GAO: Clinics should lose rural status

By TIM HEARDEN
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When Merced's Family Practice Medical Clinic was established in 1978 with federal subsidies as a rural health clinic, the city had 36,000 residents and a shortage of doctors.

Today, Merced's two hospitals are each part of e thriving network of facilities throughout the West Coast. There are a number of smaller clinics in or near town, and the 1990 U.S. census listed the city's population as more than 56,000.

Still, the Family Practice center – which has since grown into three separate clinics – still receives extra reimbursements for Medi-Cal and Medicare patients because it's still designated as a rural clinic.

That designation should change, argued a recent report by the U.S. General Accounting Office.

The GAO's report, titled "Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas," used the clinic next to Sutter Merced Medical Center as an example of the roughly 50 percent of federally aided clinics that serve areas that used to be small and isolated, but now are urban or suburban hubs.

Family Practice Medical Clinic operators counter that Merced's added population is largely made up of refugees and other immigrants – a group of people who tend to be poor and unable to afford health care, at least initially.

But Frank Fasquier, the GAO's assistant director for health issues, said the federal "rural" designation is intended for out-of-the-way areas, not poor areas, and fewer and fewer tax dollars are being used for their intended purpose.

"Hospitals were establishing these clinics and under Medicare rules, there's no limits to the per-visit charge to Medicare," Fasquier said. "We found instances (not in Merced) where the charge to Medicare was over $200 just for an office call."

By and large, the GAO isn't accusing clinics of doing anything wrong or illegal. But it made two recommendations:

- Clinics should be established only in areas where there is no other care available, or the care that is available isn't enough to serve the population.
- Clinics should be recertified periodically to make sure "rural" conditions still exist.

Of the roughly 3,000 such clinics aided by U.S. Health Care Financing Administration dollars, Fasquier said, 19 percent were in communities with more than 50,000 people, 27 percent were in communities with between 25,000 and 50,000 people, 31 percent were in towns with populations between 10,000 and 25,000 and only 23 percent were in communities of less than 10,000 people.

The report states that additional Medicare and Medicaid payments to these rural clinics amounted to $295 million last year.

Vi Celunga, director of ambulatory care for the Family Practice clinics, said the rural health

GAO: Rural clinics

(From page A1)

clinics still provide care to the community that people otherwise couldn't afford to get.

"They just made an overall statement; they really don't know all the facts," Colunga said. "They just made a statement based on what was happening nationwide. If you really want to be more specific, you should look at the community and the population living in that community.

"Right now with the availabiiity of the rural health clinic, we're able to provide specialty care for folks who would have to leave town for services like cardiology, orthopedics, neurology and rheumatolaogy ... If we didn't have a specialty clinic, people would have to go to Modesto or Fresno, and they would have no guarantee that a physician will accept them."

Merced County public health director Michael Ford pointed out that there are actually several different designations for rural health clinics. He said the fate of hospital-owned health clinics like Family Practice is apart from another debate that's been simmering in Merced County recently, over a proposal to withdraw a Health Professional Shortage Area designation everywhere in the county except in the Gustine area.

That, he said, would prevent some health centers from being able to recruit primary care physicians through the National Health Service Corps, in which doctors repay their medical-school loans by working for a couple of years in underserved areas.

All in all, Ford agreed that the current criteria for labeling areas are obsolete. But he said federal bureaucrats tend to be so locked into black-and-white rules that they don't look at the realities of each community.

"We're such an impoverished county, and we frankly do have a problem with access to care," Ford said. "Frankly they're using some black-and-white numbers and some old guidelines. Just because the population grows and just because the number of physicians increases does no mean improvement in the availability of health services or access to health services in that community."

The GAO's report has been forwarded to the House Subcommittee on Human Resources and Intergovernmental Relations, an arm of the Committee on Government Reform and Oversight.

"We're just saying the law needs to be changed to provide better criteria for 'rural' and 'underserved,'" Pasquier said. "Right now, there's no assurance the money gets targeted to where it's needed under the current rules."