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Valuation of Rural Health Clinics: Introduction

Rural health clinics (RHCs) are specially certified entities that were created in order to increase access to primary care services for patients located in rural communities.[1] RHCs were established via the *Rural Health Clinic Service Act of 1977*, which law was promulgated to address the increasing shortage of healthcare services in rural areas.[2] These clinics are specially licensed healthcare organizations through Medicare, and may be operated as either a for-profit or a non-profit entity.[3] RHCs may be *provider-based*, i.e., owned and operated as part of a Medicare-certified hospital, nursing home, or home health agency, or *independent*, i.e., as a free-standing clinic owned by a provider (or provider entity).[4] Although RHCs are typically not profitable entities, obtaining RHC certification may be particularly advantageous in areas with high proportions of patients insured by either Medicare or Medicaid, as these insurers provide enhanced reimbursement to RHCs.[5]

This *Health Capital Topics* article is the first installment in a five-part series regarding the healthcare *competitive*, *reimbursement*, *regulatory*, and *technological* environments in which RHCs operate, and will define RHCs and the market for these enterprises.

There are a number of requirements that RHCs must meet in order to become licensed and maintain their certified status with Medicare. First, the RHC must be located in a rural, underserved area (as defined by the *U.S. Census Bureau* and the *Health Resources and Services Administration*).[6] *Health Professional Shortage Areas* (HPSAs) are federal designations that indicate healthcare provider shortages based on geographic location, population, or facilities.[7] The area in which an RHC resides must be designated as a geographic-based HPSA, population-group HPSA, *medically underserved area* (MUA), or governor-designated and secretary-certified area within the last four years.[8] Additionally, the clinic must utilize *non-physician providers* (NPPs) in rendering patient services, including *nurse practitioners* (NP), *physician assistants* (PA), and *certified nurse midwives* (CNM).[9] In fact, the RHC is required to be staffed with one NPP, who must be located onsite to see patients 50% of the time the clinic is open (at a minimum) under physician supervision.[10] Although at least one NPP must be employed by the RHC, RHC physicians are able to provide services through an employment agreement or via contract, where the contractual arrangement may be directly between the RHC and physician or between the RHC and a third party that supplies the clinic with physician services, e.g., locum tenens agency.[11] RHC physicians and NPPs typically provide outpatient medical, mental health, or qualified preventive services.[12] In addition to these services, an RHC must be able to provide basic laboratory and diagnostic services such as:

(1) Chemical examination of urine by stick or tablet method or both;

(2) Hemoglobin or hematocrit;

(3) Blood sugar;

(4) Examination of stool specimens for occult blood;

(5) Pregnancy tests; and,

(6) Primary culturing for transmittal to a certified laboratory.[13]

Once an RHC satisfies all requirements and has been certified, the RHC maintains certification unless its location changes or the location no longer meets location requirements, i.e., is no longer in an HPSA.[14]

As of January 2019, there were 4,386 certified RHCs in the U.S.; however, approximately 46% of RHCs are operating at a loss, leading to increased risk of closure.[15] From 2010 to February 2019, there have been 98 RHC closures, exacerbating the rural healthcare service shortage.[16] As rural and underserved areas still have an insufficient distribution of the healthcare workforce, they are unable to adequately meet demand and provide timely and appropriate care.[17] As of the end of 2018, there were approximately 7,026 primary care HPSAs,[18] approximately 4,175 (59%) of which were rural areas, and which needed a projected 3,871 providers in order to remove these rural HPSA designations.[19] Limited access to healthcare services negatively affects health status, quality of life, and life expectancies; additionally, the inability to provide timely or appropriate care may lead to unmet health needs of the patient population, leading to preventable and costly hospitalizations.[20]

The market for rural health services is expected to experience increasing demand in the coming years, due to the aging *Baby Boomer* population and an influx of insured individuals through the ACA.[21] Both of these factors may increase the number of those seeking healthcare services. As demand increases, the supply of physicians is anticipated to decrease, due to an imbalance

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between the number of physicians who are moving toward retirement and the number of residents who are entering the profession.[22] While this may lead to a shortage of primary care services (especially in areas that are already underserved), because RHCs are required to be staffed by NPPs at least 50% of the time, RHCs may not be as strongly affected by the physician manpower shortage.[23]

In most industries, any shortage may lead to rising prices. However, in the healthcare industry, the federal government has some power to set prices through the Medicare program. Further, with respect to Medicare reimbursement, RHCs are reimbursed on an *all-inclusive rate* (AIR), which indicates that even if there is a shortage of primary care services in the next several years, prices (i.e., RHC reimbursement) may not rise to reflect this shortage.[24]

Although RHCs are typically not profitable ventures, as demonstrated by the significant proportion of RHCs operating at a loss,[25] they provide an invaluable service to areas that may not otherwise have access to primary services. Due in part to the relative dearth of RHCs in MUAs, free-standing RHCs may consequently be potential acquisition targets by entities such as *critical access hospitals* or other non-profit healthcare enterprises that are seeking to meet their charitable mission and increase healthcare access and quality of care in their communities. The remaining articles in this five-part series will explore RHCs in relation to the *Four Pillars* that influence the valuation of healthcare enterprises, assets, services: *competition*, *reimbursement*, *regulation*, and *technology*.

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