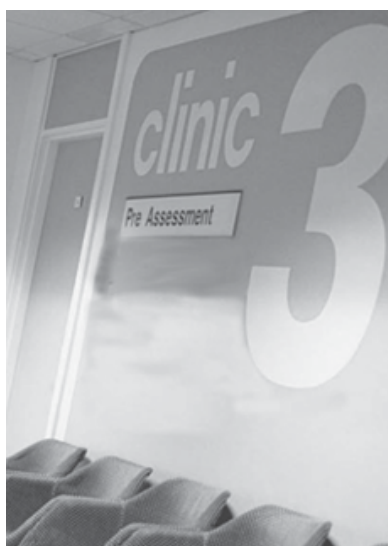


The Sustainability of Rural Community Health Service Providers



The Center for
Rural Pennsylvania
A Legislative Agency of the Pennsylvania General Assembly



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By:

**Linda K. Kanzleiter, D.Ed. and Myron R. Schwartz, M.A., Penn State College of Medicine,
and Hleziphi Naomie Nyanungo, Ph.D., Pennsylvania State University**

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Executive Summary

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The general goal of this research was to describe the role that health centers play within the health care delivery system in the commonwealth and to consider the factors that may affect the sustainability of that role.

To conduct the study, the researchers surveyed key informants from Certified Medicare Rural Health Clinics and Federally Qualified Health Centers in Pennsylvania. They also used secondary data to complement the survey findings.

In general, the research found that health centers function as safety net providers, offering health care services to underserved populations. They are widely distributed across the commonwealth, are located in areas of need, and provide services to underserved populations.

In rural areas, the health centers' safety net function is primarily related to their location in areas of low provider supply. In urban areas, the health centers' safety net function is primarily related to their service to economically disadvantaged populations.

Health centers tend to function as more than a vendor of health care services as they are part of the culture of the communities in which they are located.

In general, rural health centers differ from urban health centers as follows: (1) they offer a more restrictive range of services, (2) they have a more restricted provider mix, (3) they have a less diverse revenue portfolio, (4) they experience more difficulty in recruiting and retaining providers, (5) they are economically more vulnerable, and (6) they have a greater probability of participating in the education of health care providers.

According to the research findings, the sustainability of health centers depends on several factors including the ability to recruit and retain appropriately motivated providers, the ability of the centers to remain financially stable, and their integration in their community.

Introduction

The health care delivery system in the U.S. consists of many different types of health care provider institutions. Some are defined by the type of service they provide. For example, hospitals provide emergency and acute care, skilled nursing facilities provide long-term care for more chronic conditions, and many physician offices and clinics provide general health care and prevention, commonly called primary care.

Although most institutions offer services to the population at-large, some provider institutions are defined by the populations they serve. For example, children's hospitals serve children, and other institutions provide health care to underserved populations. Institutions that provide health care to underserved and vulnerable populations are sometimes called "health care safety nets," since those who use these facilities often find it difficult to obtain care elsewhere.

Federally Qualified Health Centers (FQHC) and Certified Medicare Rural Health Clinics (RHC) are part of a larger system of health care providers that offer primary care services to underserved populations. In addition to FQHCs and RHCs, collectively known as "health centers," charity clinics offer care to underserved populations. While charity clinics have a presence in the commonwealth, health centers are the principal component of the safety net system for underserved populations.

Populations are considered underserved when they experience difficulty in accessing health care services because they are publicly insured through Medicaid, are uninsured, reside in areas with a low supply of health care providers, or otherwise experience compromised access.

Underservice is a consequence of market mechanisms that do not provide equitable access to health care services in rural areas and to the medical assistance and uninsured populations. As a response, the federal and state governments instituted a variety of programs to fix this inequity. FQHCs and RHCs are two of these programs. Both are federal programs and are supported by the commonwealth through special medical assistance reimbursement and through administrative support.

The enabling legislation and regulatory structure of these two types of health centers share a common overall goal, although each has unique secondary goals. The common goal is an increase in access to primary health care services for underserved populations.

RHCs are specifically designed to increase access in rural areas, which typically have a low supply of primary care physicians. RHCs promote the use of mid-level providers in achieving this goal. Mid-level providers are semi-independent, non-physician health care providers and include physician assistants, nurse practitioners, and nurse mid-wives. Mid-level providers have the authority

to treat patients and prescribe medications in the absence of a physician but are required to collaborate with a physician.

FQHCs, primarily through an associated grant program, were designed to extend primary health care services to the uninsured population and to the medical assistance population. FQHCs do not specifically target rural areas; rather they are intended to serve areas in which there is a shortage of primary health care providers or areas characterized by a relatively high health care need.

The federal Rural Health Clinics Act (P.L. 95-210) was passed in 1977. As previously stated, the establishment of RHCs encouraged the use of mid-level providers. By regulation, a mid-level provider must be available for at least half of the clinic's operating hours. Additionally, the law provided reimbursement for services these health professionals provided to Medicare and Medicaid patients. At that time, reimbursement to mid-levels was either inconsistent or not allowed.

The legislation also modified the method under which clinics were reimbursed for Medicare and Medicaid services. Before the passage of the Rural Health Clinics Act, health centers were reimbursed through a fee-for-service methodology. However, government reimbursement for services often did not cover the costs associated with the care provided.

The new methodology, known as "cost-based reimbursement" and established under the Rural Health Clinic Acts, reimbursed for all allowable costs incurred in the provision of core services. Cost-based reimbursement was more beneficial to the clinic than was fee-for-service reimbursement.

In 2000, the reimbursement methodology again was changed, this time to a Prospective Payment System (PPS). The effect of PPS reimbursement on health centers varies by clinic and by state. One goal of this study was to investigate the effect of PPS reimbursement on health centers.

FQHCs qualify for special reimbursement with respect to the Medicare and Medicaid services they provide. There are two types of health centers in Pennsylvania that participate in the FQHC program. The first are health centers receiving grants under Section 330 of the Public Health Service Act. These health centers include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, Ryan White Aids Clinics, and Public Housing Primary Care Centers. By receiving a Section 330 grant, health centers are enrolled in the FQHC reimbursement program.

The most common type of health center funded under Section 330 is the Community Health Center (CHC). CHCs offer services to the entire community in which they are located and are required to provide a broad range of primary care health services on a sliding-fee

schedule¹ in exchange for a federal grant. The grant helps ameliorate the loss of income resulting from the sliding-fee payment schedule and assists in the general operation of the clinic.

The second type of health center participating in the FQHC program is the FQHC look-alike, which is intended to provide services to a more restricted population than CHCs. The clinic must formally apply and be accepted into the FQHC program to obtain look-alike status. Community health centers are sometimes referred to as FQHCs, but FQHCs include more types of health centers than the traditional community health center.

There are some differences between RHCs and FQHCs that should be noted. First, RHCs can only be located in rural areas and FQHCs are not restricted by the urban or rural status of the health center. The definition of rural for the rural health clinic program is non-urbanized. Non-urbanized refers to all areas outside of the densely settled areas in and around metropolitan cities. Second, RHCs may be located in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) and FQHCs can only be located in a MUA.^{2,3} Third, FQHCs must have a board of directors with community representation. RHCs are not required to be governed in this fashion. Fourth, FQHCs must be publically owned or non-profit and RHCs may be for-profit.

Despite the differences between RHCs and FQHCs, their role in providing primary health care services to underserved populations is the same.

There are two important populations that health centers serve that define them as part of the safety net system. They are the Medicaid population and the low-income uninsured population (sliding-fee scale qualifiers). Some health centers, such as CHCs receiving 330 Grants, receive a federal grant to help pay for the losses they incur as they provide services on a sliding-fee schedule to poorer, uninsured patients. Health centers may also receive reimbursement from public insurers, such as Medicaid and Medicare, using a different method than that used for other clinical providers. This special reimbursement was designed to help health centers

accommodate these populations without incurring undue financial loss. As mentioned earlier, the reimbursement methodology⁴ used for health centers has changed twice since health centers were first established.

The reimbursement methodology is extremely important to health centers since these centers serve a disproportionate amount of medical assistance (Medicaid) patients, which affects the lion's share of their clinical revenues. Health centers (for the most part) serve a smaller percentage of Medicare patients than many other providers.⁵ Although reimbursement for Medicare services is very important to health centers, it is less important than Medicaid reimbursement. Also, because Medicare is a federal program (funded by federal monies), it is not under the control of state policy and, therefore, of limited importance to state policy.⁶

Because of the importance of reimbursement methodology to health centers and to state policy, it is a major focus of this research.

Other matters of concern to health centers, with respect to commonwealth policy include: the role of health centers within the safety net system and within the larger health care delivery system, factors affecting that role, and factors affecting the sustainability of that role into the future.

Goals and Objectives

The research was conducted in 2007-2008. The overall goal was to document the role of health centers within the health care delivery system in the commonwealth and to explore the prospects for that role in the future.

The results of this research are intended to contribute to the development of commonwealth policy designed to improve public health in Pennsylvania.

The first objective was to develop a description of these health centers with respect to their geographic distribution, the populations they serve, their role in their communities, and their general institutional characteristics.

The second objective was to describe the role these

¹ A sliding-fee schedule is a differential payment schedule for uninsured patients in which poorer patients pay less than wealthier patients.

² HPSAs and MUAs are two different classification schemes by which areas are formally designated as areas of medical need by the federal government. Official designations based on these two schemes are used in a variety of federal and state programs. Formal designation as a HPSA is primarily based on the local primary care physician supply. In addition to physician supply, formal designation as a MUA considers other social and economic factors. There are population analogs to these two geographically based designations. For HPSAs, this is a population HPSA and for MUAs, this is a Medically Underserved Population (MUP). The population analog is usually directed toward the medical assistance population or the migrant population.

³ FQHCs must be physically located in a MUA (or MUP), while look-alikes must serve populations from a MUA or MUP, but do not have to be located there.

⁴ Reimbursement refers to the payment to health centers for services rendered by government insurers. Reimbursement methodology refers to the general method by which that payment is calculated as well as some of the more specific mechanisms that govern the payment.

⁵ This is most likely because they have such a large Medicaid patient load and, for Community Health Centers, a large sliding-fee patient load. CHCs see only about 16 percent Medicare patients, and RHCs 25 percent.

⁶ The consequences of Medicare reimbursement is important to state government since Medicare reimbursement has the potential to affect the services offered to residents of the state and also may affect the number of providers offering services.

health centers may play within the health care delivery system in the future. That role is largely dependent upon the sustainability of health centers with respect to their financial status, their ability to recruit and retain health care providers, and their ability to offer the health care services required by the populations and communities they serve.

The third objective was to examine the experience of other states and compile relevant policy information that can be used to complement the results of this project.

The final objective was to develop public policy considerations with respect to health centers.

Methodology

The researchers surveyed key informants from Pennsylvania RHCs and FQHCs. They also used secondary data to complement the survey findings.

The researchers developed two surveys, one for RHCs and one for FQHCs. The surveys were similar but were tailored to accommodate the different guidelines and regulations governing each type of health center. The surveys included both open- and closed-ended questions.

To select the participants, the researchers obtained a list of names and contact information for the 48 RHCs certified in Pennsylvania from the Pennsylvania Department of Health.

The Pennsylvania Association of Community Health Centers (PACHC) provided a list of names and contact information for the 137 FQHCs and 30 FQHC look-alikes.

However, there were only 33 administrative units for the 48 RHC sites and only 43 administrative units for all 167 FQHC and look-alike sites, since some organizations operate more than one site (See Figure 1). In this study, multiple health centers operated by a single administrative unit are referred to as health center systems.

The researchers invited all administrative units for all the health centers located in Pennsylvania to participate in this study.

While the focus of the study was on rural health centers, the researchers surveyed urban health centers for comparison purposes and to identify policy issues that affect both urban and rural areas.

About 92 percent of the survey respondents were chief executive officers, directors or administrators of clinics,

and about 8 percent were health care providers. The survey gathered data related to the health centers' characteristics and history, staffing complement, services, patients, financial operations, and public health concerns.

The researchers completed a total of 49 surveys, 23 with administrators representing RHCs and 26 with administrators representing FQHCs.

Secondary data

The researchers used 2000 Decennial Census data to identify the school district where each clinic was located to describe the social and economic characteristics of the people residing in that school district. The data included population by age, poverty status of residents, median income of residents, race of residents, percent of households that receive public assistance, completed education of the adult population, and commuting time.

The researchers chose the school district as the health center's community because it well represents the sociological and service community from which patients are enrolled.

The researchers also used data from the American Medical Association and American Dental Association to determine the local primary care provider supply for the community in which the health centers are located.

Definition of rural

The researchers used the Center for Rural Pennsylvania's definition of rural school districts as follows: a school district is rural when the number of persons per square mile in the school district is less than 274. School districts that have 274 persons or more per square mile are considered urban.

Unit of analysis and analytical methods

Many health centers operate as independent clinical sites and, accordingly, have an in-house administrative structure where billing, records, and decision-making are conducted by on-site staff. This type of structure is characteristic of nearly all independent RHCs. Many FQHCs also operate as independent clinics and are administered in-house. The governing structure of FQHCs is, by regulation, a little more complex than independent RHCs, as FQHCs are mandated to be governed by a board representing the community they serve.

Nevertheless, both RHCs and FQHCs that operate as independent clinics are largely administered in-house and key staff are knowledgeable about the structure, finances, and services provided by the clinic as well as the challenges and opportunities that confront the clinics.

On the other hand, many health centers function as a clinical site within a larger system of clinics. In general, clinics within these systems share resources and a common administrative structure. This is true of most

Figure 1: RHCs and FQHCs in Pennsylvania

	RHCs	FQHC	Totals
Number of Sites	48	167	215
Health Center Systems (Administrative Units)	33	43	76

provider RHCs and many FQHCs. In these instances, health center staff only may consist of clinical providers and support personnel. Therefore, on-site personnel may not be knowledgeable about the structure, finances, and services provided by the health center system. That knowledge would most likely be found with the administrative personnel who may be located at the main site of the system that owns and operates the RHC or the FQHC. Finances, staffing, and planning resources/strategies that are centrally developed and administered affect all health centers within the system, even though individual health centers may have unique experiences and may hold on to some functions of their own administration.

As a consequence of this diversity in administrative structures and the absence of knowledgeable informants at health center sites, the research team chose to select representatives of health center systems as key informants for the survey. Therefore, survey questions addressed the health centers in the system as a group, rather than individually, and asked about the characteristics of the system in general. The result is a unique set of responses for each system and not for each health center.⁷

To optimize the analysis of survey data, the researchers prepared two data sets: one in which the health center system was the unit of analysis and one in which the health center was the unit of analysis.

The analysis of individual health centers better describes the geographic distribution of health centers and more accurately reflects the communities served by the health centers. The analysis of health center systems more accurately describes the challenges and conditions facing the system of health centers in their capacity as a safety net for underserved populations.

Local provider supply

The researchers used a blended municipality methodology to determine provider supply and municipal location estimates. This method estimates the local provider supply for a health center's community by placing the center of the area for which the estimate is being made within the municipality of the health center, but it also considers the areas adjoining the municipality.

The use of traditional methods would typically under- or over-estimate the number of providers in contiguous municipalities that shared providers.

The researchers used the same methodology to estimate the local dentist supply and the local primary care physician supply. Family physicians, most pediatricians, most internists, and most OB/GYNs are considered primary care physicians. A primary care physician is one who treats a broad range of conditions, is a generalist, and is the primary health care provider for a patient.

⁷ Since many of the health centers operate as independent clinics and are not part of a larger system, some survey response sets are associated with only one clinic site.

Results

There are 215 health centers in the commonwealth, 167 are FQHCs/FQHC look-alikes and 48 are RHCs (See Figure 2). About half of all clinics are rural and about half are urban.

When considering the relative size of the rural and urban population, the researchers found that health centers are disproportionately located in rural areas. This disproportionate representation of health centers in rural areas addresses the fact that there are fewer health care providers in rural areas; however, it does not address the absolute size of the uninsured and medical assistance populations.

FQHCs favor urban locations and RHCs, by regulation, favor rural locations.

Figures 3 through 5 display the geographic distribution of health centers. Figure 3 shows the location of all health centers. At least one health center exists in most of the counties in the commonwealth. Figure 4 shows the location of FQHCs and look-alikes, and Figure 5 shows the location of RHCs, which are distributed throughout rural areas of the state, with the exception of the south-east quadrant.

Figure 2: Health Centers by Clinic Type and Rural-Urban Status, 2007

Clinic Type	Urban	Rural	Total
FQHC	89	48	137
	65%	35%	100%
FQHC Look-Alike	17	13	30
	57%	43%	100%
Independent RHC	4	21	25
	16%	84%	100%
Provider RHC	1	22	23
	4%	96%	100%
Total	111	104	215
	52%	48%	100%

Source: Lists provided by the Pennsylvania Department of Health and the Pennsylvania Association of Community Health Centers.

The major goal of the two safety net health center programs is providing primary health care services to underserved populations. Populations experience underservice as a result of two general situations. First, there may be a limited supply of primary care providers in their community and, second, they may have limited access because of their economic situation.

Figure 6 on Page 10 shows that health centers serve

Figure 3: All Health Center Locations (2007)

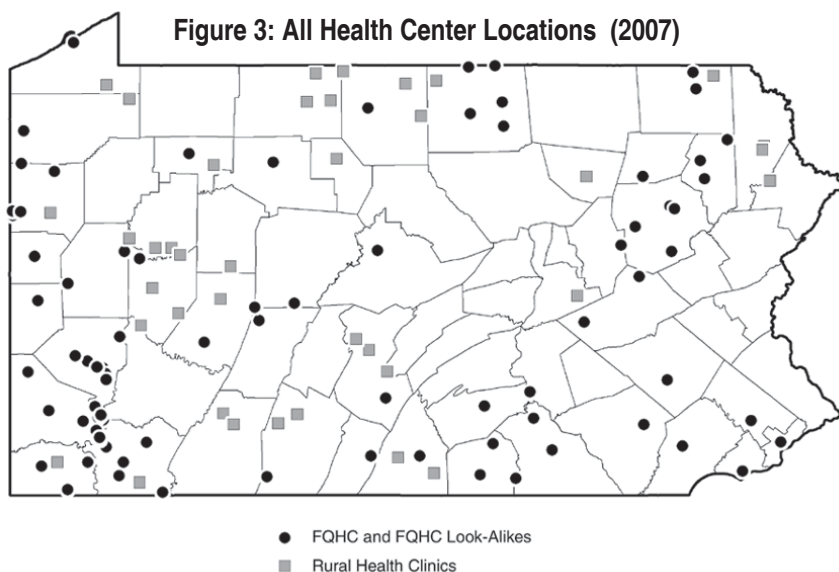


Figure 4: FQHC/FQHC Look-Alike Locations (2007)

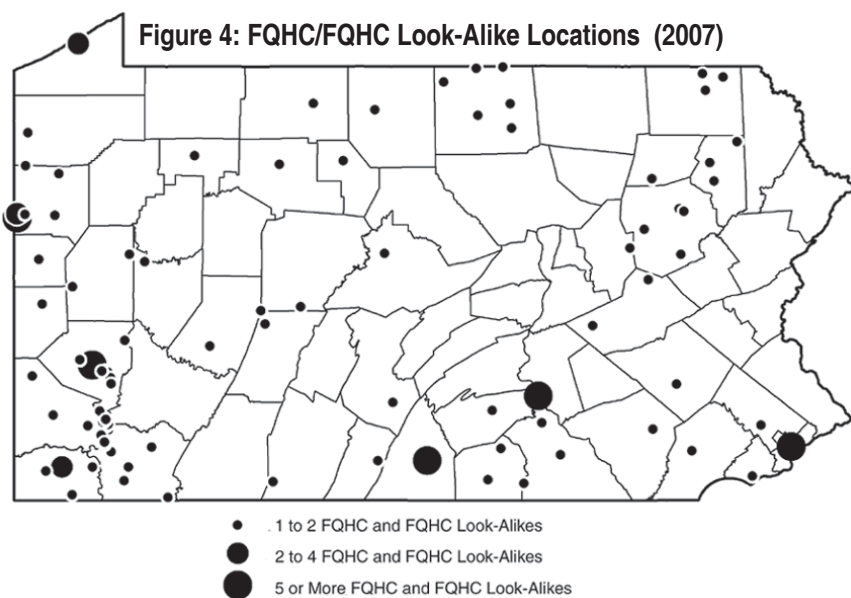
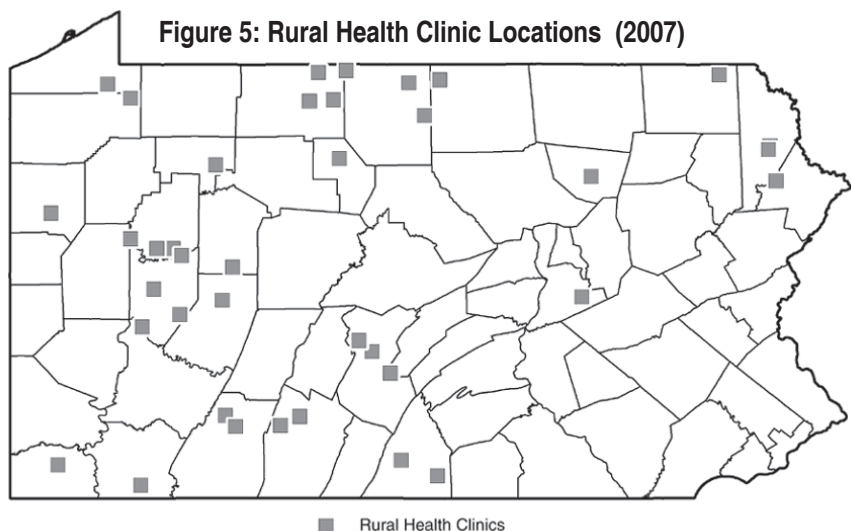


Figure 5: Rural Health Clinic Locations (2007)



communities characterized by populations that have a greater potential for underservice. The figure presents selected characteristics of the communities in which health centers are located and compares this profile with all communities in Pennsylvania. In Figure 6, the school district in which the health center is located is used to represent the health center's community.⁸ Although multiple health centers are located in some communities, such as Philadelphia, each community is counted only once in the calculation of the averages presented in the table.

Figure 6 shows that rural health centers are located in communities that have a higher potential for underservice as a result of the local provider supply, while urban health centers are located in communities that have a higher potential for underservice because of economic conditions.

Health center service to underserved populations is further documented in Figure 7 on Page 10. The medical assistance and uninsured populations are considered underserved populations and often have compromised access to care due to patient choice, inability to pay, or inability in locating a provider willing to provide care.

Figure 7 shows the percentage of all patient visits that are either Medicaid or reduced pay (uninsured) by type of health center and rural-urban status.

In Pennsylvania as a whole, 12 percent of the population is enrolled in Medicaid and 10 percent of the population is uninsured (Kaiser

⁸ All social and economic characteristics are based on decennial Census data for school districts, except provider supply ratios. Provider supply ratios are based on American Medical Association and American Dental Association data and are calculated for the municipality in which the health center is located and a buffered area around that municipality.

Figure 6: Characteristics of Health Center Communities (School Districts)

	School Districts with a Health Center		All Pennsylvania School Districts	
	Urban	Rural	Urban	Rural
Average Population-to-Primary Care Physician Ratio (Blended Municipality)	1,096	2,519*	1,097	2,014*
Average Population-to-Dentist Ratio (Blended Municipality)	1,870	3,961*	1,772*	3,287*
Average Percent Below 200 Percent of Poverty (SD)	35	35	23	31
Average Median Household Income, 2000 (SD)	\$33,885	\$33,540	\$45,277	\$36,432
Average Percent Public Assistance (SD)	4.5	2.7	2.2	2.3
Average Percent White (SD)	77	97	90	97
Average Percent w/ Less Than High School Diploma (SD)	22	21	16	20
Average Commute Time in Minutes (SD)	22	26	24	26

* In at least one school district, there are no primary care physicians or dentists in the community. Therefore, a population-to-provider ratio cannot be calculated and that community is not included in the average. This omission will bias the average ratio presented in a manner that overestimates the supply. Source: 2000 U.S. Census; American Medical Association, 2004; and American Dental Association, 2006.

Figure 7: Percent Medicaid and Reduced Pay Visits by Type of Health Center and Rural-Urban Status, 2007

Rural-Urban Status	Type of Clinic	Average Percent Medicaid/Reduced Pay	Number of Centers
Urban Health Centers	FQHC	71	15
	FQHC Look-Alike	76	4
	Provider RHC	21	1
	Total Urban	69	20
Rural Health Centers	FQHC	34	6
	FQHC Look-Alike	50	1
	Independent RHC	35	8
	Provider RHC	43	6
	Total Rural	38	21
All Health Centers	FQHC	60	21
	FQHC Look-Alike	71	5
	Independent RHC	35	8
	Provider RHC	40	7
	Total All Health Centers	53	41

Family Foundation, 2008). Combined, 22⁹ percent of Pennsylvanians are either enrolled in Medicaid or are uninsured.

In comparison, 60 percent of FQHC visits, 71 percent of look-alike visits, 35 percent of independent RHC visits, and 40 percent of provider-based RHC visits are from patients representing this underserved population. The greater percentage reported for FQHCs is most likely due to their mandate to provide sliding-fee schedule services and their disproportionate representation in urban areas. Rates of Medicaid and sliding-fee visits at urban health centers are nearly twice that found in rural health centers.

Health center characteristics

Health centers may be operated as a single clinical site or as part of a larger system of health centers. The majority of health center systems responding to the survey operated as either an independent health center or was administered as part of a two-health-center system. About 67 percent of all health center systems are one- or two-health-center systems; the remainder is larger systems. This percentage

varies by health center type. Independent RHCs are the most likely of all health center types to be a one- or two-clinical-site system. Ninety-two percent of independent RHCs are one- or two-health-center systems. In contrast, 60 percent of provider-based RHC systems, 67 percent of FQHC look-alikes, and 57 percent of FQHC systems are one- or two-clinical-site systems. Rural health center systems are also more likely to be a one- or two-clinic system than urban health center systems (75 percent vs. 57 percent, respectively). This is important because, all other things being equal, larger systems have a greater ability to absorb financial loss and distribute resources than smaller systems. Consequently, larger systems are more prepared structurally to deal with the demands of reimbursement and recruitment.

In general FQHC systems have been providing services as certified health centers longer than RHCs. On average, FQHCs have been operating as certified health centers for an average of about 22 years, look-alikes about 9 years, independent RHCs about 10 years, and provider-based RHCs about 12 years. Because of the disproportionate representation of FQHCs in urban systems, urban health centers of all types have been in operation longer, on average, than rural health centers. As multi-clinic systems add sites to their system, some sites will have

⁹ The 22 percent represents a percentage that is greater than the potential Medicaid and sliding-fee scale patients in the commonwealth, since some uninsured persons are not eligible for the sliding-fee payment schedule.

Figure 8: On-Site Services Offered by Rural-Urban Status for Health Center Systems, 2007

Type of Clinician	Percent of Systems Total (N=49)	Percent of Urban Systems (N=21)	Percent of Rural Systems (N=28)
Primary Health Care	100	100	100
Basic Lab/Pharmacy	90	91	89
Preventative Health	94	89	100
Oral Health	39	81	7
Mental Health	41	62	25
Social Services	8	19	0

been in operation fewer years than the original sites within the system and fewer years than the system as a whole.

Services and staff

The mandate of health centers is primary care. Accordingly, 100 percent of health centers, regardless of type or rural-urban status, offer basic primary health care services (Figure 8). Similarly, most health centers provide basic laboratory/pharmacy services and preventative health services.

There are, however, significant differences in the provision of oral health services, mental health services, and social services by rural-urban status. In all cases, rural health centers are less likely to provide these services. This is primarily a consequence of these services rarely or never being provided at RHCs.

The range of services required for FQHC certification is broader than that required for RHCs.

These rural-urban service differentials are also reflected in the mix of clinical staff providing services within health center systems (See Figure 9). Physicians, almost universally, are the providers around which medical service is organized. This is reflected in the

Figure 9: Clinical Staff Types by Rural-Urban Status for Health Center Systems, 2007

Type of Staff	Percent of Total Clinic Systems (N=49)	Percent of Urban Clinic Systems (N=21)	Percent of Rural Clinic Systems (N=28)
Primary Care Physicians (Includes OB-GYN)	94	95	93
Dental	35	67	11
Mental Health (Includes Social Worker)	37	57	21
Mid-Level Providers (Includes Nurse Midwife)	92	95	89
Other (Includes Nutritionist, Dietician, Health Educator, Podiatrist, Chiropractor, Optometrist)	18	29	11

nearly universal presence of physicians in a system's health center staff. Only three of the health center systems surveyed did not have a physician on staff. These included a nurse practitioner look-alike clinic in Greene County, an FQHC in Bedford County, and an FQHC in Philadelphia.

Consistent with the types of services provided, rural health center systems are less likely to have staff such as dentists, mental health clinicians, or other types of clinicians. There are substantial differences between urban and rural health centers with respect to the percentage employing dental and mental health clinicians.

Figure 10: Number of Major Clinical Staff Types by Rural-Urban Status for Health Center Systems, 2007

Number of Clinical Staff Types Present	Percent of Total Clinic Systems (N=49)	Percent of Urban Clinic Systems (N=21)	Percent of Rural Clinic Systems (N=28)
One	6	0	11
Two	45	19	64
Three	25	38	14
Four	16	24	11
Five	8	19	0
Total	100	100	100

Although similar differences exist, with respect to mid-level providers, the differences are minimal. This, most likely, is a consequence of the requirement of RHCs to staff this type of provider.

Interdisciplinary care is a favored model of primary care in both medicine and dental care. True interdisciplinary care is designed around a team approach in which providers of different disciplines provide integrated care for a patient. The mere presence of providers from multiple disciplines at a site is not a sufficient condition for the provision of interdisciplinary care, although it is a contributing condition.

Figure 10 shows the number of different provider types on staff at health center systems by rural-urban status. Urban health center systems have a more diverse mix of provider types available for interdisciplinary care than rural clinic systems.

Health centers and clinical education

A major challenge associated with maintaining an adequate supply of health care providers in Pennsylvania is developing the educational infrastructure to train clinical professionals. Representatives of clinical education programs in the state have suggested that the major barrier to maintaining and/or expanding their educational capacity is securing clinical sites for training (Schwartz, 2006). Clinical training sites are a valued commodity and are in great demand by educational institutions.

Figure 11: Health Center Serving as a Training Site for Health Care Professionals, 2007

Does Clinic Serve as a Training Site for Health Care Professionals?	Urban (N=69)	Rural (N=82)	Total (N=151)
No	41%	12 %	25 %
Yes	59 %	88 %	75 %
Total	100%	100 %	100 %

The training of health care students at remote sites¹⁰ is rarely financially compensated and is dependent upon the public service interest of the clinical site and the health care professional conducting the training. Compared to other provider sites, health centers disproportionately volunteer to train health care students.

Figure 11 shows the percentage of health centers conducting health care training by rural-urban status. About 88 percent of all rural health centers and 59 percent of all urban health centers serve as a training site for health care professionals. The high percentage of rural sites is particularly important, since rural training sites are difficult to secure and are a critical educational component of training providers to serve in rural and underserved areas.¹¹

Health center finances

Since all FQHCs and most RHCs are non-profit organizations, they are in a position to secure grants and other funds from government and charitable sources. The most frequent funding sources for health centers (other than clinical revenues) are Section 330 Grants for Community Health Centers and charitable funds (See Figure 12). Each are received by 39 percent of the health center systems. Urban systems are recipients of these funds significantly more often than rural systems. Other significant revenue sources include in-kind contributions from a parent organization, state funds, and other federal funds. State funds are the only category of funds that rural health

center systems receive significantly more often than urban systems. Since rural health center systems have less diversity in their funding sources, they may be more vulnerable to challenges presented by changes in the economy. These challenges include the change in the federal and state reimbursement methodology.

For some time now, rural and small health care provider institutions have been confronted by a tenuous financial environment. Small (100 beds or less) rural hospitals may serve as an example. Thirteen out of a potential 60 hospitals have chosen to become Critical Access Hospitals under the federal Rural Hospital Flex program. To convert to a Critical Access Hospital, a rural hospital must downsize to 25 beds or less and eliminate many of their acute care services. Such a restructuring considerably changes the nature of the institution and the role that it plays in its local community. The reason hospitals choose to convert is a pessimistic financial prospectus and a history of financial loss. The conversion offers preferential reimbursement by government payers

Figure 12: Major Funding Sources for Health Center Systems Other than Clinical Revenues, 2007

Grant Type	Percent of All Clinic Systems Receiving Funds (N=49)	Percent of Urban Clinic Systems Receiving Funds (N=21)	Percent of Rural Clinic Systems Receiving Funds (N=28)
Community Health Center Grant	39	67	18
Individual, Foundation, or Charity	39	52	29
In-Kind	27	33	21
State	18	14	21
Other Federal	10	10	11
City or County	8	19	0
Healthcare for the Homeless Grant	6	14	0
Ryan White AIDS Grant	4	10	0
Migrant Health Center Grant	2	5	0

Figure 13: Current Financial Status by Rural-Urban Status for Health Center Systems, 2007

2007 Financial Status	Status		
	Urban	Rural	Total
Positive or Neutral Balance	17 85%	16 64%	33 73%
Negative Balance	3 15%	9 36%	12 27%
Total	20 100%	25 100%	45 100%

¹⁰ A remote site refers to a clinical training site that is not located at the educational institution and the training is conducted by a professional who is not a core faculty member at the educational institution.

¹¹ The value of remote sites to educational institutions, the difficulty in securing sites, and the value of the sites is based on the experience of the Pennsylvania AHEC program in collaboration with health profession schools. The research literature supports these claims.

Figure 14: Current Financial Status by Type of Health Center System, 2007

Current Financial Status	Type of Health Center System				
	FQHC	FQHC Look-Alike	Independent RHC	Provider RHC	Total
Positive or Neutral Balance	17	4	7	5	33
	85%	67%	70%	56%	73%
Negative Balance	3	2	3	4	12
	15%	33%	30%	44%	27%
Total	20	6	10	9	45
	100%	100%	100%	100%	100%

and increased hope of keeping the institution operating, albeit in a significantly different capacity.

In addition to these critical access conversions, a few hospitals have closed their doors and many more have been purchased or merged with larger regional hospitals.¹² Rural health centers should be considered part of the provider institution class confronted by this fiscal environment.

Figures 13 and 14 present the 2007 operating balances for health center systems by rural-urban status and by type of health center. Just over one-quarter of all health center systems were operating with a negative balance. Rural systems are more likely to be in the negative than urban systems (36 percent and 15 percent, respectively). FQHCs have the most favorable balance sheet; only 15 percent have a negative operating balance. For the other health center types, between 30 and 44 percent are experiencing financial loss.

Health center sustainability

In this study, sustainability refers to the capacity of health centers to maintain essential health care services appropriate for the communities they serve now and in the future.

The data reveal three factors relevant to the sustainability of health centers: community integration, recruitment and retention of clinical staff, and financial viability. Community integration highlights the role played by health centers in the communities they serve. Recruitment and retention of clinical staff and financial viability are two key components in the capacity of health centers to sustain the delivery of health care services to communities.

Community integration

A dominant theme emerging from the interviews conducted with system administrators is the historical

connection that health centers have to the communities they serve.

Health centers provide access to health care services for populations who would otherwise have limited access as a consequence of provider supply, insurance status, ability to pay, or access to transportation.

Administrators also said the patient population served by the health centers consists of a significant portion of uninsured, low-income individuals.

The administrators identified chronic disease and mental and behavioral health as the two most prominent health issues facing communities served by health centers. Ninety percent of the 49 administrators interviewed, representing both urban and rural health systems, identified chronic diseases as a major health issue facing their community. Thirty-six percent of the 28 rural health center systems and 19 percent of the 21 urban health center systems mentioned mental and behavioral health as another major health issue. However, only 21 percent of the rural health center systems offer mental health services.

It is the perception of the administrators that patients are generally satisfied with the service they receive at the health centers.

Administrators also share the opinion that a key factor in the provision of quality health care is committed and knowledgeable practitioners.

Overall, the accounts provided by representatives of health center systems, both urban and rural, indicate that these institutions function as an integral component of the community. And the role of a health center, which has developed as part of a community's history, is not limited to the provision of health care services. In collaboration with other organizations, health centers facilitate access to services and programs assisting low-income individuals. For example, individuals may access information about the Women, Infants and Children (WIC) program at the health centers. Administrators also said that, when staff and financial resources permitted, health centers organized and/or participated in offsite and onsite community outreach services such as health fairs, educational programs for diabetes patients, and school and sports programs.

Sustainability also refers to the capacity of the health centers to sustain the health care services they provide. This largely depends on their ability to recruit and retain clinical staff and to maintain financial viability. Data collected for this study provide insight into factors that influence the capacity of the health centers in these two areas.

Recruitment and retention of clinical staff

Without clinical staff, most importantly physicians and mid-level providers, health centers would not be able to

¹² Information about rural hospitals has been provided by the Pennsylvania Office of Rural Health (PORH). PORH assists the commonwealth in the administration of the Rural Hospital Flex program.

Figure 15: Provider Recruitment Experience of Health Center Systems by Provider Type and Rural-Urban Location of Health Center System, 2007

Reported Recruitment Difficulty	Provider Type and Rural-Urban Location			
	Physician Rural	Physician Urban	Mid-Level Rural	Mid-Level Urban
Extremely Difficult	14	3	4	4
	56%	17%	16%	19%
Difficult	8	12	11	10
	32%	66%	42%	48%
Not Difficult	3	3	11	7
	12%	17%	42%	33%
Total	25	18	26	21
	100%	100%	100%	100%

provide health care services. Administrators of health center systems who participated in this study were asked to categorize their experience of recruiting physicians and mid-level providers (See Figure 15).

While recruiting physicians is generally difficult for all health center systems, rural health center systems find it more difficult to recruit physicians than urban systems. The difference between urban and rural health center systems with regard to their experience in recruiting mid-level providers, such as physician assistants and nurse practitioners, was not as great.

Recruiting physicians requires a significant amount of time and resources of the health center systems.

An analysis of the survey data revealed several factors that influence recruitment efforts including health center location, the market for health professionals, available incentives, and the professional values and attitudes of health providers.

As illustrated in Figure 16, administrators believe the location of health centers significantly influences recruitment efforts.

Sixty-five percent of administrators of rural health center systems perceived location to be a factor that negatively influences their efforts to recruit physicians.

Figure 16: Key Informant's Perception of Influence of Health Center Location on Recruitment Efforts by Provider Type and Rural-Urban Location of the Health Center System, 2007

Perceived Influence of Location on Recruitment	Provider Type and Urban-Rural Location			
	Physician Rural	Physician Urban	Mid-Level (PA and NP) Rural	Mid-Level (PA and NP) Urban
Negative	17	8	7	7
	65%	45%	27%	41%
Neutral	7	6	11	6
	27%	33%	42%	35%
Positive	2	4	8	4
	8%	22%	31%	24%
Total	26	18	26	17
	100%	100.0%	100%	100%

This percentage is higher than the 45 percent of administrators for urban health center systems that considered their location to be a negative influence.

Administrators of rural health center systems believe the rural location of health centers makes it difficult to find physicians to practice in their health centers.

According to administrators interviewed for this study, there are several reasons that make rural locations unappealing to physicians. For example, rural locations might be unattractive to physicians because they generally offer limited social, cultural and professional prospects for the physicians and the physicians' spouses and families.

Although limited, the study revealed situations in which location has a positive influence on recruitment and retention, such as when a physician has some connection and/or commitment to the particular area.

Connection to and familiarity with an area partly explains why administrators perceive location as more of a positive influence than a detriment in recruiting mid-level providers.

About 27 percent of respondents considered location to be a negative influence on their efforts to recruit mid-level providers for rural health centers. This is no surprise as many of the administrators said they were generally able to recruit mid-level professionals who are from or were trained in the area.

The presence of educational institutions that offer training for mid-level professionals and/or physicians makes it possible for the health centers to recruit locals with connections to the area. Approximately 75 percent of the health centers that participated in this study serve as training sites for health care professionals, including mid-level providers and physicians.

The market for health providers is highly competitive.

Figure 17: Key Informant's Perception of Influence of Health Center Budget on Recruitment and Retention by Provider Type and Rural-Urban Location of the Health Center System, 2007

Influence of Budget	Provider Type and Urban-Rural Location			
	Physician Rural	Physician Urban	Mid-Level Rural	Mid-Level Urban
Negative	15	7	8	5
	58%	39%	32%	30%
Neutral	7	7	11	6
	27%	39%	44%	35%
Positive	4	4	6	6
	15%	22%	24%	35%
Total	26	18	25	17
	100%	100%	100%	100%

Figure 18: Key Informant’s Perception of Influence of Loan Repayment Programs on Recruitment and Retention by Provider Type and Rural-Urban Location of the Health Center System, 2007

Influence of Loan Repayment	Provider Type and Rural-Urban Location			
	Physician Rural	Physician Urban	Mid-Level Rural	Mid-Level Urban
Negative	3	6	4	7
	12%	38%	17%	41%
Neutral	3	1	3	1
	12%	6%	12%	6%
Positive	19	9	17	9
	76%	56%	71%	53%
Total	25	16	24	17
	100%	100%	100%	100%

A health centers’ ability to recruit and retain clinical staff depends on their budget. Figure 17 summarizes the administrators’ perceptions of the influence that their budgets have on recruitment and retention of clinical staff.

The percentage of administrators representing health center systems whose budget negatively impacts their ability to recruit and retain physicians is significantly higher for rural health center systems (58 percent) than it is for urban health center systems (39 percent). Administrators said their systems cannot offer physician salaries at the going market rate because of budget limitations.

The demand for primary care physicians is high across all areas of health care. Consequently, health center systems compete for physicians with hospitals and for-profit health care systems. Data from this study suggest that competition is an issue for rural health center systems when recruiting physicians.

Since health center systems cannot compete on salaries, they use other means to entice physicians and mid-level providers to join their practice. Health center systems offset their competitive disadvantage with respect to salaries by employing two types of incentives – internal and external.

Internal incentives are benefits offered by the health center systems that are comparable or better than the competition. Benefits mentioned by administrators who were interviewed include more attractive hours or health and life insurance.

Health centers with strong affiliations to larger organizations, such as hospitals and educational institutions, have an advantage with regard to recruitment and retention. By virtue of these affiliations, these centers are in a position to offer better packages.

External incentives, consisting of federal and state programs, are the second type of incentives employed by the health center systems. Three incentive programs identified by administrators interviewed in this study are:

malpractice insurance coverage, loan repayment, and the J-1 visa waiver. The Federal Tort Claims Act (FTCA) is a federal program providing malpractice insurance coverage for physicians. FQHCs are the only health centers eligible to receive this benefit. Administrators of FQHC systems mentioned this program as a factor that assists them in recruiting and retaining physicians. On the other hand, administrators representing health center systems that are not eligible to participate in this program noted that malpractice insurance requirements negatively influence recruitment and retention.

Unlike the FTCA program, all four types of health centers are eligible to participate in state and federal loan repayment programs. These programs help both physicians and mid-level providers working at health centers to pay off educational loans. The data reveal these loan repayment programs to be a popular means for recruiting clinical staff to serve in rural areas. Figure 18 shows that more rural health care systems find loan repayment programs to be a positive influence for recruiting physicians and mid-level providers than urban health center systems.

Despite the high regard afforded to the loan repayment programs, administrators expressed some concerns about the programs’ negative effects on recruitment and retention. One concern is that, while such programs help centers recruit clinical staff, they do not necessarily help retain staff. Administrators noted that physicians and mid-level providers can move on to jobs in other areas once their loan is paid off. In addition, administrators perceived the inflexibility of program requirements, such as the number of work hours required of the providers, as negatively influencing recruitment.

The J-1 waiver program is another program employed by the health centers to recruit physicians. This federal program helps the centers recruit physicians who are foreign nationals needing to fulfill visa requirements. The J-1 waiver program is only applicable to physicians and not to mid-level providers. Twenty-three percent of administrators of rural health center systems who participated in this study find it to be a positive influence on recruiting and retaining physicians. In contrast, 44 percent of administrators of urban health center systems consider the J-1 waiver program to be a positive influence. Based on this data, it appears that the J-1 waiver program is more successful in urban areas than it is in rural areas. Fifty percent of administrators of rural health center systems perceived the program as a negative influence on physician recruitment and retention.

Like the loan repayment programs, administrators perceive the J-1 waiver program as helpful for recruitment but much less helpful for retention of physicians. Consequently, a prevalent opinion among administrators is that it is not worth the effort it takes to go through the

paperwork and other requirements necessary to get a physician through the J-1 visa waiver program.

A theme emerging from the study is that administrators perceive external state and federal incentive programs as generally helpful in recruiting physicians and mid-level providers but not as helpful in retaining clinical staff. The administrators believe a key factor that determines whether or not a physician or mid-level provider stays is the individuals' professional values and attitude to public health service.

The data suggest that individuals who work for and stay with the health centers tend to be those who understand and appreciate the mission of the health centers. Consequently, a prevailing opinion among the administrators interviewed is that commitment and passion for public health play a significant role in the retention of clinical staff.

Administrators also believe it is important for physicians working in rural locations to be comfortable with practicing without supporting specialists nearby. This is because there are generally few medical specialists in rural areas. In some cases, the health centers are either the only facility providing health care in the community, or the only facility accepting uninsured and underinsured patients.

In summary, the recruitment and retention of clinical staff is an important component in the capacity of rural health centers to provide health services. To sustain delivery of health care, health centers must be able to recruit and retain clinical staff.

The data revealed that health centers, in general, and rural health centers, in particular, experience more difficulty recruiting physicians than mid-level professionals. Also, recruitment efforts are hampered by location and market competition. The centers employ a variety of incentives to recruit and retain clinical staff. Administrators share the opinion that professional values and attitudes of the clinical staff play a role in recruitment and retention. Financial viability is the second key component in the capacity of rural health centers to provide health services.

Financial viability

Approximately 64 percent of rural health center systems in the study were operating in the black. This percentage is significantly lower than the 85 percent of urban health center systems that were operating in the black. Based on this data, the researchers concluded that the financial status of rural health center systems is more tenuous than that of urban health center systems.

A few administrators described situations where their

Figure 19: Key Informants' Perceptions of Influence of Prospective Payment System on Adding New Health Services by Type of Health Center System in Rural Location, 2007

Difficulty Adding New Services	Rural FQHC/ FQHC Look-Alike	Rural Provider Rural Health Clinic	Rural Independent Rural Health Clinic
Not At All	3	4	6
	60%	50%	86%
Somewhat	0	1	1
	0%	12%	14%
Difficult	2	3	0
	40%	38%	0%
Total	5	8	7
	100%	100%	100%

health center systems found it necessary to take drastic measures, such as cutting down on staff or adjusting incomes, to continue operating in the black.

The researchers also assumed that health center systems that are financially viable have the capacity to sustain or expand services. Following this assumption, they asked administrators to rate the capability of their health center system to sustain and expand services. About 59 percent of administrators of rural health center systems and 38 percent of administrators of urban health center systems rated their capability to sustain and/or expand services as low. This data supports the earlier finding suggesting that rural health center systems are less financially viable than urban health center systems. It is worth noting that the capability to sustain and/or expand services varies among the different types of rural health centers.

Sixty-seven percent of independent RHCs are rated as having low capability to sustain and/or expand health services. The type of services administrators reported as being important to the expansion of health care include: obstetrics/gynecology/mammography services, mental health/psychiatry services, laboratory services and oral health services.

In contrast, 59 percent of provider-based RHCs are rated by their administrators as having medium to high capability to sustain and/or expand health services.

This variation might be explained by the differences in organizational structure between the types of health center systems. Provider-based RHCs are supported by the hospitals or entities that own them. Independent RHCs generally do not have such support.

The financial viability of the health centers depends largely on expenses incurred and revenues generated by the health centers. Health center system administrators noted increases in three categories of expenses in the most recent fiscal year: staffing costs, operational costs, and equipment costs. Staffing costs included expenses associated with recruiting physicians.

Also included are expenses related to the provision of health insurance coverage for employees, and salary

increases. Administrators also mentioned increases in operational costs, such as utilities, supplies, and drug costs, and increases in costs associated with equipment upgrades and replacements.

According to the administrators, revenue changes experienced by the health centers in the recent fiscal year are attributable to increases in patient volume, improved billing and enhanced reimbursement. Medicaid reimbursement has significant implications for revenues generated by health centers.

With the passing of the Benefits Improvement and Protection Act of 2000, the prospective payment system (PPS) has gradually replaced the traditional cost-based systems of reimbursement to qualified community health centers (Schwartz, 2006). The data do not reveal any significant differences between rural and urban health centers with regard to how the change from cost-based to PPS has impacted their operations. Administrators did not categorically perceive PPS as making it more difficult to recruit and retain clinical staff, replace and upgrade existing equipment and/or add new health services, although some concern over PPS exists. Comparing the different types of rural health centers, there is noticeable variation in perceived difficulty of adding new health services, recruiting health providers and upgrading or replacing equipment. For example, Figure 19 shows a significant percentage of administrators representing FQHC systems (40 percent) and provider-based RHC systems (38 percent) in rural locations who perceive that PPS has made it more difficult to add new health services. In contrast, none of the administrators of independent rural health clinic systems indicated that PPS had made adding new health services more difficult.

When asked what legislative bodies might do to help sustain clinic operations, administrators representing 22 percent of both rural and urban health center systems specifically mention enhancement of reimbursement.

In addition to revenues received from services provided, more than 40 percent of administrators representing rural health center systems indicated that they receive additional support through financial donations from individuals, foundations and charities and in-kind donations from volunteers. Most of the grant funding noted by the administrators was allocated for specific programs. Without the grants, the programs would cease.

To get a sense of the financial needs of the health centers, administrators were asked to indicate how their health center system might use a one-time award of \$25,000.

The three major categories mentioned by administrators were: staff recruitment and retention; equipment upgrade and replacement, most notably for the implementation of electronic medical records systems; and service expansion, most notably mental and dental health services and community outreach.

Lessons from other states

Every state except New Hampshire has fully implemented their PPS system. However, the experience among states continues to vary. Regarding the strict application of the PPS methodology, 24 states (57 percent) use only the statutorily mandated PPS model. Several states chose to keep some type of cost-based reimbursement system: 18 states (43 percent) apply an alternative payment method (10 of these states offer some form of cost-based reimbursement as the alternative payment method). A few states, such as Arizona and Tennessee, did not change the status quo and had waivers in place.

States adopting the PPS methodology used a variety of payment structures. Payment structures were modeled as: 1) one, all inclusive, per-visit rate covering all services, 2) one-per-visit covering most services, selected other services reimbursed on a fee-for-service basis, and 3) multiple rates based on types of services (medical, dental, mental health, etc.). Most states either used multiple rates or excluded one or more services from their rates. Dental and prescription drug services were most likely to be carved out of the PPS rate.

Difficulties are associated with assessing the impact of the PPS rates due to the variation in data available. In addition, given the wide variety in PPS rates that may occur in one state, an average rate may not reveal a true picture of the rates' impact. Of the 20 [Medicaid] agencies that used one rate and provided an exact figure, the rates ranged from \$88 to \$195.

Reimbursement rates

Reimbursement rates also vary by state. Most states use a single all-inclusive rate when paying health centers for services rendered to Medicaid beneficiaries. There are some states that use separate rates for medical and dental services and a few states will cost out separate mental/behavioral health rates. Regardless of what rate structure is selected, almost every state will exclude reimbursements for at least one service and many states eliminate several areas of coverage. The most common eliminated service is pharmacy (Schwartz 2005).

It is difficult to compare the effectiveness and utility of rate packages because of the variety of services included and excluded in the rates and the number of rates used by different states. Non-uniform reporting prevents a comparison of rates for services. Therefore, some states report averages and others report ranges of service rates.

Pennsylvania experience

Pennsylvania elected to operate within the most restrictive structure of the PPS. It offers two rate schedules, one covering medical services and the other dental services. The services included in the PPS rate are

Figure 20: Status of SCHIP Benefits Improvement and Protection Act Implementation for Pennsylvania

Dimension Surveyed	PA Response
Payment methodologies	PA uses the PPS reimbursement methodologies for FQHCs and RHCs. The state Medicaid agency has not issued a PPS policy.
Number and type of payment rates	PA has more than one rate. It reimburses for medical and dental services.
Inclusion and exclusion in the payment rates	Physician services, services and supplies incident to physician services, pneumococcal and influenza vaccine and its administration, physician assistant services, CRNP services, licensed clinical social worker and dental services. Mental health is not provided by specific providers mentioned above or through licensed mental health outpatient clinic. Each community health center has the option to include or exclude services in the development of the rate as long as the service is part of the state Medicaid plan (lab, x-ray-prescriptions not included).
Average rate (figure rounded to the nearest dollar)	Limits for the range of rates are as follows: low = \$77 and high = \$135. Billable allowances for a day are as follows: one medical, one dental and one mental health. PA uses the MEI.
Payment rate for new starts	Based on estimated cost report. Department will pay initial year on a per visit basis, 100 percent of reasonable costs based on rates of other centers in same or adjacent areas. In the absence of other centers, the cost report is used. The next fiscal year, the rate is adjusted to reflect the actual audited reasonable costs.
Scope of service	<u>Definition of scope of service:</u> An increase or decrease in scope of services must be federally approved, covered under the state plan & listed on the Medical Assistance Fee Schedule. Services considered are defined as distinct clinical services to include, but not limited to, physician services, licensed clinical psychologist services, licensed clinical social work services, laboratory, pharmacy, radiology, family planning, dental and emergency services. <u>Scope of service rate adjustment process:</u> Provider submits to DPW the federal approval for new service or deleted services and a modified cost report reflecting change. DPW reviews the change and modifies rate if approved. DPW provides written notification of decision, provider may appeal decision. A cost report is filed in the form required by the Office of Medical Assistance programs.
Effective date of rate adjustment	The rate change takes effect with the beginning of the date of service, but not to precede the federal effective date. Average time to process request to receipt of actual payments is not reported by the state.
Experience of health centers seeking a change in the payment rate	Not reported by the state.
Wrap around payments	Wrap around payments are provided quarterly. The process is not reported as problematic, but the PCA has worked with the Office of Medical Assistance staff, individually and collectively, informally and formally to address issues of mutual concern. There is much information sharing that generally reduces problems.
Impact of the state payment system of type of health center	No data provided for the following categories: smaller/larger; rural/urban; new starts, special populations or other categories.
Detrimental aspects of the state payment system	Not reported by the state.
Beneficial aspect of the state payment system	PA Medicaid provides comprehensive covered services. The implementation of PPS has been a collaborative process between the PCA and State Office of Medical Assistance Programs.

physicians' services, services and supplies incident to physicians' services, pneumococcal and influenza vaccines and its administration, physician assistant services, licensed clinical psychologist and clinical social worker, and dental services. Mental health services are excluded if not provided by a Medicaid approved professional.

PPS rates range from \$77 to \$135. Medicaid beneficiaries are allowed to receive three billable visits in one day: one medical, one dental and one mental health. The services outlined in Pennsylvania's plan cover the core primary care services and other ambulatory services detailed in the federal requirements for FQHC and RHC programs (Schwartz 2007).

The formula used to calculate the PPS rate of reimbursement for new health centers is based on cost reports from other health centers. The Pennsylvania Department of Public Welfare pays the initial year on a per visit basis for 100 percent of the reasonable costs, based on the rates of other centers in an adjacent area.

The scope of service definition adopted by the Department of Public Welfare for an increase or decrease in scope of services must be federally approved, covered under the state plan and listed on the Medical Assistance Fee Schedule. To process a scope of service request, a health center submits the federal approval for new or deleted services and a modified cost report reflecting the change to the Department of Public Welfare. The report is reviewed and the rate is modified if approved. The health center is notified of the decision and an appeal can be made to the department if there is disagreement regarding the ruling. The effective date when rate changes can take place is consistent with the initial date of service. However, it cannot precede the federal approval date.

There is no systematic documentation of three important factors related to PPS in Pennsylvania. These are experience with turn-around time for requests for PPS rate changes, the impact of the state's payment system on the type of health center, and detrimental elements of the payment system.

Pennsylvania strictly abides by the enabling legislation that establishes and defines the range of allowable services for health centers and the CMS guidelines for rate and reimbursements of services.

Figure 20 provides an overview of Pennsylvania's status implementing the PPS methodology at the time of the study.

Pennsylvania compared

States that receive exemplar status based on annual surveys conducted by the National Association of Community Health Centers differ in two ways from the commonwealth. First, these states apply a combined PPS/APM rate structure. This approach provides a broader

base of funding to support services and center operations. Second, the trend is to use a statewide model in areas where a more standardized approach works well. New Jersey is considered a good model for maximizing outcomes within the structure of the PPS.

There is a range of state policies and reimbursement structures. These vary with respect to the amount of flexibility in reimbursement allowed. Low flexibility does not allow easy changes to be made to cover changes in the real cost at health centers. Since health centers are required to provide certain services and serve certain people, they are assuming the financial risk resulting from a change in the environment (patient mix, case mix, community need, etc.) that changes their real average cost per visit. Because they are generally small organizations, this makes them vulnerable and threatens sustainability. Pennsylvania should be considered a state with policies that result in a high risk to health center sustainability.

Conclusions

The results of this research may be summarized as follows:

- Health centers function as safety net providers, providing health care services to underserved populations. They are widely distributed across the commonwealth, located in areas of need and provide services to underserved populations. Health centers' safety net function in rural areas is primarily related to their location in areas of low provider supply. Health centers' safety net function in urban areas is primarily related to their service to economically disadvantaged populations. Health centers function as more than a vendor of health care services; they are part of the culture of the communities in which they are located.
- Health center sustainability is dependent on several factors including the ability to recruit and retain appropriately motivated providers, financial stability, and integration into the community.
- Rural health centers differ from urban health centers as follows: they offer a more restrictive range of services, they have a more restricted provider mix, they have a less diverse revenue portfolio, they experience more difficulty in recruiting and retaining providers, they are economically more vulnerable, and they have a greater probability of participating in the education of health care providers.
- Within the range of allowable state policies with respect to the important matter of reimbursement for Medicaid services, Pennsylvania scores relatively low on system flexibility and support for health centers.

Policy Considerations

The Pennsylvania Department of Public Welfare should consider completing all FQHC and RHC program audits necessary to calculate the final PPS rate so that safety net providers may effectively project and manage costs for services and clinic operations. This may be accomplished by a state-imposed deadline or earmarked resources.

There are a significant number of health centers providing health services with an assigned interim PPS rate. Although the interim rate provides a transitional payment schedule for clinical services, there is no guarantee to the health center that the current expenditures are allowable. Costs have been disallowed in the past through audit findings. If the FQHC or RHC program is disallowed costs, there is the problem of reconciling overpayment by Medicaid to the clinic and funds may need to be returned to the commonwealth. The impact in the short term is the loss of revenue, decreased budget and limitations on current programs or future growth and development. In the long term this may contribute to the dissolution of the safety net program and loss of access to care for underserved populations.

Since the PPS rate is a unique payment rate for each center established through an audit process of cost reports over a 2-year period, the Department of Public Welfare should have all necessary information available to establish the rate within a 12-month period. The Benefit Improvement Protection Act (BIPA) was passed in 2000. Understanding that payments were likely to be controlled under the new Medicaid system, state Medicaid agencies were to begin working with community health centers immediately. The following areas require special attention:

- Communication of changes in any federal guidelines applicable to the PPS reimbursement process should be updated within the Department of Public Welfare.
- Technical assistance should be provided to health centers that use the PPS reimbursement rate and payment system.

The Pennsylvania Department of Public Welfare should consider developing a clear and concise written policy detailing the PPS and reimbursement rates that include descriptions of the process FQHCs and RHCs must use to petition for a change in scope of service and a defined turn-around time for PPS rate changes. The policy should also describe an evaluation system that tracks the impact of the state's payment system on the sustainability of health care services and the FQHC or RHC organization. The evaluation system should also

assess detrimental aspects of the payment system over time that threaten sustainability and develop action plans to effectively intervene.

There is no systematic documentation for three important factors related to the PPS within Pennsylvania including:

- Time required for requests for PPS rate changes by health centers to be reviewed and resolved;
- Effect of the state's PPS payment system on the type of health center; and
- Detrimental elements of the payment system.

Technical assistance should be provided to health centers that use the PPS reimbursement rate and payment system.

The Pennsylvania General Assembly should take into consideration both intended and unintended changes in current Medicaid policies on the viability of the health centers, the maintenance and expansion of health care services, and the populations served.

The commonwealth should carefully review the impact of changes in the Medicaid PPS reimbursement methods on community health centers. It is important to explore and understand the potential for a negative effect on the ability for core safety net providers to continue to provide care for the uninsured, underinsured and at-risk populations.

Expenditures associated with the provision of care to these populations are said to be more costly. This question needs to be explored. It is a matter of significant concern to community health centers that the Medicare Economic Index (MEI) index be reviewed as to its efficacy and utility in assessing the inflationary cost associated with providing care to populations served by the safety net. The Department of Public Welfare should review other indices that consider the types of services required by these populations. The MEI is based on increases in practice costs associated with a very different patient mix. The following issues should be considered:

- In depth analysis of PPS and its effect on the capability of community health centers to continue their mission to serve the uninsured, underinsured and at-risk populations.
- The adequacy and fairness of the MEI on managed care rates as it applies to health centers.

The General Assembly should consider assessing state programs and policies for their effectiveness and responsiveness to the intent and mission and their direct applications toward meeting the needs of the community health centers and the populations served.

Many forces alter the financing and delivery of health care services, including the move toward a capitated system of care. These dynamics call for a careful review of programs and policies affecting vulnerable populations to assess how these programs are targeting their original mission and objectives. This type of analysis is especially important given the growing number of uninsured citizens and the declining ability to meet their health care needs.

The Pennsylvania General Assembly should consider reexamining current loan repayment and scholarship programs that serve to retain physicians and other health professionals trained within the commonwealth, especially in terms of the costs for a health care education and training.

The primary care workforce has become a statewide issue. Special attention should be given to the following:

- Loan repayment programs and scholarship programs committing dollars to health profession education and debt forgiveness programs;
- Loan forgiveness programs for training of primary care physicians committed to practicing in the commonwealth's areas of need;
- Funding allotted to the commonwealth's medical schools to train primary care physicians;
- Funding allotted to primary care residency programs training in rural and underserved areas; and
- Funding allotted to schools of dentistry to create community-based training models established in areas of health care need.

Commonwealth programs that provide incentives to health care providers to serve in Pennsylvania or in an area of designated underservice should include additional incentives for them to serve at health centers, and further incentives to serve at rural health centers. This may include loan repayment programs, any special reimbursement from the Department of Public Welfare, or any new "pipeline" program designed to encourage Pennsylvania-educated providers to stay in-state and serve in areas of need.

Program funds should be targeted to help rural health centers with start-up costs and expansion of services costs.

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The Center for Rural Pennsylvania
625 Forster St., Room 902
Harrisburg, PA 17120
Phone: (717) 787-9555
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