

Profile of Rural Health Clinics and Federally Qualified Health Clinics in Minnesota

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are considered lifelines for many rural communities that otherwise may not have access to health care services. This profile explains the overall mission of RHCs and FQHCs and presents what is known about Minnesota's own RHCs and FQHCs.

Rural Health Clinics

In 1977, under federal legislation, the Rural Health Clinic Services Act (Public Law 95-210) was enacted to increase and ensure the availability and accessibility of primary health care services to rural areas by establishing Rural Health Clinics (RHCs). RHCs ensure the delivery of essential medical services in communities that are both "rural" and "underserved."

To be federally certified as a RHC, a clinic must:

- be located in a non-urbanized area as defined by the U.S. Bureau of Census (population is less than 50,000), and located in a designated health professional shortage area (HPSA), or a medically under-served area (MUA), or a Governor Designated Shortage Area.
- be capable of delivering outpatient primary care services furnished by either a physician, physician assistant (PA), nurse practitioner (NP), Certified Nurse Midwife (CNM), a clinical psychologist and/or clinical social worker (CSW).
- employ one mid-level provider onsite 50 percent of the time the clinic is open.

Quick Facts:

- ◆ According to the 2000 Census, rural Minnesotans make up 29% of the state's population.
- ◆ Rural residents are less likely to obtain certain preventive services and are further behind urban residents in meeting Healthy People 2010 objectives.¹
- ◆ As of 2003, there are 62 Medicare Certified Rural Health Clinics (RHC) in Minnesota and 22 are located in communities with a designated Critical Access Hospital (CAH).
- ◆ A total of 27 Federally Qualified Health Clinics (FQHCs) currently exist, three of which can be found in communities with a designated CAH.
- ◆ As of 2003, 22 (32%) counties outside a Metropolitan Statistical Area (urbanized area with a population of 50,000) in Minnesota contained at least one region officially designated as a Health Professional Shortage Area (HPSA).
- ◆ According to the Minnesota Primary Care Association, roughly three out of every four patients visiting a Federally Qualified Health Center has an income below 200 percent of the federal poverty level.

¹ Casey M, Call K, Klingner J. *Are Rural Residents Less Likely to Obtain Recommended Preventive Healthcare Services?* American Journal of Preventive Medicine, 2001; 21:182-188.

- receive medical direction from a physician who reviews the clinic’s services and is present onsite at least once every two weeks. Other necessary requirements include credentials, licensure, a governing policy and referral arrangements.

Before a clinic can be considered for federal approval, it has to meet the above RHC eligibility criteria as well as submit the necessary paperwork and undergo an onsite survey by the state. Final decisions are made by the Centers for Medicare and Medicaid Services (CMS) based on the state’s recommendation.

RHCs can be either independent, freestanding clinics or provider-based, and ownership can be private, non-profit or public. A provider-based RHC is part of a hospital, skilled nursing facility, or home health agency participating in the Medicare program and operates under the same licensure, governance, and professional supervision as other divisions within the provider facility. RHCs also can operate in a permanent or mobile facility.

Currently, 34 (58 percent) RHCs in Minnesota are provider-based while 28 (52 percent) are independent. Nationally, independent RHCs outnumber provider-based RHCs (53 percent to 47 percent). During the mid-1990s, Minnesota experienced substantial growth in the number of RHCs. Currently, 62 RHCs exist statewide. See Maps 1 and 2.

Out-patient primary care, therapeutic, diagnostic, basic laboratory services, emergency care for acute injuries or illnesses and prearranged hospital specialty care are core RHC services that receive enhanced reimbursement from Medicare and Medicaid. The law also authorizes Medicare and Medicaid reimbursement for professional services of physicians, NPs, PAs, and CNMs. Subsequent amendments to the RHCS Act allowed the services of clinical psychologists and social workers to be covered as well. Items listed as non-core RHC services include durable medical equipment, ambulance services, prosthetic devices, and speech and occupational therapy. Operating expenses are excluded as well.

Reimbursement to RHCs is based on an “all-inclusive payment rate,” which may increase a clinic’s revenue. All visits, regardless of whether they are private pay, Medicare, Medicaid or charity care, are used in determining the payment rate. Providers turn to the RHC program for its cost-based reimbursement system, which allows them to continue to provide health care services to the rural poor and elderly, despite some associated drawbacks. See Table 1.

Table 1. Considerations when converting to a RHC:	
<ul style="list-style-type: none"> • Cost of operating the RHC (depending on the hours of operation). • Major cost of staffing clinic. Physician cost ranges anywhere from \$6000 to \$140,000 depending on services and \$40-60,000 for one mid-level provider. • Basic operating costs range from \$75,000 to \$150,000. • Delays in reimbursement from Medicare and Medicaid can range from 60 to 120 days or more. • Amount of community support. 	
<small>Source: Oregon Office of Rural Health</small>	

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are distinct from Rural Health Clinics. Often regarded as “safety net providers,” FQHCs provide essential medical services to the most disadvantaged and vulnerable populations. FQHCs must serve medically underserved areas (MUAs) or a medically underserved population (MUP) and meet program requirements in clinical management, governance, and financial management. Health centers that meet these criteria are federally funded under the Public Health Service Act Section 330 or Indian Health Service. FQHCs may be located in urban as well as rural communities. The Omnibus Budget Reconciliation Act (OBRA) of 1989 designated FQHCs as those centers that were being federally funded to provide health care services to Medicaid beneficiaries. OBRA 1990 expanded this to include services received by Medicare beneficiaries as well.

Health centers that comply with all the requirements to be a community health center but do not receive Section 330 funds also are qualified for FQHC designation and are classified as Federally Qualified Health Centers Look-Alikes (FQHC Look-Alikes). FQHC Look-Alikes are eligible to receive cost-based reimbursement from Medicare and Medicaid and participate in the Federal Drug Pricing Program, which guarantees discounted drug prices agreed upon by participating drug manufacturers.

All FQHCs are required by the federal government to provide low cost health care to patients regardless of ability to pay. Basing fees on a sliding scale is common. FQHCs must be either private nonprofit organizations, tribal or governmental entities. Some FQHCs only serve special populations, such as migrant workers or the homeless. Most FQHCs provide services at multiple satellite delivery sites some of which are facilities in counties other than the location of the main clinic. There were 13 FQHCs with 38 satellite service delivery sites in 2002 in Minnesota. Additionally, Minnesota has four FQHC look-alikes with three satellite clinics. See Map 2.

In Minnesota, FQHCs include ten community health centers, two health programs for the homeless, one migrant health program, one public school health program, and one public housing assistance program. See Table 2. Although FQHCs are open to everyone, they must provide culturally

competent comprehensive primary care services to all age groups and serve a medically underserved population (MUP) or be located in designated medically underserved areas (MUAs) where a majority of the patients are likely to be uninsured or

Program Type	7-County Metro	Greater Minnesota	Grand Total
Community Health Center	7	3	10
Migrant Health Center	0	1	1
Health Care for the Homeless	2	0	2
Healthy Schools Healthy Communities	1	0	1
Public Housing Primary Care	1	0	1
Satellites Clinics (located in MN only)	22	16	38
Grand Total	33	20	53

underinsured. While only 5.4 percent of Minnesota's population is uninsured, some rural counties have some of the highest uninsurance rates in the state.¹ There are 61 FQHC sites, including satellite sites, delivering primary care services in Minnesota. In 2000, FQHCs were reported to "serve nearly 125,000 people living in Minnesota."²

It is acceptable to convert from a FQHC to a RHC and vice versa, but a facility cannot be both simultaneously. All FQHCs are obligated to provide comprehensive primary care directly, by contract or through formal referral arrangements. Preventive health care along with basic lab, dental, x-ray, mental health and substance abuse are among the core medical services FQHCs provide. As an FQHC, a health center can bill Medicaid and Medicare for the actual cost of providing these core services to patients. "Support services" such as childcare, transportation, and housing assistance are sometimes offered in addition to basic primary care services.

RHCs and FQHCs and Critical Access Hospitals

Access to health care oftentimes is the defining factor for establishing RHCs and FQHCs. The U.S. Department of Health and Human Services' *Healthy People 2010* prevention agenda lists health care access as a leading health indicator of the nation's health status.³ Another federal program, the Rural Hospital Flexibility Program (Flex Program), also is intended to preserve a rural community's access to basic primary health care services. The Flex Program, which promotes the coordination of rural health care services by designating Critical Access Hospitals (CAHs), presents rural communities with RHCs or FQHCs the additional capacity to develop a coordinated community network of health care delivery. Characterized by their degree of community involvement, RHCs and FQHCs in combination with the Flex Program can help strengthen the rural health infrastructure.

In Minnesota, 22 RHCs are located in the same community as a Critical Access Hospital (CAH). These RHCs are either owned or operated as part of the CAH and designated as a provider-based rural health clinic or an independent rural health clinic. In Minnesota, three FQHCs are in the same communities as Critical Access Hospitals (CAHs). These FQHCs are independent from the CAHs and receive 330-grant funding from the Bureau of Primary Health Care. They also have community boards and offer sliding fee scale discounts.

The remaining 20 CAHs most likely don't qualify for either program because their location is not in a Health Professional Shortage Area or Medically Underserved Area.

¹ Health Economics Program, Minnesota Department of Health, *2001 Health Insurance Coverage for Minnesota Counties*, Issue Brief #2002-5, Dec. 2002.

² Minnesota Primary Care Association, *The Role of Needs Assessment in Addressing Health Disparities – The Community Clinic Experience*, June 28, 2001.

³ U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

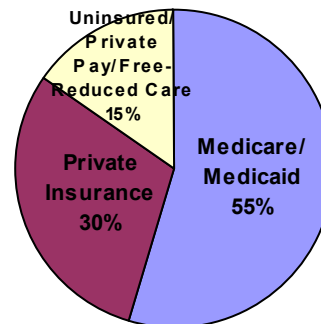
Issues

An undersupply of medical practitioners and an older, uninsured, poorer rural population with declining health conditions are some of the challenges that RHCs and FQHCs currently are facing. Additionally, the rural population is more reliant on Medicare compared to their urban counterparts.⁴ These demographic issues are contingent on a single factor: the financial sustainability of RHCs and FQHCs.

Both RHCs and FQHCs are regarded as safety net providers given a vast majority serve the health care needs of public program enrollees and the uninsured. According to the Minnesota Primary Care Association, “4 out of every 5 patients receiving care [in 2000] at a FQHC are either uninsured or enrolled in a public health program.”⁵ A national survey of RHCs revealed that Medicare and Medicaid account for slightly more than half of RHCs’ revenue volume. See Figure 2. Both programs contrast with the general populace where private insurance is a commonality for a majority of Minnesotans. See Figure 3.

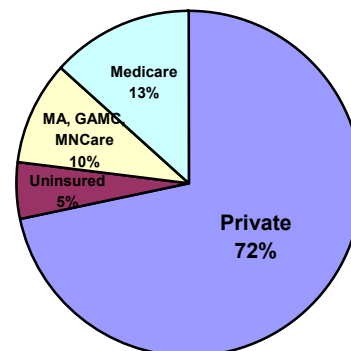
Some RHCs and FQHCs face financial challenges despite enhanced reimbursement. It should also be remembered that cost-based reimbursement covers only the costs of providing health care services to Medicare and Medicaid patients. For example, “51 percent of independent RHCs and 55 percent of provider-based RHCs wrote off 0 to 4 percent of total charges as free and reduced cost care during 2000.”⁶ Additionally, rural Minnesota’s large and growing elderly population is expected to intensify as the baby boomer generation ages and starts retiring. Current and proposed payment methodologies of federally funded programs like Medicare lack the economies of scale making it more difficult for RHCs or FQHCs operating in rural Minnesota. RHCs and FQHCs in rural areas typically do not have the patient volume or the

Figure 2.
Rural Health Clinics (RHCs) Percentage of Revenue, United States, 2000



Source: 2000 National Survey of Rural Health Clinics
Edmund S. Muskie School of Public Service, University of Southern Maine

Figure 3.
Minnesota Insurance Status, 2001



Source: MDH, Health Economics Program

⁴ National Rural Health Association, *Rural America’s Health Care Safety Net Providers*, p.3.

⁵ *The Role of Needs Assessment in Addressing Health Disparities: The Community Clinic Experience*, Minnesota Primary Care Association, June 28, 2001.

⁶ University of Southern Maine, Edmund S. Muskie School of Public Service, *The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook*, January 2003; p 29.

benefit of “cost-shifting” services to private insurance revenue sources, or, in the case of RHCs, obtaining other financial resources such as grants. Therefore, enhanced reimbursement sufficient to cover all costs, including safety-net services, provides additional financial support intended to protect both the financial stability and availability of these rural health providers.

RHCs serve an important role by providing health care to primarily rural, underserved communities. FQHCs extend these efforts by targeting preventive and primary health care to the more vulnerable populations such as low-income, homeless, uninsured, and migrant workers. Both are essential to the provision of adequate health services in rural communities.

Resources

Publications:

National Rural Health Association, *Rural Health Clinics in Rural America*, Issue Paper, February 1997.

U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

Minnesota Primary Care Association, *The Role of Needs Assessment in Addressing Health Disparities The Community Clinic Experience*, June 28, 2001.

Minnesota Department of Health, Health Economics Program, *2001 Health Insurance Coverage for Minnesota Counties*, Issue Brief 2002-05, December 2002.

University of Southern Maine, Edmund S. Muskie School of Public Service, *The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook*, January 2003.

Regan J, Schempf AH, Yoon J, Politzer R, *The Role of Federally Funded Health Centers in Serving the Rural Population*, *The Journal of Rural Health*. Spring 2003; 19(2) 117-124.

<http://www.health.state.mn.us/divs/orhpc/funding/grants/pdf/rhc.pdf>:

Listing of Minnesota’s Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) managed by the Office of Rural Health and Primary Care. [Eligibility requirements for becoming a RHC or FQHC](#), and links to the Centers for Medicare and Medicaid Services are also provided.

<http://www.narhc.org/>

The website of the National Association of Rural Health Clinics (NARHC). NARHC works with Congress, federal agencies, and rural health allies to promote, expand, and protect the RHC Program. The website is a resource for current federal legislation impacting the rural health clinic program.

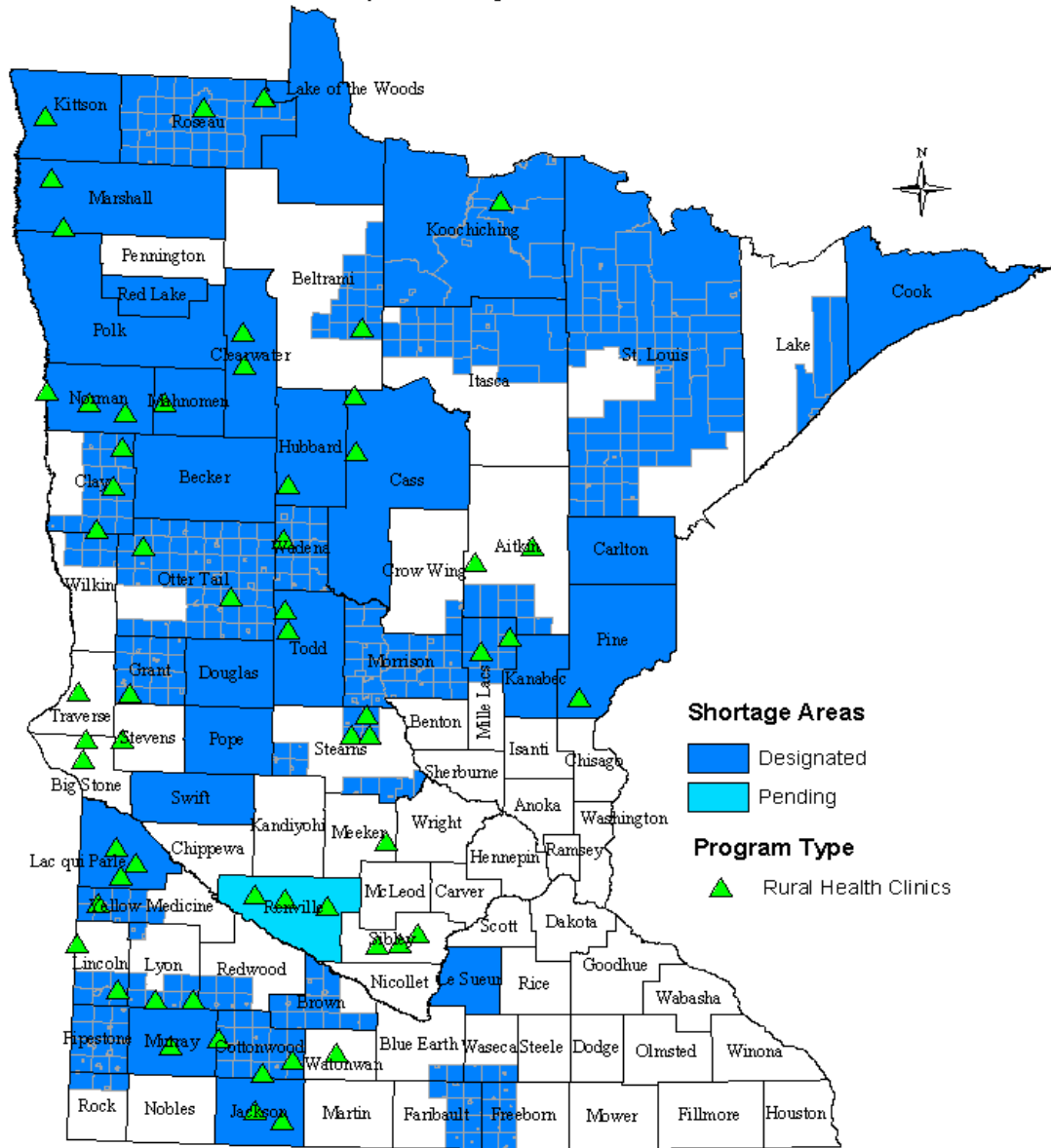
<http://www.healthypeople.gov/>

The publications that set out the goals and objectives of Healthy People 2010, document the statistical basis for the initiative, and provide guidance for its implementation are available online at this website.

Map 1

Health Professional Shortage Areas and Rural Health Clinics (RHCs) Minnesota 2003

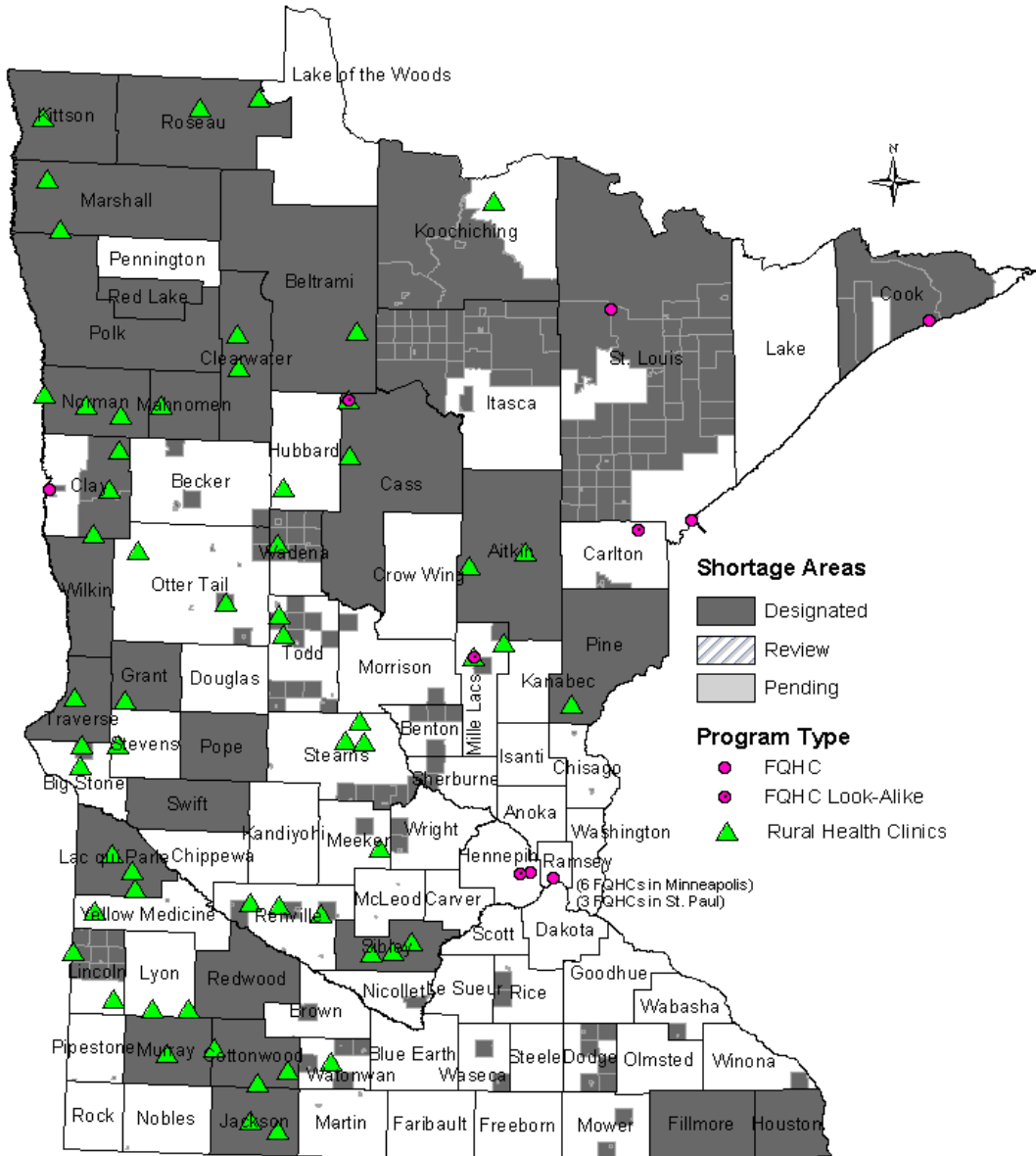
Primary Care Designations



Data Source: Minnesota Department of Health, Office of Rural Health and Primary Care - February 2002

Map 2

Medically Underserved Areas (MUAs), Federally Qualified Health Clinics (FQHCs), and Rural Health Clinics (RHCs) - Minnesota 2003



Data Source: Minnesota Department of Health, Office of Rural Health and Primary Care