewing areas after an RHC has been certified. Despite these important steps, a huge hole in the process would continue to exist that would permit certification of RHCs where they might otherwise be deemed inappropriate.

Without a change in the formula mandating inclusion of PAs, NPs and CNMs, the Office of Shortage Designation could be forced to continue a community on the shortage area list because the principle source of health care in that community is a PA, NP or CNM. OSD must effectively say, they don't exist. Consequently even though the community could have 5 RHCs staffed full-time by a combination of NPs and PAs with only minimal physician on-site availability, as far as the government is concerned, this community is underserved.

This is illogical and absurd and must be changed.

We have been told by the Bureau for the past four years, "we're working on it". We can no longer afford to wait. Congress must step in and mandate the inclusion of PA, NPs and CNMs in the shortage area designation formulas.

Mr. Chairman, the vast majority of clinics are located in truly underserved areas. Our task is to revise the process to ensure that all Rural Health Clinics are in underserved areas.

These recommendations only deal with preventing future clinics from being certified in areas that are not truly underserved. We are still left with what to do with those clinics that are already certified but that would not have been eligible had the shortage area designations been accurate to begin with.

The difficulty in correcting this problem stems from the fact that the Rural Health Clinics statute has always had what is known as a grandfather clause. Clinics would not lose their RHC status, even if an area was subsequently determined to be well-served or no longer rural. The purpose of this clause was and is very important.

There were principally two reasons behind this grandfather clause.

First, Congress did not want to create a situation whereby it used cost-based reimbursement as an incentive to attract a health care professional to an underserved area and then, by virtue of being successful at recruiting that person, took away that incentive because the area was no longer underserved. Then, because the incentive no longer existed, the health professional leaves, returning the community to its previous underserved status, thereby once again making it eligible for cost-based reimbursement. This would create what some have referred to as a yo-yo effect.

The second reason I believe Congress consciously decided to create the grandfather clause has to do with the utilization of PAs and NPs. When Congress created the Rural Health Clinics program, it was the only mechanism for Medicare and Medicaid payments for physician services provided by NPs and PAs. I believe there was a legitimate concern that by failing to have this grandfather clause, you could have a situation where a nurse practitioner or physician assistant establishes a practice in an underserved area, with minimal physician availability. After setting up the practice and demonstrating that it was possible to generate sufficient revenue in the community to support the practice, a physician could come into the community, set up his or her own practice, apply to have the area dedesignated, and shut-down the RHC.

The RHC would have been forced to close because without the grandfather clause, the RHC would have lost its certification and without the certification, there was no way for Medicare or Medicaid to continue to cover physician services provided by the PA or NP. I would note that a similar problem can exist for Federally Qualified Health Centers, Community Health Centers and Migrant Health Centers that utilize PAs and NPs

Despite these legitimate reasons for the grandfather clause, I must also acknowledge that there are examples where the grandfather clause is being used to perpetuate RHC status for clinics that probably do not deserve that status. The challenge we face, Mr. Chairman, is to develop a mechanism that will allow us to continue RHC status for those practices where it is necessary and discontinue RHC status in those clinics where it is no longer justified.

I have two possible suggestions.

First, create a phase-out mechanism that is triggered when the

community has a health care infrastructure that is 1 1/2 - 2 times the level needed to classify the area as underserved. In other words, if the practitioner-to-population ratio for underserved status is one practitioner - 3,000 people, shortage area designation for that community would continue until there was a ratio of 1 practitioner for every 1,000 - 1,500 people. The actual ratio is open for discussion but the point is that you want to have the additional capacity in the area to have some assurance that we don't have the yo-yo effect I spoke of earlier.

Second, it will be necessary to legitimize Medicare and Medicaid payments for physician services provided by NPs and PAs outside the RHC. During the last Congress, legislation was approved as part of the Budget Act to authorize Medicare Part B coverage for PAs and NPs in all outpatient settings. Unfortunately, this ended up being vetoed when the entire budget bill was vetoed. President Clinton, in his most recent budget submission, recommends authorizing Medicare Part B coverage for physician assistants and nurse practitioners.

I would be remiss if I did not mention that Congressman Ed Towns, a member of this Committee has been one of the sponsors of this legislation for several years and we applaud him for his work in this area. In addition, Congress Waxman, when he served as Chairman of the Commerce Committee' Health Subcommittee, was instrumental in making some of the changes in Medicare reimbursement policy that have improved the situation over where we were 15 years ago. Other members of this Committee, have also been strong supporters of correcting this problem.

Mr. Chairman, as I stated to Secretary Shalala's Rural health Advisory Committee last week, the challenge we face in this area is not how to improve the system for designating clinics as Rural Health Clinics, I think the answers are fairly straightforward. Our challenge is how to dedesignate them. The suggestion I've offered above regarding de-designating areas really needs more study. I think the best thing we can do here is ask the Secretary to study this issue and make recommendations.

Payment Issues

GAO also identified significant problems with payments for RHCs.

Although PL 95-210 created one Rural Health Clinic program, the regulations implementing that statute actually created two types of Rural Health Clinics: Independent Clinics(those owned by physicians and other individuals) and provider-based clinics (those owned by hospitals, nursing homes or home health agencies).

Independent RHCs are paid on a per encounter cost basis up to a statutorily prescribed cap. For 1997, the cap is $57.77. Each independent clinic is required to submit a cost-report from which the clinic's reimbursement rate will be determined. In no case, can the per encounter rate exceed the cap.

For example, if, after undergoing an audit, the per encounter rate is $38.00, then Medicare and Medicaid will pay the clinic $38.00 for every Medicaid and Medicare visit (less the 20% co-pay for Medicare). If the audit determines that the per encounter rate is $60.00 per visit, Medicare and Medicaid will pay the RHC $57.77 per visit (again, less the 20% co-pay for Medicare). In addition, in order to receive the full payment authorized by the cost-report, the clinic must meet certain productivity standards for both physicians and physician assistants and nurse practitioners. Failure to meet these productivity standards will result in reduced payments.

By contrast, provider-based clinics are paid using a lesser of costs or charges methodology. This is the way hospital outpatient departments were typically reimbursed by Medicare. Under this methodology, RHC costs are simply allocated to the hospitals outpatient department. There is no cap on provider-based reimbursement nor are there any productivity standards applied to provider-based RHCs.

I must point out, however, that because of the way Medicare requires hospital-based clinics to report their costs, this area of payment is not only misunderstood, but also misrepresented.

For example Mr. Chairman, suppose we have three hospitals that each owned a Rural Health Clinic. Each of the clinics is identical in every way - staffing, equipment, overhead, administrative costs, etc. The cost of operating each of these clinics is $250,000.00 per year. They are all located in truly underserved areas. The only difference is that they are each located in communities of different sizes.

RHC - A is located in a town that has a population of 5,000 people, RHC - B is located in a town that has a population of 3,000 people and; RHC - C is located in a town that has a population of 1,000 people. Based on the assumption of 2 visits per resident per year, Clinic A conducts 10,000 visits, Clinic B 6,000 visits and Clinic C 2,000 visits.

Under GAO's calculations, Clinic A would have a per encounter rate of $25.00 per encounter, Clinic B would have a per encounter rate of $42.00 and Clinic C would have a rate of $125.00. Is this good or is it bad? Ironically, by GAO's standards, Clinic C would be an appropriate clinic based on the size of the community, but inappropriate because we are paying them too much. By contrast, GAO would applaud the per encounter rate of Clinic A but decry the fact that it is located in a "suburban" area.

If you imposed a cap at the current $57.77 level, clinics A & B would not be adversely affected. On the other hand, Clinic C would probably be out of business.

My point here, Mr. Chairman is not that we don't have a problem, but that the issue is more complicated than the GAO report would suggest.

The National Association of Rural Health Clinics believes the imposition of a cap on provider-based clinics at a level equivalent to the independent cap is appropriate. We do believe, however, that greater flexibility must be granted in the productivity standards - particularly for sparsely populated frontier areas. We also believe the level of the cap must be revisited, for both independent and provider-based RHCs.

It is perfectly appropriate and desirable for hospitals, nursing homes and even home health agencies to own and operate rural health clinics. What causes problems is when clinics providing essentially the same services to the same populations are reimbursed differently. Requiring one group of Rural Health Clinics to operate under a cap with productivity standards and permitting another group of RHCs to operate without a cap or productivity standards is not sound public policy. Making a distinction solely on ownership status makes not sense.

Finally, Mr. Chairman, in the GAO report, it states that there are no screening guidelines to disallow costs in cases where provider salaries are excessive. This, I am sure, will come as news to the many RHCs whose cost reports are handled by Blue Cross/Blue Shield of Tennessee. Physician salaries, physician assistant salaries, nurse practitioner salaries and administrator salaries are all reviewed for reasonableness. In addition, we constantly hear complaints from RHCs about the disallowance of costs. Frankly if we need to tighten up or have some of the Fiscal Intermediaries take a more vigilant stand, then we would welcome such scrutiny. But the fact of the matter is, the FIs have the authority and in many cases, they exercise that authority.

Conclusion

Mr. Chairman, I believe I was asked to appear before you this afternoon because the National Association of Rural Health Clinics has tried to take

an honest, responsible approach to the RHC program. Many of the problems cited in the GAO report, we have complained about for several years. How ironic that the very problems we have identified are now being used to sully the reputation of the thousands of clinics delivering high quality health care to millions of Americans in underserved rural areas.

Mr. Chairman and members of this Committee, taped to my computer in my office is a quote I took out a medical publication a few years ago. Quite simply, it states, "Worry About the Patients." Every day, I use that as a constant reminder that it is for the patients that this program was created. As you consider the comments I have made today and the potential recommendations you might make to the Committees with jurisdiction over this program, I ask that you, too, worry about the patients.

Working together, we can come up with ways to address the legitimate concerns of GAO without harming patients. We look forward to working with you and other members of the Committee to ensure that all people, have access to quality, affordable, cost-effective health care.

When is 15 miles not 15 miles?

The GAO report produced some rather fancy maps that purported to show that many RHCs were located in areas with substantial populations. Besides the fact that there is little correlation between the size of a community and access to health care, the maps themselves were very misleading.

Take for example, the Rural Health Clinic located in Wolfeboro, New Hampshire, population 2,000. According to the GAO report, this clinic is located in an area with a population in excess of 50,000 within a 15 mile radius. I found this somewhat surprising but sure enough, when I looked the area up on a map, I discovered that GAO was right, there are more than 50,000 people within a 15 mile radius of Wolfeboro.

Unfortunately for the residents of Wolfeboro, this is very misleading. You see, over half of that 50,000 population is located in communities 14 miles west of Wolfeboro. At least 12 of those 14 miles is composed of Lake Winnipesaukee. In order to get from Wolfeboro to those communities center, it is necessary to travel nearly 50 miles around the lake!

Other examples of this geographic slight of hand exist in areas cited by GAO as having large populations. GAO failed to factor in mountains that stand between communities or rivers that only have bridges every so often or even state boundaries. As you know, Mr. Chairman, many Medicaid beneficiaries doe not have access to providers located in other states. Consequently, even though there may be physicians located a short distance away, the Medicaid population does not have access to these physicians because they are in a different state.

The point is that the simplistic approach used by GAO, while it produces some interesting looking maps, it fails to paint a true picture of the community in question.

Mr. SHAYS. Mr. Harward.

Mr. HARWARD. Thank you for the opportunity to be here. In this setting, I'm about as nervous as some of these people would be feeding my horses. So I'm going to stick with my statement, but I think that it addresses what's going on here.

Mr. SHAYS. Let me just say something to you. We all get nervous sometimes before this committee, for different reasons. So we're happy to have you read your statement.

Mr. HARWARD. Thank you.

Mr. SHAYS. And don't rush when you read it.

Mr. HARWARD. OK. Thank you very much.

Thank you for the opportunity to comment on the Rural Health Clinic Program. My name is Tom Harward. I'm a physician assistant, and I practice in a small community clinic in Belington, WV. I've been the only resident health care provider in our town of 1,800 for the past 19 years.

There are other health care services in towns 14 to 16 miles away. Although not every single person in Belington uses the clinic, I believe that most take a certain amount of security in having the clinic there. I'm equally sure that the RHC Program has been valuable to many other rural areas in West Virginia.

In 1985, I talked a friend of mine into relocating to a small town called Riverton. Riverton has about 500 residents, and its' clinic had closed. The town is on a fair-sized creek in the mountains, about 50 miles east of where I practice.

About 2 weeks after he arrived, he found himself, along with his wife, mother-in-law, and 4-year-old, sitting in a barn loft. He was watching his home and about half of that town float down the creek. I had a little trouble looking him in the eye for a while after that flood, but he rebuilt his home, and he rebuilt his clinic. He is still practicing there today.

My friend is a PA. I think he represents the hearts and guts about what non-physician providers are supposed to be about, and that is cost-effective care, particularly to underserved populations. That's what the Rural Health Clinic Program is supposed to be about, a lean, cost-effective program providing care to rural and underserved populations.

Perhaps the respective agencies and professions need to be reminded of this focus on occasion. Perhaps we need our collective professional feet held to the fire a bit. So be it. But like the lady said earlier, don't throw the baby out with the bathwater.

The GAO report does not make good reading for those who are advocates of the Rural Health Clinic Program, particularly when it States that it was adrift, without focus. I cannot speak for the areas mentioned in the report. I found it well written, but I know it doesn't reflect anything about my clinic, and I know it does not generally reflect what has transpired in West Virginia.

Our clinics are in rural areas. They do serve rural populations. They are also in areas where the weather can be treacherous, the terrain rough, and there is often no public transportation. The GAO report cited a failure to increase the number of patients served. When I joined our clinic in 1978, we saw less than 3,000 patients a year. This year we will see nearly 14,000.

The report cited a failure to increase the number of health care providers. When I began, there was a physician a half day a week and myself. Today, we've got another full-time PA and a half-time OBGYN nurse practitioner. Two family docs give us two half-days a week each; a pediatrician, the same; and a surgeon also comes in. In the western end of the county, a new provider-based RHC has brought in another family physician and a PA.

Mention was made in this report of the failure to provide care to the underserved and a lack of a sliding fee schedule for this group. We do offer a sliding fee schedule. We provide care for every single person who walks through the door and asks for it. We have programs for indigent children, adults, and seniors.

The report was critical of the cost-based system whereby high overhead and administrative costs resulted in counter rates which, in some cases, were cited as $200. The two provider-based clinics in the western end of our county have rates of $52 and $56, respectively. I represent the administrative overhead of our clinic, and I see 4,000 to 6,000 patients a year. Our rate is $38, and I believe it is good value.

For this $38, we are able to provide our community with a clinic that is open 5½ days a week, a call system where help is available 24 hours a day, 7 days a week, a comprehensive family practice situation where we can provide both inpatient and outpatient care, including obstetrics. We have a house call service that reaches hundreds of the elderly and disabled a year. And we have health programs such as cervical cancer screening and the pediatric health service.

We also have two innovative projects—and I want to make this clear—that are not financed by the Rural Health Clinic Program, but because of the stability we have by it, we've been able to move forward on these. We have one of the finest school-based clinics in the State. We provide screening services there, acute care to kids who can't get services elsewhere, and health education programs.

We also have built, from donations in the community, because of the support that our clinic has, a preventive health center that is opened from 7 a.m. until 8 p.m. We offer nutrition counseling here, exercise instruction, aerobics, water aerobics, hydrotherapy services, stretching exercises for seniors, et cetera. We feel like that people need to take responsibility for their own care, and this is our attempt.

I would like to close with these final thoughts. I grew up here in the Washington area. I left Connecticut Avenue and Chesapeake Street here about 20 years ago. And I know that we are not completely unique, or my area is not completely unique in its weather and terrain, but people do come to care late and they are sicker.

We deal with an extraordinary number of people that have diabetes, obesity, chronic obstructive pulmonary disease, and other illnesses. We provide care to families who really do exist on $6 and $8 an hour, in areas where the unemployment rate is likely to run 12 to 22 percent.

I just ask you to remember, as you take a look at this program, that it has been important to us. We have adhered to its original concept. Obviously, it needs fixing. Reasonable caps would be a good start, and also redesignation.

I want to throw one issue out here in the comments made today. We talk about decertification. I've been there 19 years. I'm 56 years old. If you decertify my clinic, I can't practice. I put my whole life in this place, because I would not be eligible to be reimbursed under Medicare. So if you fix this, it needs to be fixed right.

Another issue, in terms of decertification, at our rate, $38, I challenge you to go to a doctor in Washington for $38, in most cases. It has given us a floor, and it has allowed us to develop these other programs.

I have watched dozens—and I mean dozens—of physicians and other providers come into this area. There are cultural reasons; there are social reasons; there are economic reasons. They fear the school system. You know, if you want your kid to be a physician or a lawyer, you might not want him in our high school. And they are there a year or two, and their kids start to grow up, and they pull out—not everybody—but they pull out.

I've been there when we got $7.50 from Medicaid for a patient encounter, and I've also been there when Medicaid took 6 months to pay us. So I want to make those points. If you fix this thing, it's got to be fixed right, and I think it should be done in an expedient manner.

[The prepared statement of Mr. Harward follows:]

Belington Community Medical Services Assn., Inc. Phone (304) 823-2800

210 Sturmer Street • Belington, WV 26250

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February 12, 1997

Christopher Shays, Chairman
Subcommittee on Human Resources
Room B-372 Rayburn Building
Washington, D. C. 20515

Dear Chairman Shays and Committee Members,

Thank you for the opportunity to comment on the Rural Health Clinic program. My name is Tom Harward. I am a Physician Assistant and practice in a small community clinic in Belington, West Virginia. I have been the only resident health care provider in our town of about 1800 for the past nineteen years. There are other health care services in towns 14-16 miles away. Although not every single person in Belington uses the clinic, I believe that most take a certain amount of security in having the clinic there. I am equally sure that the RHC program has been valuable to many other rural areas in West Virginia.

In 1985 I talked a friend of mine into relocating to a small town called Riverton. Riverton has about 500 residents and its' clinic had been closed due to the lack of a health care provider. The town is on a fair sized creek in the mountains about fifty miles east of where I practice. About two weeks after he arrived he found himself, along with his wife, mother-in-law and four year old sitting in a barn loft. He was watching his home and about half of the town float down that creek. I had a little trouble looking him in the eye for awhile after that flood, but he rebuilt his home and his clinic. He is still practicing there today. My friend, Don Munday is a PA. I think he represents the heart and guts of what non-physician providers are supposed to be about. And that is cost effective care, particularly to underserved populations. That's what the Rural Health Clinic program is supposed to be about. A lean, cost-effective program providing care to rural and underserved populations.

Perhaps the respective agencies and professions need to be reminded of this focus on occasion. Perhaps we need our collective professional feet held to the fire a bit. If it takes a hearing such as this, the Congress or even the media to keep this program on track. So be it. But I am here today to ask that you not throw the baby out with the bathwater.

The G.A.O. report does not make very good reading for those of us who are advocates of the RHC program. It was hard to read that it was "adrift without focus" and was not meeting its' goals. I can not speak for the areas mentioned in the report. I respect the work that went into this report, but I know it does not reflect what our clinic is about, nor does it generally reflect what has transpired in West Virginia.

Our clinics are in rural areas and do serve rural populations. They are also in areas where the weather can be treacherous, the terrain rough and there is often no public transportation.

The G.A.O. report cited a failure to increase the number of patients served. When I joined our clinic in 1978 we saw less than 3000 patients a year. We should see 14,000 patients this year.

The report cited a failure to increase the number of health care providers. When I began, there was a physician one-half day a week and myself. Today we have another full-time PA, a half-time OB/Gyn nurse practitioner, two family physician who each provide two half days a week, a pediatrician for a half day and the same arrangement with a surgeon. In the western end of our county, a new provider based RHC has brought in a another family physician and PA.

Mention was made in the report of the failure to provide care to the underserved and the lack of sliding fee schedules for this group. We do offer a sliding fee scale and provide care to anyone who walks through the door. We have programs for indigent children, adults and seniors.

The G.A.O. report was critical of the cost-based system whereby high overhead and administrative costs resulted in encounter rates which, in some cases, exceeded $200. Not all of us operate this way. The two provider based clinics in the western end of our county have rates of $52 and $56 respectively. I represent the administrative overhead cost of our clinic and also see four to five thousand patients a year. Our rate is $38. I believe it is a good value.

For this $38 we are able to provide our community with:

*a clinic which is open five and one-half days per week.

*a call system where help is available twenty-four hours a day, seven days a week.

*a comprehensive family practice offering both in and outpatient coverage including obstetrics.

*a house call service that provides hundreds of home calls to the elderly and disabled yearly.

*we participate in a number of health programs such as Cervical Cancer Screening and Pediatric Health Services.

*we also have two innovative health projects which are not part of our RHC cost basis, but the stability provided by the program has permitted us to move forward with these initiatives. We have one of the finest high school based health care facilities in the state. We provide a full-time nurse where there was none before. We provide on-site acute health care and screenings on a daily basis. Our

second project is a preventive health center attached to our clinic which is open from 7am until 8pm daily. This center offers nutrition counseling, exercise instruction and equipment, floor aerobics, water aerobics, hydrotherapy services, and senior stretching and exercise programs. We offer swimming lessons to every second and third grade student in the county at no charge. If we are ever going to conquer this health care beast, we must get people to assume responsibility for their own health. This is our attempt.

I would like to close with these final thoughts. I grew up in the Washington area. I left Connecticut Avenue and Chesapeake Street for West Virginia over twenty years ago. I know where I work is not completely unique in it's weather and terrain, but it can be very different from urban and suburban areas. People do come to care late and they are sicker. We deal with extraordinary rates of diabetes, obesity, chronic obstructive pulmonary disease and other illnesses. We provide care to families who exist on $6 to $8 per hour wages in areas where the unemployment rate may vary between 12% and 22%.

I ask you to remember that the Rural Health Clinic program is important to us. I believe we have adheared to its' original concept. It can be fixed with the application of a little common sense. Reasonable caps for all participants and realistic designations for both RHCs and FQHCs would be a good start.

Thank you for the opportunity to speak here today.

Tom Harward, PA-C
Administrator
Belington Medical Clinic

Mr. SHAYS. Tell me again how many years you've had your clinic or you've been involved in the clinic.

Mr. HARWARD. Nineteen.

Mr. SHAYS. I don't think you need to fear, for a variety of reasons, that we will be acting too quickly. You don't need to go to sleep at night fearful that the next morning HCFA or Congress will have taken decisive action. But I'm going to be a little more sympathetic and sensitive to the areas you describe. So I look forward to having a dialog with you.

Mr. Tessen.

Mr. TESSEN. Mr. Chairman, members of the committee, I do want to follow my script to some degree.

Mr. SHAYS. Where are your cowboy boots?

Mr. TESSEN. Well, I wanted to act urban today. I figure this is Washington, you can't act Texan up here.

Mr. SHAYS. I don't know one Texan up here who wears normal shoes, as a Member of Congress.

Mr. TESSEN. I would challenge you to see what's in their closet, then.

Mr. SHAYS. OK.

Mr. TESSEN. I figure a good pair of Niconas these days cost $600, so we can't afford too many.

Mr. SHAYS. OK.

Mr. TESSEN. I appreciate the opportunity to share some information with you. I just want to follow the script and bring out some points particularly reflective of some of the comments that had been made earlier.

I am representing the National Rural Health Association, which is a national member organization comprised not just of rural health clinics but physicians, Federal qualified health clinics, community-operated practices, research and education, everyone. I am the founder and the chair of the division which we call constituency groups within the NRHA, to represent rural health clinics.

I would suggest that there are some other reasons that the number of RHCs has exploded in the last 6 or 7 years, other than those that have been brought out so far during testimony today. No. 1—and I will use Texas as an example—the reason there were no functioning RHCs in Texas up through 1989—there were 12 originally, and they all went under after the 1977 legislation.

So by 1989 there were none, because in Texas the State regulations did not allow independent practice by a physician assistant. So we could not have a rural health clinic without over the shoulder supervision of a physician assistant until 1989. After 1989, the numbers took off like crazy, but it was because of the change in State regulations that allowed PAs to practice.

I would also suggest another reason for some of the numbers, something we have experienced in some of the western States, a lot of the physicians in rural areas are aging. I guess we're all aging, at least some of us, faster than others, it seems. But in rural areas, a lot of the physicians are or are at retirement age. One of the things that the Rural Health Clinic Program has allowed communities to do is, instead of that practice closing and the community losing its access to care, allow a rural health clinic to come in. That's going to show up as a conversion, No. 1.

Mr. SHAYS. Fair enough.

Mr. TESSEN. But what it's going to do, it's going to allow a mid-level practitioner, nonphysician provider to be brought into that community to continue that practice. Whereas, without the Rural Health Clinic Program, there may not have been the ability to convert that practice and convert that primary care. I think that's another aspect of rural conversions we have to look at, in terms of rural health clinics.

I would emphasize that one of the biggest problems with this program is the lack of data. OIG did a report. GAO did a report. Bill's association did a report a couple years ago. There have been a couple studies. But I would challenge anybody to be able to tell you what is going with rural health clinics in the United States, across the board, with objective data. There isn't any. There simply is no data. Instead of being proactive, we end up reacting to a study or something that was done that wants to change something.

I guess what I would recommend is that there really be an effort made to find out what is really going on. I think clinics like Tom's don't get the recognition they need. They don't show up in the data.

I would also point out that I think there are some other discrepancies or faults with the design of the GAO study. One of the things that I would suggest is that there is an assumption made, it seems, in their report, that all those RHCs they found are full-time clinics. That's not necessarily true.

We had one county in Texas that received notorious play in the media because there were 10 RHCs in the county. I went down there. Four of those are owned by the same physician assistant who has opened each of those clinics 1 day a week.

Mr. SHAYS. Interesting.

Mr. TESSEN. That's not brought out in the GAO report.

It also assumes, I think, in the GAO report, that all clinics serve all patients, and that's not true. There are some rural health clinics that serve just pediatric patients. In that case, that clinic does not provide access to Medicare patients. That was not brought out in the GAO report.

I also think using population assumes that all patients in all locales are the same, and that's not true. I think that every area has a different patient mix. Number of Medicare and Medicaid patients, unemployed, indigent care, levels of poverty, those are different. You may have some areas 15 miles away—which, by the way, I think 15 miles in Texas is a little bit different than 15 miles in Connecticut. If I've got to drive 15 miles in Texas, I'm in another town half a county away. And I think we, in the western States, look at it a little bit differently.

Mr. SHAYS. But that would imply you would look at 15 miles as being pretty close, not a big deal.

Mr. TESSEN. Except that, in terms of access to care, the orientation of the folks in that town 15 miles away is going to be to that community rather than to a town 15, 20, or 30 miles away.

Mr. SHAYS. But isn't the issue whether someone can get a health care?

Mr. TESSEN. It is, yes.

Mr. SHAYS. That's really the issue. And I'm seeing the abuse. Let me let you finish your statement. I'm really happy you all are here, because I think we will learn a lot.

Mr. TESSEN. I would also assume that 15 miles assumes the presence of transportation. I would contend that, for a lot of the elderly, particularly in a lot of rural areas, transportation is not available, as a matter of just a way of life.

I would also suggest the current system is broken in another way. I think left unspoken here today has been the idea that the current system is working as it is supposed to have been working in a number of ways. And I'm going to tell you it's not. I have clinics in Texas that have not been surveyed, even though the regulations require an annual survey, have not been surveyed in 6 or 7 years. There has been no one coming in to check on those clinics to see if they are in compliance with the existing law, much less any abuses that may be going on.

I would also suggest that the feedback system is poor. We have clinics in the western part and some of the fiscal intermediaries out west that are not giving feedback to the individual RHCs on their cost reports, their allowable costs, if their data is in line with what it should be, for 18 months after the data has been submitted.

I would suggest, if we were running a private business and had to wait on our accountant's report for 18 months before we could determine if we were in line or not, or if we tried to convince that when we appear before the IRS tax board, it wouldn't fly, but that's what rural health clinics face as a matter of routine.

I think the National Rural Health Association is in full agreement that the program needs to be fine-tuned. We agree that access to care should be the primary determinant for placement and certification of a rural health clinic. But what we would also contend is that the objective definitions be that, objective and consistent across the board. I mean, when we talk about developing policies, we can't even agree on the definition of "rural." I think we're going to have to have objective data.

I just want to make a couple other quick points.

Mr. SHAYS. OK. And then we would like to get to questioning. Just make one or two more points, and then we will get to the questioning.

Mr. TESSEN. I would say that there has been a thing in the GAO report that said that conversions in even the rural health clinics in the suburban areas did so without adding staff. I would contend that's not possible, because, by requirement, by definition, a rural health clinic has to have at least a mid-level practitioner 50 percent of the time. So by simply going to a rural health clinic certification, they have to add a mid-level practitioner at least 50 percent of the time. They can't avoid that and still be in compliance with the law. So I would contest that.

[The prepared statement of Mr. Tessen follows:]

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Robert Tessen
Rural Health Clinics Constituency Chair

NATIONAL RURAL HEALTH ASSOCIATION
Testimony Before the Committee on Government Reform and Oversight, Subcommittee on Human Resources, U.S. House of Representatives

Robert J. (Sam) Tessen
February 13, 1997

Donna M. Williams
Executive Vice President

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Mr. Chairman and Members of the Committee:

Good Afternoon. I appreciate the opportunity to share some perspectives on the Rural Health Clinic program and its impact on primary health care delivery in many parts of rural America. My name is Robert J. (Sam) Tessen and I am from Galveston, Texas. I am here representing the National Rural Health Association (NRHA). The NRHA is a national membership organization representing rural practitioners, administrators and researchers - the entire spectrum of rural health care in our country. My specific role within the NRHA is as Founder and Chair of the Constituency Group (division) for Rural Health Clinics. I also sit on the organization's policy board.

Since I only have five minutes today I am not going to give you the history of the program but address some of the issues brought up in the recent Government Accounting Office report on Rural Health Clinics and share the NRHA's recommendations. In addition, I am submitting a more detailed white paper on the RHC program for the record.

Over the past 5 or 6 years, there has been major growth in the RHC program. Expansion of number of Rural Health Clinics seem to fall into 5 general categories:

1. By non-physician providers as primary providers.
2. Into areas that may have not had enough population to support a full-time physician, and related costs.
3. By rural hospitals expanding primary care networks into outlying communities or communities in danger of losing primary care services.
4. By physician practice conversions - physicians receiving levels of reimbursement reflective of their actual costs.
5. By urban hospitals attempting to stretch referral networks into rural areas.

One of the major problems with the current RHC program is the lack of general data collection. The Health Care Financing Administration has recognized this problem and has commissioned a study by Mathmatica. The results of that study are not in yet however and several of the conclusions reached in the November 1996 GAO study are based on incomplete or lack of accurate data:

- The study assumes all clinics are full-time clinics. This is not necessarily true because many communities cannot financially sustain a full-time clinic; some clinics are regularly scheduled part-time clinics. One county in Texas has 10 certified Rural Health Clinics but 4 of those are part-time (1-2 days per week only) with a Physicians Assistant.

- The study assumes all RHCs serve all types of patients. This is not necessarily true. For example, a pediatric clinic serves children, including Medicaid children, but does not serve adults.

- Using census data on population only does not take into consideration patient mix within that population such as the percentage of Medicare and Medicaid patients, level of poverty, number of unemployed, etc.

In addition to the absence of sound data, the following issues have greatly contributed to the current status of the RHC program and correlate directly with some of the issues raised in the GAO study:

1. Lack of specific rules for provider-based Rural Health Clinics, including the cost-reporting process for those RHCs.
2. Failure to maintain current, up-to-date listing of both federal and state (HPSA and MUA) shortage designations,
3. Failure to provide annual surveys of existing clinics as required by regulation.
4. Failure of fiscal intermediaries to provide timely feedback on annual cost reports.
5. Failure to accomplish audits of clinics.

The NRHA recommends the following steps to improve the Rural Health Clinics program:

- Rural Health Clinics should be required to serve the populations for which the designation of need for the area was granted and thus provided the eligibility criteria for the certification of the clinic.
- Rural Health Clinic should contribute to the overall health of the community by providing primary health care services to indigent and/or uninsured citizens to the extent financially feasible for that clinic.
- Rural Health Clinics should be reimbursed at reasonable and adequate levels for the primary health care services provided.
- Regular assessments of the MUA and HPSA designations for a given area already provided for under existing rules could help to define ongoing need and help address the issue of proliferation.
- State involvement in the evaluation of need process is also a possibility. Such involvement should be clearly defined and based upon a pre-determined set of objective criteria, then equally applied. The system should continue to include federal oversight and minimum standards.
- Timely and consistent surveys and audits would greatly contribute to the assurance of compliance of rural health clinics, address many of the concerns facing providers today, and contribute to the success of those rural health clinics striving to fulfill the letter and intent of the originating legislation.
- Efforts by the federal and state governments and the rural health clinic providers should be focused on the development of a single, comprehensive, objective data collection system on a national level that will meet the needs of the regulators, payers, community health planners and rural health clinics in the communities.

While we look today at some of the needed reforms to the Rural Health Clinic program, we must not lose sight of the fact that a vast majority of RHCs are providing access to families in rural and frontier underserved areas who would otherwise be without quality health care services. Along with many in the rural health community, the NRHA is committed to seeing reforms enacted that will strengthen the RHC program's ability to increase access.

In conclusion, I appreciate this opportunity to share the views of the National Rural Health Association and would like to emphasis its commitment to rural health and to the Rural Health Clinic Program. The NRHA would like to continue to be a resource and partner on these issues as we all work together to improve the primary health care delivery system in rural America.

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Rural Health Clinics in Rural America

An Issue Paper Prepared by the National Rural Health Association-February 1997

Background

Public Law 95-210. In 1977, the U.S. Congress passed legislation that established criteria for the establishment of federally certified Rural Health Clinics. The law was designed to support and encourage access to health care by rural residents.

It was noted that due to economic conditions, the rural population was becoming poorer and more elderly, and that providers were becoming older and not being replaced by younger physicians as the older physicians retired.

It also was noted that provision of health care to the rural poor and elderly was more costly than to those populations in urban areas. Rural health care also is more costly because a limited, constricted patient mix restricts the percentage of revenue from private third-party payers.

The number of these Rural Health Clinics has proliferated in the past 10 years due to decreasing reimbursements from the standard fee-for-service system. Because Rural Health Clinics receive cost-based reimbursement, providers are turning to Rural Health Clinics program to be able to continue providing service to the rural poor and elderly.

As health care providers--both independent and provider-based facilities--strive to maintain service to this vulnerable population, the Rural Health Clinics have become an integral part of this health care system.

As Rural Health Clinics have proliferated, so has scrutiny of the amount of money being spent for the clinics by the federal and state governments on the program. It is important to remember that the Rural Health Clinic status has helped maintain health care in areas that otherwise have not historically been able to recruit or maintain providers.

When examining the cost of a Rural Health Clinic, it must be balanced against the cost of having no access or limited access for the patients the Rural Health Clinic serves. Preventive health care and early intervention in acute illnesses would suffer and the ultimate healthcare cost would increase if there was not such access to that provided by the Rural Health Clinics. Cost also

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should be evaluated on another less quantifiable continuum–the quality of life issue that either encourages or discourages providers from locating in rural areas. Rural providers are typically within the reach of local citizens 24 hours a day, seven days a week, making quality of life in a rural community more difficult to attain, much less maintain.

Health care provision to rural populations through Rural Health Clinic certification (1) allows access in areas that otherwise would not have sustainable health care; (2) encourages mid-level providers to be an integral part of the health care delivery system; (3) gives rural citizens the opportunity to learn and accept the skills of mid-level providers; and (4) allows the potential for other services to be brought to the rural area that otherwise would not be available in a private practitioner's office, such as dietitian, social and physical therapy services.

Rural Health Clinics receive cost-based reimbursement from Medicaid and Medicare for services already provided to patients and are regulated by and audited by a survey process. This concept of cost-based reimbursement has facilitated the recruitment of providers into rural areas.

The National Rural Health Association (NRHA) fully supports the Rural Health Clinics program as one major component of a rural health care delivery system. As the rural health care concept is re-examined at the national level by federal agencies, the NRHA will be actively supporting the Rural Health Clinics program and will be active in any discussion of revisions.

With the above stated support, it is noted that the Rural Health Clinics program is designed like many other health care delivery programs at the federal and state levels. A program is legislated, qualification requirements are established, certification processes are put in place and ongoing monitoring mechanisms are developed. There is a system of checks and balances for the program to ensure both initial and ongoing compliance with established goals and requirements.

In the case of the Rural Health Clinics program, this system does not appear to have worked as effectively as it was designed, mainly because certain segments of the system have not been regularly instituted, applied or addressed.

Access to Care

1. Access to care has become a defining argument for and against the establishment of Rural Health Clinics. A working objective definition remains elusive and perhaps arbitrary at some state levels. Access to health care should be defined in workable terms considering both the needs of specific communities as well the short- and long-term primary and emergency health care services needs of those communities.

2. Rural Health Clinics should be required to serve the populations for which the designation of need for the area was granted and thus provided the eligibility criteria for certification of the clinic.

For example, Rural Health Clinics should serve all Medicare beneficiaries and Medicaid recipients seeking services at the clinic. Rural Health Clinics originally obtaining certification under a population-based, underserved or shortage area designation should serve members of the population for which the area was certified as needing health care providers. For instance, if a Rural Health Clinic's certification is based on a HPSA-based area with a population below 200 percent of poverty level, that Rural Health Clinic should have to offer services to that population on a sliding-fee basis or a similar mechanism.

3. Rural Health Clinics should contribute to the overall health of their resident communities by providing primary health care services to indigent and uninsured citizens to the extent financially feasible for that clinic, taking into consideration that no reimbursement typically is received for such services.

4. Rural Health Clinics are reimbursed for services provided, typically without the benefit of other financial resources such as grants. Therefore, Rural Health Clinics should be reimbursed at reasonable and adequate levels for the primary health care services provided.

5. The limiting circumstances involved in the establishment and retention of access to care in frontier and other significantly rural areas should be taken into special consideration in any possible revision of the eligibility and reimbursement provisions for Rural Health Clinics.

6. Provider-based facilities constitute a significant number of Rural Health Clinics. The size and physical location of the provider entity should be a consideration in any possible revision of the reimbursement provisions for Rural Health Clinics, e.g., Rural Health Clinics of hospitals in rural, medically underserved or health professional shortage areas with 75 acute-care hospital beds or fewer should be accorded reimbursement levels commensurate to the critical role played in the delivery of primary health care services in the shortage areas.

7. Rural Health Clinics also face the onward march of managed care programs across the country. Such clinics should be recognized as historical providers of Medicare and Medicaid services as well as essential community providers and should be afforded inclusion in any such managed care system.

8. The recent rapid growth in the number of Rural Health Clinics has been noted. Yet, it is too soon to say whether this growth rate is positive or negative. Further study appears warranted and should be directed as specific, measurable aspects of direct access to care–for example, numbers of clients served in the program, increases in number of patients served due to different reimbursement, increases in the cost of care that affects all programs, and increases in the volume of services should be assessed.

9. Rural Health Clinics should actively serve the specific populations on which the qualifying geographic area was designated as a shortage area. This aspect of access is seen as an integral part of the intent of the original federal legislation and a responsibility that Rural Health Clinics have an obligation to meet.

Eligibility for Certification

1. Rural Health Clinics program eligibility requires only the designation of a medically underserved area (MUA) or a health professional shortage area (HPSA). Originally, designation also included medically underserved populations. No definite measure of ongoing need was established beyond these minimum requirements.

   Such a management function should be developed, or the initial eligibility requirements should be revised. Regular assessments of MUA and HPSA designations for a given area already provided for under existing rules could help to define ongoing need and to address the issue of proliferation. This assessment needs to include protection for existing essential community providers. This does not appear to be a function of Rural Health Clinics themselves, but of the system that applies the criteria for establishment.

2. Increasing and retaining access to care are both critical considerations for most rural communities as they face the need for provider services today and in years to come. Definition of a community's needs also should include consideration of the retention and recruitment of primary care providers.

3. There should be a determination of the unmet need in an area and the resources necessary to meet that need before certification of new Rural Health Clinics. The federal government should establish standards to measure this need, and the state should apply them in making recommendations for certification of Rural Health Clinics. Such standards should include, but would not necessarily be limited to, the number of health care providers available to the population or area and also should include community input.

4. Critical criteria for evaluating need at both the community and state levels should include consideration of actual and potential patient utilization assessed by patient type and patient need, taking into consideration such factors as age, demographics, income and poverty levels, prevalent diagnostic patterns, and community economic needs and planning.

5. Needs assessments for new rural health clinics should consider the effects on the existing primary care infrastructure in rural communities and should not cause fragmentation of that infrastructure.

6. Geographic distance, provider type, patient transportation requirements and limitations, and other proven access considerations must be included in evaluating access to health care.

7. Mid-level providers are required by the enabling federal law to be key Rural Health Clinics components in the delivery of primary health care services by Rural Health Clinics and, therefore, should be included in some objective manner in the assessment of need for Rural Health Clinics at the federal, state and community levels.

Survey Process and Audits

Regular and annual surveys of Rural Health Clinics are included in the original requirements of the original legislation, providing a method of checks and balances when applied objectively and consistently. Yet, such surveys have not been conducted in any consistent manner in the Rural Health Clinics program.

Rural Health Clinics of both types (independent and provider based) submit required cost-reporting documents, yet audits of any real meaning either are not conducted at all, or are not conducted in a timely or consistent manner.

1. Timely and consistent surveys and audits would greatly contribute to the ensured compliance of Rural Health Clinics, address many of the concerns facing these providers today, and contribute to the success of those Rural Health Clinics striving to fulfill the letter and intent of the originating legislation.

2. Another facet of regulatory oversight to be addressed should be the enforcement of the mid-level provider waiver process. Because the Rural Health Clinics program was established specifically to include mid-level providers, waivers of this requirement should be legitimate, short term, and enforced.

Independent Versus Provider-based Rural Health Clinics

Much attention has been focused on provider-based Rural Health Clinics, yet no specific manual of regulations and rules has been developed or implemented pertaining to the functioning of this type of clinic, unlike the rules that have been developed for independent Rural Health Clinics.

1. The existence of concrete rules and regulations would be a significant start to ensuring compliance of provider-based Rural Health Clinics. Prime examples would be that of a specific definition of allowable costs for these clinics and the application of productivity standards for their providers. Active consideration also

should be given to the development and implementation of a comprehensive billing manual for provider-based Rural Health Clinics.

2. Provider-based Rural Health Clinics are challenged by the strict regulations of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) and the Omnibus Budget Reconciliation Act (OBRA) regarding denial of patient care due to poverty and regulated/appropriate transfers from the clinic to acute-care facilities. These additional constraints cause a large monthly fiscal deficit due to uncompensated care costs. Capping the reimbursement level to that of non-provider-based clinics would prove to be financially devastating to small rural hospitals, causing closures and patients being abandoned without access to care.

Data Collection

Data collection, or the lack thereof, is a serious problem in evaluation of the Rural Health Clinics program and its participating facilities, particularly as such evaluation would relate to access to care. The cost report is the single means through which data is collected beyond individual patient bills submitted to Medicare and Medicaid. Additionally, the cost-report collection of productivity standards, for Medicare utilization, holds true only for independent Rural Health Clinics.

1. Efforts by the federal and state governments and Rural Health Clinic providers should be focused on the development of a single, comprehensive and objective national data collection system that will meet the needs of the regulators, payers, community health planners and Rural Health Clinics.

Additional Considerations

It also should be noted that Rural Health Clinics are fertile ground for the training of primary health care providers and increasing the health care awareness of their resident communities.

1. The use of Rural Health Clinics for provider training should be encouraged and expanded, offering another avenue to increase access.

Conclusions

Rural Health Clinics provide access to health care services, which may be seen as a multifaceted factor that includes definitions not only of specific utilization by specific types of patients, but also of recruitment and

retention of primary care providers and ongoing contributions to the long-term economic and health factors of their local communities.

The aspects of the program that work should be strengthened and the problem areas should be refined and improved. Efforts to change the program entirely would appear to be premature.

Equal emphasis also should be given to the consistent accomplishment of required federal government actions relative to the eligibility and regulatory aspects of the program. Such factors are outside the realm of responsibility of or action by Rural Health Clinics, although responsibility for the integrity of the program is seemingly being placed solely at the feet of the participating Rural Health Clinics and those that operate them.

The risk of too much intervention with Rural Health Clinics could result in the loss of momentum that the Rural Health Clinics program has achieved in helping to address access to primary and emergency health care services in rural communities.

Another long-term risk is that if today's momentum is lost, the issue of access to care in rural communities may have to be dealt with once again years from now. Rural communities and their citizens, as well as federal and state governments, cannot afford this. The NRHA strongly supports the concept of Rural Health Clinics as a major component in improving access to health care services in rural communities and believes that the program deserves careful, rational and objective fine tuning.

The NRHA will join in any discussions and efforts to improve this program and will advocate for changes consistent with the proposals in this paper.

Mr. SHAYS. Let me just have a sense of where your perspective is, in terms of background. There are approximately 3,000 rural health clinics today.

Mr. TESSEN. Yes; 3,273.

Mr. SHAYS. How many belong to the National Association of Rural Health Clinics?

Mr. FINERFROCK. Well, we have about 450 that pay dues, but they represent, in many instances, because you have multiple clinics, we have about 900 clinics.

Mr. SHAYS. You are part of the National Rural Health Association.

Mr. TESSEN. Right.

Mr. SHAYS. How many members do you have?

Mr. TESSEN. Just over 200 now.

Mr. SHAYS. Now, do these two different—your association, do you have the same basic type clinics part of it, or do you kind of go after a certain group?

Mr. FINERFROCK. Our membership is both independent and provider-based. I don't want to speak for Sam.

Mr. SHAYS. Is it geographically based?

Mr. FINERFROCK. I think the way I would describe the difference in our organizations is—and I mean this positively—NRHA is a department store, and we are a boutique. NRHA has a variety of rural entities that are members, all under the broad, so there are rural hospitals, independent providers.

Mr. SHAYS. So you have other organizations besides.

Mr. TESSEN. Using that analogy, we would be like Saks.

Mr. FINERFROCK. And we're the boutique on the corner. We just work on rural health clinics.

Mr. SHAYS. So, Mr. Harward, did you join a "Saks," or which one are you in?

Mr. HARWARD. Rural Health Care Association.

Mr. SHAYS. Now, Mr. Tessen, do you have clinic of your own? You have your own clinic besides being part of an association?

Mr. TESSEN. I manage a clinic at this point.

Mr. SHAYS. You manage a clinic.

Mr. TESSEN. But that's not my full-time job. I also work at a medical school in Texas, in Galveston.

Mr. SHAYS. And you're basically in charge of this association.

Mr. FINERFROCK. I'm kind of a policy wonk.

Mr. SHAYS. OK. Listen, we're policy wonks. We can't be totally against you guys.

Mr. Harward, you're in the trenches.

Mr. HARWARD. Yes, sir.

Mr. SHAYS. OK. Describe to me your community.

Mr. HARWARD. My community has one stop light, one bridge, a Quick Stop, a couple small grocery stores. As I said, the population is about 1,800. It's primarily marginal farming, timber industry, a declining coal industry. The town itself is about 1,800. The county is 16,000, probably 350, 450 square miles.

Mr. SHAYS. So the closest community of more than 50,000 would be how far away?

Mr. HARWARD. 150 miles.

Mr. SHAYS. See, in my own mind, that's the kind of community that I would visualize we're trying to focus in on. Now, I do understand your point, Mr. Finerfrock. Your point is that you could even make an argument that a rural health clinic could be in the Bronx, in terms of need.

Mr. FINERFROCK. Yes. You have heard reference here to the FQHC program, federally qualified health centers program. Some of the previous witnesses made reference to that program. That, in essence, is very similar in its financing to the RHC program. Those facilities get cost-based reimbursement under a cap, and their costs look at the same things that the RHC costs do. So there is, in essence, an urban component or model of this.

Mr. SHAYS. Yes, there is a model, but my sense is that when Congress started this—and we will look at the record—in "rural," certainly the implication was that we were talking more like areas that Mr. Harward is part of.

Mr. TESSEN. Under the initial legislation, there was also the certifiability in medically underserved populations, MUPs. HCFA has gotten rid of that.

Mr. SHAYS. HCFA has gotten rid of?

Mr. TESSEN. The RHC eligibility under the MUP certification process. But when that was in effect, we have "rural health clinics" in downtown Dallas because of the population being poor, impoverished, no work, and no medical services whatsoever.

Mr. SHAYS. I'm not saying we don't have to deal with that problem, but my sense was, this program was not designed for that.

Mr. TESSEN. Right.

Mr. SHAYS. That's all I'm saying. I can make a strong argument that you need to be in Bridgeport, CT, in one sense. But what I don't like is, where people were, in fact, serving the community, they decided to be under a new system that gave them a greater reimbursement. I do think you're making the point of older physicians selling.

Mr. TESSEN. Retiring.

Mr. SHAYS. Retiring, and then a clinic coming in. You have answered one question. All three of you answered one question. To me, it appeared to be a no-brainer, and you're saying, you just need to get into this a little deeper to understand.

Mr. Harward, I'm just going to say to you that I will use you as the test. If we're doing anything or if HCFA is doing anything that would negatively impact your circumstance, then I think we're headed in the wrong direction. So I will use you as the benchmark, in a way, and others like you, because I do want you to go to sleep at night.

Mr. HARWARD. I want to go.

Mr. FINERFROCK. I'm really glad to hear that, because, I mean, for me, personally, Tom is kind of the benchmark. This is where this grandfather clause, I think—if we could spend a little bit of time perhaps on that.

Mr. SHAYS. I don't want to spend too much time. I don't want to grandfather people who shouldn't be grandfathered.

Mr. FINERFROCK. That's right. I don't think we do. But my point is that there are reasons why that grandfather clause was put in there, and Tom mentioned one of them at the end of his presen-

tation, which is that you have PAs and NPs who are staffing these clinics. If you take away the certification from them, there is no mechanism for Medicare, in many instances, to pay for their services.

Mr. SHAYS. I want to let Mr. Towns ask questions. The one thing that I'm going to qualify my own response, I could see where you were truly in what I would call a rural area, serving people that aren't going to get care elsewhere. And I can see how that community can change. And then I can see how you've devoted 20 years of your life. I would be very sensitive to not saying, "Oh, my gosh, no longer should you be there," if you have shown that kind of commitment to the community.

So I think there should be some way to give credit to, and allow for, that individual to continue to practice. The question would be, not that you would decertify, but would you put them on a different reimbursement rate that would be competitive with the area and be fair?

Mr. FINERFROCK. I would agree. There has got to be some kind of a glide path or some mechanism for transition. I just saw it earlier. I mean, HCFA mentioned they are working on legislative proposals. I saw it just as we were coming in here. Their proposal is, you would immediately be kicked out of the RHC program. If your area was decertified as an underserved area, you would be immediately shut down as a rural health clinic, which means he's out of business. My view is, that's too simplistic.

Mr. SHAYS. Would you be put out of business? I'm sorry. I want to get to Mr. Towns.

Mr. HARWARD. If we cannot be reimbursed.

Mr. SHAYS. No, no. It seems to me that you would meet the test of reimbursement.

Mr. HARWARD. I can't be reimbursed unless I'm in a rural health clinic.

Mr. SHAYS. Right. I don't see how your health clinic would be one that would be targeted for decertification, is what I'm saying.

Mr. HARWARD. Not likely, except we have two other rural health clinics in the other end of the community, provider-based clinics. You factor us in as providers—currently we're not factored in, in figuring a medically underserved area—that's going to change the ratio a little bit. It might be a little plus or minus.

I'm not afraid for our clinic to compete, what I'm saying, on the "private" market, but I want an even playing field.

Mr. SHAYS. But you're an independent, correct, or are you provider-based?

Mr. HARWARD. We're an independent.

Mr. SHAYS. So you're not even getting reimbursed at the rate that some of your competition is.

Mr. HARWARD. We don't need it.

Mr. SHAYS. No, let me back up a second. You're not even getting reimbursed at the rate that some of your competition is getting reimbursed.

Mr. HARWARD. No, we're not.

Mr. SHAYS. OK. So I'm just saying it's interesting that you're not upset that others are making more money than you are in this system, that you may tend to compete.

Mr. HARWARD. I might be a little more upset than I show.

Mr. SHAYS. OK. At least your human. I wanted to know.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me thank all of you for your testimony. I know you have heard the comments that were made earlier by GAO and also the Deputy Inspector General. I guess I could start with you, Mr. Harward. I would like to ask each member to tell us how you would correct the problems that GAO and the Deputy Inspector General described earlier.

Mr. HARWARD. The cap is absolutely essential. I mean, the cap is going to take care of a hugh amount of the problem. I think that's important. The designation issue is tremendously important, to be updated regularly. And it's tremendously important to include, on some formula, nonphysician health care providers in this designation. Those are two most important things. Those two things alone, I believe, would give you the kind of cost control that you need and stop the proliferation.

Mr. SHAYS. May I just ask?

Mr. TOWNS. Sure.

Mr. SHAYS. Do you mean new designation, or do you mean decertification?

Mr. HARWARD. The first thing you need to do, I guess, is level it off, OK. And then, in terms of the decertification, I think it has to be on the table. Yes, I agree.

Mr. TOWNS. I want to move to also ask Mr. Finerfrock, and you, too, Mr. Tessen. Before I do that, if a clinic is closed in the State of West Virginia, just assume that it happens, the worst, what happens to the medical records?

Mr. HARWARD. There is no central repository that I'm aware of.

Mr. TOWNS. You are educating us here, too, you know. I want you to know that.

Mr. HARWARD. Yes. They would be locked up somewhere. We would advertise in the paper, you know, when that's going to happen. Once my clinic was provider-based, many, many years ago, and it was one of the very few, one of two or three. And the hospital that I worked for in the early 1980's, before this happened, went bankrupt and closed down. A lot of those records are just sitting in a basement somewhere, and people can't get to them.

So, I mean, you know, they advertised for a while. We've been an independent, private clinic now, or community clinic, since that bankruptcy, for I guess 12 years.

Mr. TOWNS. In other words, they just left the records.

Mr. HARWARD. Yes, sir. Yes, sir. Now, people, when you advertise, would ask that they be transferred to another health care provider, you know, in an adjacent area or the same town. We just don't happen to have any in our town. It would be one of those providers in a nearby town.

Mr. TOWNS. Mr. Finerfrock.

Mr. FINERFROCK. I would agree with Tom that a cap is really important on the provider-based side. One of the other issues that has not been addressed, concurrent with that, is a productivity standard. On the independent clinics, in addition to the cap, clinics are

required to maintain a productivity standard in order to get their reimbursement rate.

That standard is 4,200 visits per year on a full-time equivalency for a physician; 2,000 visits per year for a PA or a nurse practitioner. If they don't achieve that level, then there's a downward adjustment in their payments to reflect that they were not operating at what was considered to be maximum productivity.

In addition to there not being a cap on the provider-based clinics, there is not a productivity standard, the issue I was addressing earlier. So simply imposing a cap on provider-based is not sufficient. There also needs to be a productivity standard, in order to make sure that they are operating efficiently, as well.

In terms of the shortage area issue, I would agree those need to be updated and updated immediately. Short of that, we need to institute into the law, "currently certified," which would be the area has been reviewed in the last 3 years, in order to prevent people from doing a designation based on information that is outdated. It also needs to include the availability of PAs and NPs at some appropriate FTE substitution rate for physicians.

There should be a tie-in notice. Once a clinic is certified, the Health Care Financing Administration should notify the Office of Shortage Designation that that clinic has been certified. Otherwise, what you run the risk of is that, during that 3-year intervening period, you know, people come in and set up multiple rural health clinics when it perhaps was no longer warranted.

So we need to have a mechanism for alerting the Office of Shortage Designation that there may have been a change in the provider availability in that community, so that designation may no longer be appropriate.

We need to create a glide path in order to transition folks off of rural health clinics, if, for some reason, the area is no longer rural or no longer underserved. What I would recommend there is that we look at a situation where they would actually be excess capacity. In other words, you heard earlier that it requires 1 physician to 3,500 population in order for a designation to occur. So if the community exceeds that, if there were 1 physician for 3,000, it would lose its designation.

What I would suggest is that dedesignation wouldn't kick in until you had an infrastructure perhaps that was 1 to 1,500 or 1 to 1,000. In other words, so that you were sure that there was adequate capacity within the community such that losing that designation would not result in them being back as an underserved area, what I refer to as the yo-yo effect. I think Kathy Buto talked about that, where you create an incentive to get someone to an area, then by virtue of being successful at recruiting to the area, the area is no longer underserved, and so we pull away that incentive.

I think those would be my recommendations.

Mr. TOWNS. Just before I leave you, Mr. Finerfrock, how many provider-based clinics do you represent?

Mr. FINERFROCK. You know, I'm not sure. I mean, I don't make that distinction in our membership. We have provider-based on our board, and we have provider-based on our policy committee. But I can find that out for you.

Mr. TOWNS. Mr. Tessen.

Mr. TESSEN. I think there are a couple of things. I think the cap on provider-based is in the right direction, but I would make a case that there should be some sort of exception or level or some differentiation for those rural hospitals that have rural health clinics that are really rural hospitals, out in the middle of no place, that are just struggling to survive with patient loads of one or two patients per day. I mean, we've got to do something to protect the people in the frontier areas and the really rural areas from just pulling out infrastructure across the board.

Mr. SHAYS. May I?

Mr. TOWNS. Yes.

Mr. SHAYS. In a sense that raises the two-tiered approach. Are all three of you comfortable with that approach?

Mr. HARWARD. I would like to respond. You asked do I resent that $20 difference between the people in the other end of the county. One is a rural hospital that's now one of these each piece hospitals. Their bed capacity went from 90 to 12, and they are associated with a distant hospital. They are sort of the junior partner in this program. That clinic is real important to the survival of that hospital, and they do maintain emergency room there, and it's part of their financial base. I think we have to avoid doing things to these small hospitals that could hurt that.

On the same subject, on the question of decertification, it's real important. One of the things that you could do in decertification is just knock the rate to 75 percent of the maximum, if you reach a point. Because these people that are abusing it are way, way above. If you've got the cap and even you limited my community-based clinic to 75 percent of the maximum rate because we hit that magic number where we were no longer served, we could continue to do what we do best, which is community health.

Mr. TESSEN. I think another thing that really concerns me is, we're talking about all kinds of changes in the system without addressing the fact that we aren't following the current system. I mean by that the lack of surveys, the lack of audits, the lack of timely feedback and cost reports, the waivers for the mid-level practitioners are not being enforced. If we change the system and don't address that part of it, we're going to have the same problem. I mean, people are going to go into it, and there's no real way to find out if people are in compliance or not.

I guess my point is, why have a system if we're not going to follow the basics of it, even it's required by regulation and law at this point.

The other thing that I would say is that the NRHA, the National Rural Health Association, has put together a white paper on a whole list of proposals for rural health clinic refinement. I guess that has been submitted as part of the testimony. It is intriguing, in NRHA, the process of devising policies, because I have to sit and argue with the rural hospital folks, and I have to sit and argue with the FQHC people, and I have to argue with the research and education people when we develop policies.

So the policies that are in this NRHA paper are really a real strong reflection of kind of the microcosm that is going on in the whole argument about rural health clinics on a national basis. So these are fairly good, I think.

Mr. TOWNS. Thank you very much.

Thank you, Mr. Chairman.

Mr. FINERFROCK. Mr. Chairman.

Mr. SHAYS. Yes.

Mr. FINERFROCK. You asked about the two-tiered approach. On that, we've had some discussions with the Health Care Financing Administration on that concept of having a different cap and different standards for clinics that are located in what are defined as frontier areas. I think that's a reasonable thing to take a look at.

The only difference I would make, perhaps, on this point, with Sam, is that I don't think that we should make that exclusive to hospital-owned clinics. To me, the payment should be based on the services that you are delivering and the care that you are delivering. The ownership of the clinic shouldn't make that distinction.

So if we're going to create this level playing field—I just got a call the other day, a physician in the Upper Peninsula of Michigan is 40 miles from the nearest town of any size, he's by himself, could really use to be a rural health clinic, but can't be for a variety of reasons. If you were to do the two-tiered approach, I suspect that he would be able to do that and make it attractive. He's on the verge of leaving that community, and I think that kind of an approach would really help.

Mr. SHAYS. I just wonder, in that case, if knowing that we might change the rules to benefit him would keep him there.

Mr. FINERFROCK. We might.

Mr. SHAYS. The process is still going to take so long.

Mr. FINERFROCK. It will, but it may keep him there.

I think another point needs to be made. There was a reference to managed care, I think, by one of the earlier witnesses, that perhaps the growth was a result of managed care and the concern about that. I think we also have to consider the Health Care Reform plan that the Clinton administration proposed back in the first Clinton administration.

The reason I say that is, in that plan there was a proposal to create facilities that are called, "essential community providers," and that those "essential community providers" would have special status when it came to negotiating with managed care or any plan that the Clinton proposal was going to put into that community. And rural health clinics were automatically defines as an essential community provider.

I think, for the same reason that you were suggesting that the prospect that we might be able to do something for that physician, might encourage him to stay in, I think the prospect that the government was going to create this "essential community provider" category and give you special status for purposes of negotiating with managed care also was an incentive to become a rural health clinic, even though they didn't intend to expand their services to Medicare and Medicaid. They were looking down the road, trying to provide some kind of a special status for themselves when the world, as they new it, was going to change.

Mr. SHAYS. Very interesting.

We have been joined by Mike Pappas, from New Jersey, a new Member, and a wonderful new Member. I don't know if you would like to just enter into this dialog or just say hello.

Mr. PAPPAS. Yes, if I could, Mr. Chairman.

Mr. SHAYS. Sure.

Mr. PAPPAS. Thank you. I'm sorry for getting here late.

You may have covered this, but if you would bear with me, I understand there is a program called Partnership for Rural Opportunities. I'm wondering if you folks, in various capacities, are familiar with it and, if so, if there has been any work with them?

Mr. SHAYS. This may be a viable program none of you have heard about, but we are continually learning of government programs that we voted for, right?

Mr. PAPPAS. As I understand it, it's a division within the Department of Health and Human Services.

Mr. TESSEN. Never heard of it.

Mr. FINERFROCK. I'm not familiar with it.

Mr. SHAYS. Is there anyone in our audience who might know?

Ms. RAPP. I know.

Mr. SHAYS. If you don't mind just coming up. We won't even swear you in. I'm just curious.

Ms. RAPP. I won't go to the front.

Mr. SHAYS. No, no. We need you to be in the mike here. Just identify who you are.

Ms. RAPP. I'm Jennifer Rapp. I'm the government affairs director for the National Rural Health Association here in Washington. We work closely with the National Rural Development Partnership, which is affiliated with the PRO. The PRO was formed within the Department of Health and Human Services by a number of divisions within HHS. The Federal Office of Rural Health Policy belongs, so do several of the other divisions within HHS. They formed this group to kind of cut across division barriers, but to look at rural issues department-wide.

So I know what the group is, and we have had communication with them. They are a relatively new group. I think they just started holding meetings within HHS about 6 months ago.

Mr. SHAYS. Do you want to pursue that a minute?

Mr. PAPPAS. Yes. I just would be curious, these folks who are very involved, on the witness stand—what effort is going to be made to—if folks such as these should be made aware of this. I'm assuming this new conglomeration has been established to try to, say, improve the situation. Their input may be helpful. Do you know?

Ms. RAPP. So far they have involved outside groups through the larger, National Rural Development Partnership, which there is a Washington component called the National Rural Development Council, which I sit on. They, in the past year, have invited outside organizations such as other associations to sit on the council, indirectly interacting with this department group called the PRO.

So I don't attend PRO meetings, because it's only intra-HHS. But I do participate, and I'm sure other outside organizations could participate through serving on the National Rural Development Council.

Mr. SHAYS. And the purpose of the organization is what?

Ms. RAPP. I think to really have a rural filter. I know the woman who heads it up, in the Office of the Secretary, actually spoke at our meeting on Monday about the group, and she likes to call it

a rural filter for all issues that pass through the Department of Health and Human Services.

I would also like to mention that I think Jake Culp, from the Federal Office of Rural Health Policy, is here, and he participates.

Mr. SHAYS. Would you like to just comment on this?

Mr. CULP. I could just say one more thing.

Mr. SHAYS. Let me just say this to you. You're going to come up here, but just would you say your name again so our recorder has it. Do you have a card?

Ms. RAPP. Yes, I do. It's Jennifer Rapp, R-a-p-p.

Mr. SHAYS. And you represent?

Ms. RAPP. I'm the government affairs director for the National Rural Health Association.

Mr. SHAYS. And you, sir, are?

Mr. CULP. I'm Jake Culp. I'm with the Office of Rural Health Policy. I work with Dr. Puskin, who was here testifying earlier.

Mr. SHAYS. Now, did you want to make a response?

Mr. CULP. Yes. I would just like to elaborate. Jennifer got at that. This is a group that was formed, I think it's about 9 or 10 months ago, and it's serving two purposes in our Department, in my view.

The first purpose is to get all of the various components of the Department together on a regular basis, who have something to do with rural health care, and that's a lot of us. That's the Health Care Financing Administration, that's our office—we're in another part of the Department, the Health Resources and Services Administration—the Administration on Aging, another part of the Department that also has some rural interest. So it's an opportunity for us to come together, and the leadership for that is provided out of the Office of the Secretary.

One of the goals of the group that's a little different is, we've been working hard over the years, our office and the Department, as well, to get a close tie-in between economic development issues in rural issues and health. The Department of Agriculture, for example, has agents out there in small rural communities all over the country, and we're trying to work with them to make health a part of their agenda as they work on local economic development issues in small communities. So this group also has that role, to work closely with the Department of Agriculture and other parts of the executive branch on rural health care kinds of issues.

It's a very important activity.

Mr. PAPPAS. Thank you. One of the things, I think, that could be done to maybe even improve what I think is a very worthwhile effort is to provide some sort of a mechanism where people out in the community could then be given a forum to maybe express what their views are as to what the various Federal programs do or don't do.

Ms. RAPP. May I make one comment about that? State rural development councils do sit on the larger body. So within each State there is a State rural development council, and that's kind of the ground-up approach.

Mr. PAPPAS. OK. Thank you, Mr. Chairman.

Mr. SHAYS. You're welcome. I will say, I've broken my rule, not swearing in two witnesses here, but circumstances dictated that. Thank you both very much.

I want to ask if there is anything you wish we had asked you, that you wanted to make a point on before we close up here. You have given a nice definition to the hearing, and I thank you all for being here. Is there any closing statement you want to say?

Mr. TESSEN. I would just invite members of the committee or their staffs to come out and visit some real rural health clinics, like Tom's or some others. Some are closer.

Mr. PAPPAS. Easy for you to say.

Mr. SHAYS. Be careful. He's from Texas.

Mr. TESSEN. I think that rural health clinics, in reality, are really interesting animals, and I think that seeing them in operation is an experience to behold.

Mr. SHAYS. As you were testifying, particularly Mr. Harward, I was thinking that it would be important for us to find a way to visit a few. I have, obviously, seen community-based health care clinics who do some of the same stuff.

Any other comments?

Mr. FINERFROCK. If I could. In the testimony that Dr. Gaston presented, she made reference to the fact that the Department was going to now incorporate PAs, NPs, and CNNs into the designation process. If you could get clarification, in the written testimony, there was a caveat that was not addressed in her oral presentation, which was, once we feel that there is sufficient data.

I don't think that that should be taken lightly. I think there is data. They have suggested that there is not sufficient data. We've done some checking around. Tom was on the medical board in West Virginia and can provide accurate information there.

I would be remiss to Congressman Towns if I didn't acknowledge your efforts on the part of correcting the problem for Medicare reimbursement for PAs and nurse practitioners outside of the rural health clinic. You have been a real leader on that issue. I know last year, as part of the budget act, that provision was adopted by Congress, through no small effort of yours, and I know the PA and NP communities are very appreciative of everything that you have done in that regard.

Mr. SHAYS. He's a good guy.

Mr. FINERFROCK. The last thing I just wanted to say is that Tom's calm demeanor, he has earned that honestly. Tom is the father of 15 kids.

Mr. TOWNS. No wonder he's so calm.

Mr. FINERFROCK. Anybody who can survive that experience—ranging in age from 9 to 33—anybody who can survive that experience, I think coming before Congress is probably a piece of cake.

Mr. HARWARD. Actually, when they left home, we would be dedesignated. [Laughter.]

Mr. TOWNS. Mr. Chairman, if I could just ask one quick question.

Mr. SHAYS. Sure.

Mr. TOWNS. I'm concerned that there seems to be no continuity in terms of records, when facilities close and facilities consolide. What happens to records in your area? Because I think it's some-

thing we're going to have to look at, at some point in time, as to what happens to records when facilities happen to close.

Mr. TESSEN. As I understand it, legally, medical records are the property of the owner of the clinic. I guess there's legal precedent for that someplace. If whoever owns that clinic, whatever clinic it is, rural health clinic or anything else, if that clinic closes or anything else, those medical records remain the property of that owner.

Mr. HARWARD. They should go to the patient. I mean, you can mandate that they go to the patient if the facility closes. If they have not assigned them to another provider, it's pretty simple. You know, if they choose to abuse them or throw them away, that's their problem. It's simple enough.

Mr. TOWNS. What I'm thinking about, see, most clinics or most hospitals do not close down with everyone elated over the fact that it's closing. It generally closes, and people are upset, the union is involved, and everybody is mad. I can sort of picture them throwing the records out the window. I think that somewhere along the line we have to have a uniform way of doing this as we move along. I don't know exactly what we need to do, but I think it's something we need to investigate.

Mr. FINERFROCK. I know you have a background in hospital administration and medical records. I've heard you raise this issue at other hearings, and I think you're right. This is not the first time. I mean, a couple years ago I heard you raise this issue.

The whole area of medical records is getting a lot of attention now, in terms of privacy, and security, et cetera, and computerization of medical records. I think you talk to the health professionals and see. It's not something we've looked at, but I think it's a serious issue. My understanding is that each State handles it differently. It's an area that is governed, at the current time, by State law.

Mr. SHAYS. Let me ask, before we close up, is there anyone from the GAO's office here? Anyone from the Inspector General's Office here?

I'm not going to ask you to come up. Thank you for staying.

Is there anyone from HCFA or the Health Resources and Services Administration?

I just want to thank you for staying. I appreciate your doing that, because the third panel deserves to be heard by the people that ultimately impact your lives. So thank you for staying.

Thank you all. We will call this hearing to a close.

[Whereupon, at 4:20 p.m., the subcommittee adjourned.]