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Valuation of Rural Health Clinics: Competition

As discussed in the first installment of this five-part series regarding *Rural Health Clinics* (RHCs), the significant proportion of RHCs operating at a loss has led to an overall reduction in the number of RHCs.[1] Despite this decrease, the demand for RHCs continues to rise, limiting access to care for patients in rural communities.[2] This second installment will review the *competitive environment* of RHCs.

Supply of RHCs

As of July 2018, there were approximately 4,300 RHCs across the U.S.[3] However, the number of RHC closures is rising, with 98 closures from 2010 to February 2019, and approximately 46% of active RHCs operating at a loss (potentially signaling additional closures in the future).[4] These financial issues typically stem from the disproportionate number of Medicare and Medicaid patients (i.e., patients whose insurance coverage reimburses providers less than commercial insurance) that utilize RHCs.[5] As of 2018, there were 7,026 primary care *Health Professional Shortage Areas* (HPSAs) in the U.S., with 59% of those HPSAs located in rural areas.[6] These statistics indicate an insufficient supply of healthcare organizations such as RHCs for the size of the U.S. population living in rural areas.

Additionally, the overall supply of rural health services is expected to decrease as the number of physicians (especially primary care providers) decrease, with more physicians currently moving toward retirement than the number of residents entering the profession.[7] Further, the primary care physician to patient ratio is 39.8 physicians per 100,000 people in rural areas, compared to 53.3 physicians in urban areas.[8] Due to a lack of primary care physicians entering the field, and the current limited number of primary care physicians practicing in rural areas, the supply of rural health services could further decrease in the future.

Demand Drivers of RHCs

The demand for rural health services is driven by various social and health determinants, as well as by the proximity of a patient to an RHC. As set forth in Table 1, the rate of various social determinants of health are more acute in the rural areas of the U.S. than in the urban areas, potentially indicating a less healthy population (and thus greater need for healthcare services) in rural locations.

Table 1: Social Determinant Comparisons between Urban/Rural Areas

	A	B	C
	Social Determinant	**Urban Figure**	**Rural Figure**
1	Average Per Capita Income[9]	$59,652	$44,020
2	Poverty Rate[10]	14.3%	17.2%
3	Unemployment Rate[11]	4.8%	5.4%
4	Percent that Lacks a High School Diploma[12]	12%	14%

In addition to these *social* determinants, a number of *health* determinants, such as smoking and obesity, drive demand for rural health services. Across the U.S., those who live in rural areas have higher rates of smoking and smokeless tobacco utilization, as well as an earlier age at which smoking habits develop.[13] Smoking increases the risk of coronary heart disease, stroke, and lung cancer, and diminishes the overall health of an individual, contributing to the increased demand for healthcare resources.[14] Not only do more rural residents smoke than urban residents, they also smoke more frequently – those that live in rural areas are more likely to smoke more than 15 cigarettes a day, compared to those in urban areas, who are more likely to smoke six or fewer cigarettes a day.[15]

In addition to an increased demand for healthcare services, driven in part by the smoking habits of adults in rural areas where RHCs are located, a large number of Americans are considered obese. Approximately 39.6% of U.S. adults are obese (i.e., reported a body mass index ≥ 30).[16] Additionally, a majority of adults are physically inactive, with only 51.7% of adults meeting the national Physical Activity Guidelines for aerobic activity.[17] In turn, obesity, which has a greater prevalence among rural adults, contributes to increased chronic conditions and higher utilization of medical services, leading to increased demand for rural health services, driven by complications due to obesity.[18] In addition, obesity rates are higher among rural children and adolescents than in urban children, with rural children having 26% greater odds of becoming obese compared to urban children.[19] Studies have also shown that rural children engage in less physical activity compared to urban children, in which

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physical activity barriers include: isolation; lack of transportation; climate and terrain; safety concerns; and, lack of access to locations with physical activity opportunities.[20] Further, overweight children are more prone to become overweight adults, exacerbating this health determinant within rural areas.[21] The high rate of obesity in adults and children, as well as the contributing factor of physical inactivity, effectively increases healthcare demand by the rural patient population.

However, according the *U.S. Department of Agriculture* (USDA), population growth rates have been significantly lower in rural counties than in urban counties.[22] Many communities have experienced a net population loss, with a majority of the Northeast and Midwest rural counties losing population since the 2000s.[23] Many of those individuals leaving rural communities are younger, causing the median age in rural communities to rise, exacerbating the age difference compared to urban or suburban areas.[24] Additionally, the older population is expected to rise significantly as the *Baby Boomer* cohort ages, causing the number of older adults to increase by 18 million by 2030.[25] With the increase in the elderly population in rural communities (who will inevitably utilize a disproportionate amount of care), demand for RHCs will continue to rise despite the rural population out-migration.

Future Outlook

Despite current instability in the RHC market, as well as in rural healthcare generally, the *Centers for Medicaid and Medicaid Services* (CMS) is taking steps to implement new policies that will positively impact rural healthcare. On September 20, 2018, CMS released a proposed rule to reduce unnecessary regulatory burdens within the Medicare program, including several proposals to reduce burdens for RHCs.[26] Reduced regulatory burden may increase the ease of entry into the rural health market or improve the financial status of RHCs, potentially increasing the supply of RHCs in the future. Additionally, the *RHC Modernization Act*, introduced by Senators John Barrasso (R-WY) and Tina Smith (D-MN), aims to ensure that people in rural areas have access to healthcare services, as there is still a shortage of providers.[27] Because many RHCs are heavily dependent on Medicare and Medicaid reimbursement, the Act proposes to increase the RHC *all-inclusive rate* (AIR), i.e., the fixed reimbursement for all RHC visits.[28] An increase to reimbursement could potentially help the 43% of RHCs that are operating at a loss and are at risk for closure.[29] Additionally, an increase in reimbursement could draw more physicians into rural areas, as well as loan forgiveness and repayment options available to physicians practicing in *Health Professional Shortage Areas* (HPSAs).[30] Additionally, *non-physician providers* (NPPs), such as *nurse practitioners* (NPs) or *physician assistants* (PAs), often have extended scope of practice, which can range from autonomous practice to direct physician oversight depending on state regulations.[31] Increased reimbursement, as well as options for loan forgiveness and repayment programs, may draw NPPs to rural communities.[32]

The increase in demand for rural healthcare services is expected to increase due to the aging *Baby Boomer* population and the overall unhealthiness of rural communities, due to both *social* determinants, e.g., the relatively high unemployment and poverty rates, and *health* determinants, e.g., higher rates of smoking and obesity rates, in those areas.[33] However, the decrease in supply of RHCs and primary care providers results in a critical shortage of rural health services that are wholly insufficient to meet the rising demand. The next installment of this series will examine the *reimbursement environment* of RHCs.

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