March 8,2005

Rural Health Clinic Report

OFFICE OF RURAL HEALTH

Office of Rural Health (ORH)

- ORH was created and funded by the Oregon Legislature in 1979
- Located at OHSU
- Mission is to improve quality and availability of health care for rural Oregonians

- To fulfill our mission, the ORH
  - Coordinates statewide efforts to provide health care in rural areas;
  - Serves as a clearinghouse for information on health care;
  - Assists rural communities to recruit and retain health care practitioners;
  - Administers the state tax credit program for rural providers;
  - Provides on site technical assistance to rural communities; and
  - Initiates and participates in policy development that improves delivery of health care to rural Oregonians.

RHC Overview

- Survey process
- Map of Oregon RHCs & Who is Eligible for RHC Status
- History of RHCs in Oregon
- Key Findings
  - Fees
  - Market Share
  - Productivity
  - Practice Management Indicators
  - Technology
  - Qualitative Issues
- Isolated Rural Health Facilities

Survey Methodology

- All 2004 (38 at time of survey) RHCs in the state were sent a packet of information
- 37 Clinics received an on site visit to achieve:
  - Discuss data collection process
  - Conduct qualitative interviews
  - Clinic contact information
  - Clinic picture

Survey Methodology, cont.

- Information Collected:
  - Audited Financial Statements
  - Profit & Loss Statement
  - Balance Sheet
  - Hours of Operation/Employee Hours and Numbers
  - Services Offered
  - Physical Plant Condition
  - Technology
  - Qualitative Questions

Summary of Financial Data Collected

- Balance sheet:

15 received

23 not received

- Profit and Loss statement

13 received

25 not received

- Audited Financial report

12 received

5 not complete

26 not received

Survey Purpose

- Education tool for communities
- RHC benchmarks
- Identify issues and problems facing Oregon RHCs
- Help ORH improve technical assistance for RHCs
- Potential policy issues

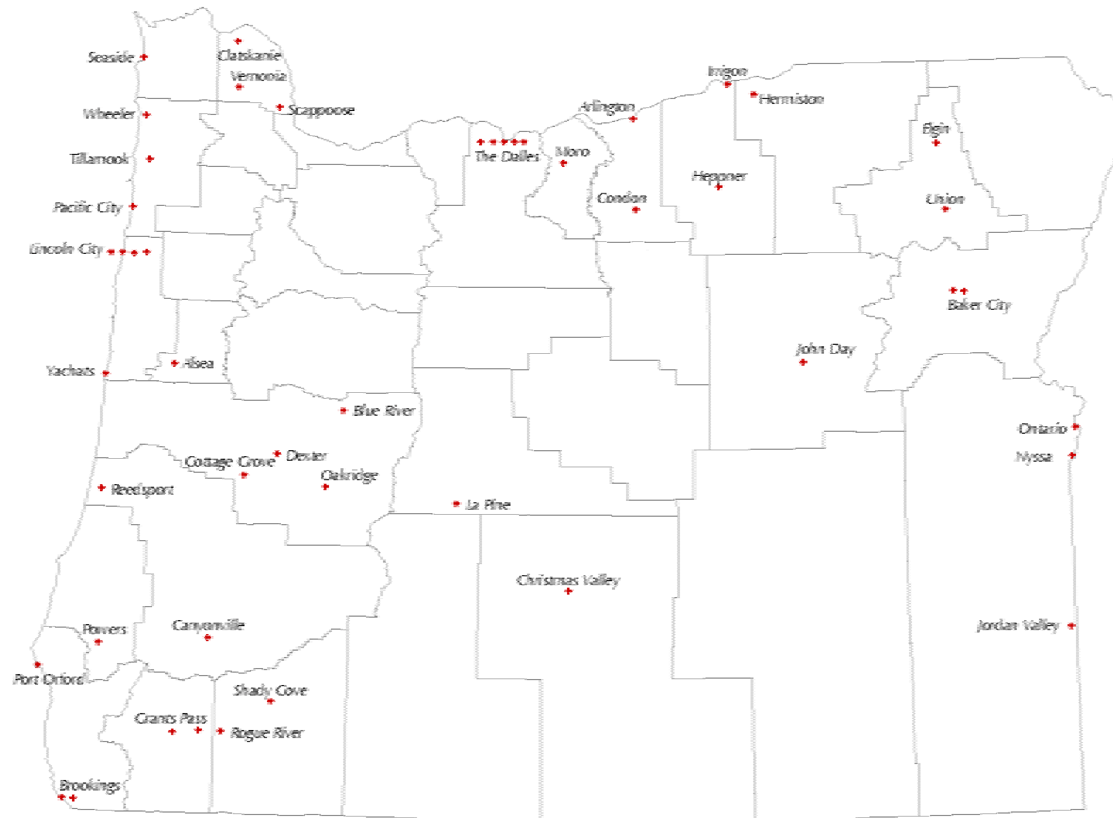
RHC Requirements

- Clinic must be located in an area defined by the US Census Bureau as **NOT an Urbanized Area**
- Clinic must be located in an area defined as either a Health Professional Shortage Area (HPSA) or in a Medically Underserved Area (MUA); or in an area designated by the State's Governor as underserved.
- Clinic must employ a mid-level provider (Nurse Practitioner, Physician Assistant, or Certified Nurse Mid-Wife) at least 50% of the time the clinic is open.
- Clinic must have physician oversight from a physician who is on site once every two weeks available to see patients, consult with the mid-level and review medical practices when necessary.

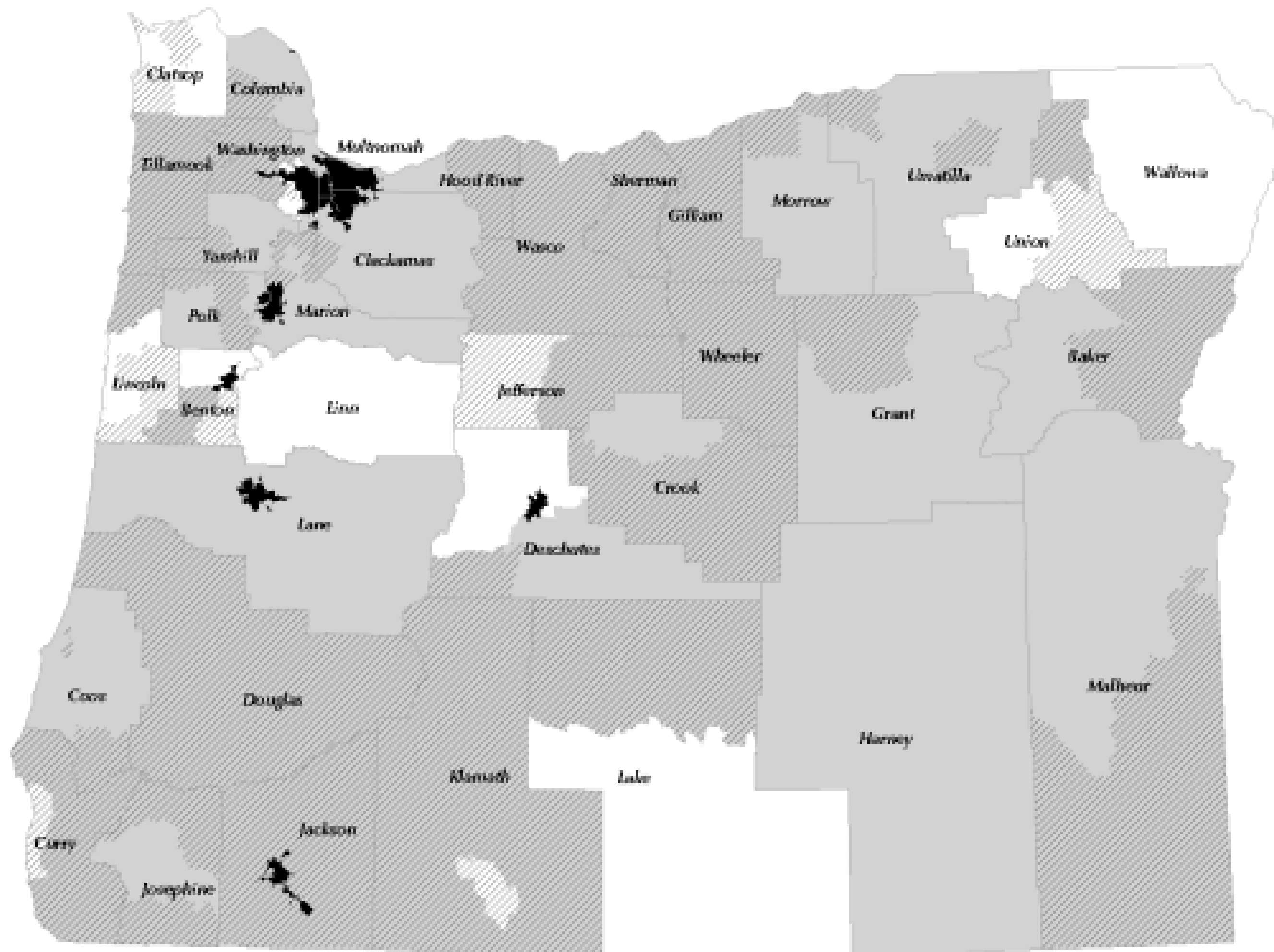
RHC Requirements, cont.

- Six basic lab tests on site:
  - Pregnancy Test
  - Examination of stool occult
  - Glucose
  - Primary culturing for transmittal Clinic
  - Hemoglobin or Hematocrit
  - Urine
- Shortage area designation has been updated within last three years.

Oregon RHCs December 2004



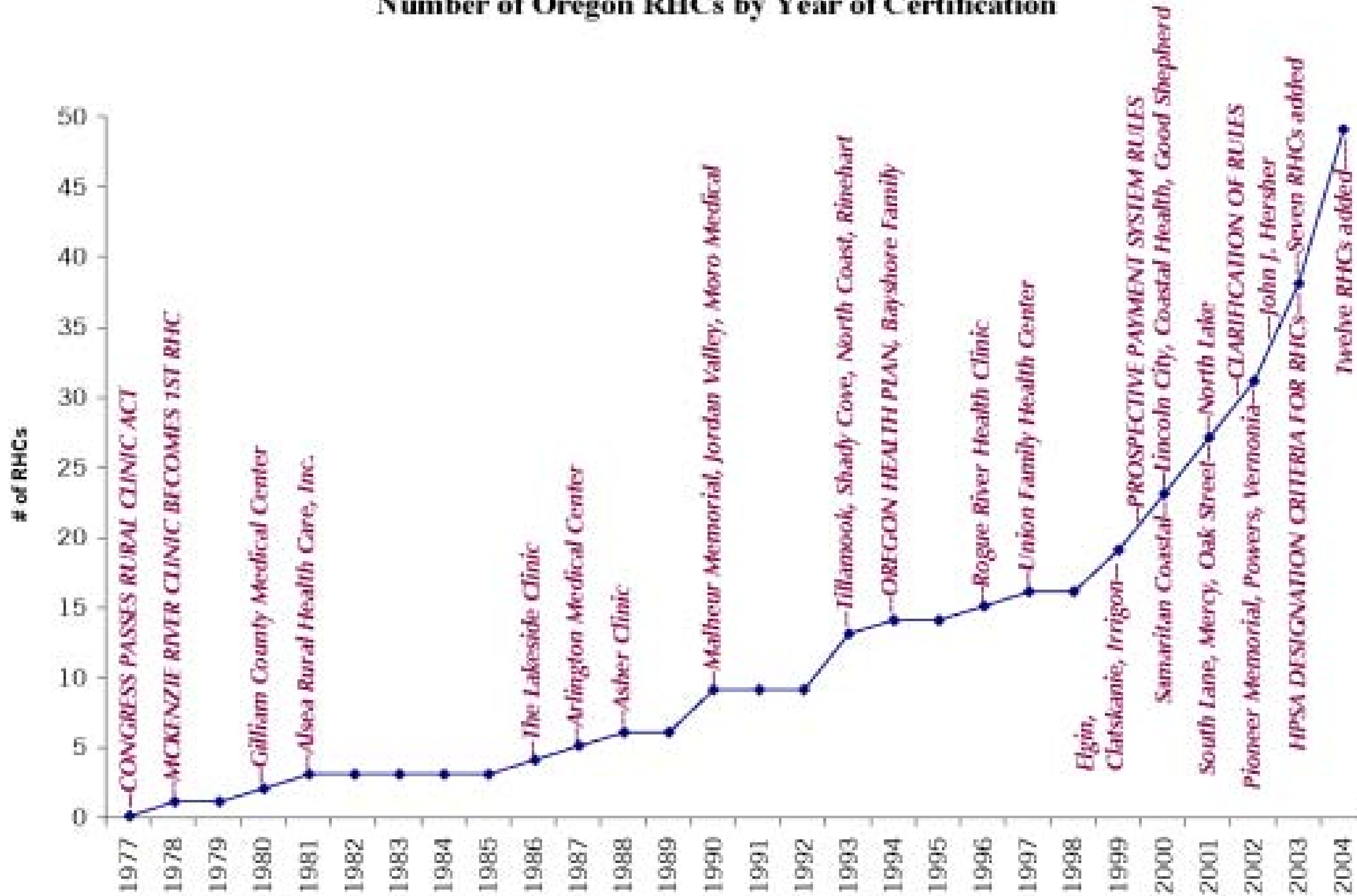
Map of HPSA and MUA in Oregon



Oregon Clinic Type Compared to National

RHC Type	% Of Oregon Clinics 2004	% Of National Clinics 1999
Private/For-profit	34%	29%
Independent/Not-for-Profit	38%	41%
Public/Health Districts	27%	16%

Oregon RHC



*during this period, two RHCs left the program for a total of 47 RHCs as of Dec 2004.

Oregon RHC Significant Events

- Definition of Rural
- 1994, 1115 waiver to create Oregon Health Plan had a provision which allowed OMAP to pay RHC & FQHCs less than 100% of reasonable cost
- All primary care HPSAs are eligible
- 2000 Prospective Payment System (PPS)

Fee Comparison by Clinic Type

Clinic Type	Average Fees for 99213	Range
Private (for-profit)	$87.02	$80-90
Provider-based	$85.00	$80-95
Non-profit	$76.17	$54-95
Public/Health Districts	$67.56	$52-75

Fees by Town Size

Size of Town	Average Fees for 99213	Range
Large Town (10,000 – 49,999)	$84.05	$48-95
Small Town (2,500 – 9,999)	$80.81	$52-95
Rural Community (<2,500)	$67.50	$54-75

Fees, cont.

- The rural areas stand out as having significantly lower average fees than the larger communities. This may be in part due to the fact that practitioners tend to know the people better and may have a harder time feeling comfortable charging higher fees, particularly if they perceive an inability to pay.

- Health districts may keep their fees lower than other clinics based on the idea that tax payers are already paying for the clinic

Market Share

- Market Share: number of visits provided as a percentage of the total estimated primary care visits needed in the service area

- How we calculated:
  - 2003 population numbers
  - Actuarial data formula to estimate total estimated visit demand
  - Multiply total demand by 65% to get estimated primary care visits; nationally primary care makes up 65% of total care (National Ambulatory Medical Care Survey)
  - Actual visits are taken from clinics' current (last year) cost report

Market Share – Key Findings

- The market share range among all clinics is quite significant from a low of 7% to a high of 165%.
- 20 of 33 clinics are below 50% Market Share
- 8 clinics are between 50% - 99% Market Share
- 5 clinics are above 100% Market Share
- 3 clinics are at or below 10% Market Share

Market Share by Clinic Type

Clinic Type	Average Market Share	Range
Non-profit	82%	34 – 165%
Health Districts	77%	43 – 124%
Provider-based	54%	7 – 123%
For-profit	33%	10 – 97%
Public	33%	13 – 45%

Market Share by Town Size

Size of Town	Average Market Share	Range
Large Town (10,000 – 49,999)	39%	7 – 123%
Small Town (2,500 – 9,999)	64%	13 – 165%
Rural Community (<2,500)	67%	34 – 124%

Market Share by Population

Population

35000
30000
25000
20000
15000
10000
5000
0

0% 20% 40% 60% 80% 100% 120% 140% 160% 180%

Market Share

Market Share by FTE

FTE

9
8
7
6
5
4
3
2
1
0

0% 20% 40% 60% 80% 100% 120% 140% 160% 180%

Market Share

Productivity Standards

- 23 of 33 clinics are at or exceeding productivity standards
- No clinic is below 75% of the productivity standard based on FTE
- Of the 11 clinics with over 50% market share, seven of them are over the productivity standard
- Of the three clinics under 10% market share, two are over the productivity standard
- Of the clinics at, or above, 100% market share, all are OVER the productivity standard

Productivity Standards

- Medicare payment is based on the total allowable costs divided by the actual number of encounters or the productivity standard, whichever is higher
- Productivity Standards (for 1 FTE):
  - 4200 Physician
  - 2100 Nurse Practitioner, Physician Assistant, Certified Nurse Midwife
- Pro-rated based on actual FTE

Productivity Standards by Clinic Type

Clinic Type	Average Productivity	Range
Public	100%	No Range
Non-profit	99%	96-100%
For-profit	99%	88-100%
Health Districts	92%	76-100%
Provider-based	92%	58-100%

Below Productivity Standard

Actual Encounters	1850	
Productivity Standard	2100	
Total Allowable Costs	225,000	
Actual Cost Per Encounter	225,000/1850	$121.62
Encounter Rate at Productivity Standard	225,000/2100	$107.14
Dollar Difference		($14.48)

At Productivity Standard

Actual Encounters	2100	
Productivity Standard	2100	
Total Allowable Costs	225,000	
Actual Cost Per Encounter	225,000/2100	$107.14
Encounter Rate at Productivity Standard	225,000/2100	$107.14
Dollar Difference		$0

Above Productivity Standard

Actual Encounters	2350	
Productivity Standard	2100	
Total Allowable Costs	225,000	
Actual Cost Per Encounter	225,000/2350	$95.74
Encounter Rate at Productivity Standard	225,000/2100	$107.14
Dollar Difference		($12.60)

Practice Management Summary

- 77% of RHCs surveyed had a negative operating revenue
- RHCs continue to rely on grant funds, tax dollars, and donations
- 2003 Cost per encounter is $99.01
- Revenue per encounter is $79.90
- Even with Prospective Payment System (PPS) clinic's revenue is less than their cost
- Medicare payment ($68.65 for 2004) has increased less than ten dollars in past six years

Technology

- 22 Clinics use Practice Management Software
- 13 Clinics use Electronic Medical Records
- 17 Clinics use other software like Quick Books, etc. on a regular basis

Online Capacity

Connection Type	How Many	
Dial-up	10	
DSL	13	
T-1	6	
Cable	1	
Other	4	Includes Fiber-optics
Would Switch?	22	Only switch to faster connection

Connection Used For:

Electronic Billing	30
Research	30
Oregon RHC E-Group	24
General E-Mail	29
E-Mail Protected Health Information	1

Clinics' Biggest Challenges

- The number one reported challenge is operating revenue. Eleven clinics report struggles with operating revenue and many of those clinics report that keeping the doors open is a constant struggle.
- Concerns about RHC rules and regulations being burdensome and hard to understand/follow were voiced by ten clinics.
- Declining patient volume is reported as the biggest challenge for nine clinics.
- Seven clinics find the government payers difficult to work with, primarily Medicare and Medicaid; this included complaints that OMAP takes too long to pay.

Clinics' Biggest Challenges, cont.

- Recruiting and retaining providers is the biggest challenge for six clinics. Recruiting and retaining qualified staff was stated by four clinics as the biggest challenge.
- For three clinics problems with computer repair and tech support was reported as the biggest challenge.
- Significant administrative burden was mentioned by three clinics as a major challenge.

Isolated Rural Health Facility

*criteria- for being considered a Safety Net Clinic

- Annual board training on roles and responsibilities
- Private nonprofit or governmental unit
- Health service utilization
- Financial status
- Progress toward plan implementation
- Implementation of a Community Oriented Primary Care
- Participate fully in Medicaid and Medicare
- Operate a schedule of discounts
- Maintain FQHC or RHC status