

incentives. Once the clinic successfully attracted the needed health care professionals to the area, the Congress wanted to ensure that the service area did not return to its previous underserved status because we removed the clinic's RHC status and reimbursement incentives.

Although the grandfather provision was based on justifiable policy considerations, we are now confronted with RHC participation in some service areas with extensive health care delivery systems where Medicare and Medicaid beneficiaries are not having difficulty obtaining primary care. Both the General Accounting Office (GAO) and the Department of Health and Human Services' Inspector General (DHHS/IG) recommended the establishment of a mechanism, under the survey and certification process for Medicare facilities, to discontinue RHC status and its payment incentives in those service areas where they are no longer justified. (See the next paragraph.) In section 4205(d)(3) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33, enacted on August 05, 1997), the Congress responded to these recommendations by amending the grandfather provision to provide protection only to clinics essential to the delivery of primary care.

Medically Underserved Designations

Another reason for the continued growth of the RHC program was that two types of shortage area designations, specifically the medically underserved area (MUA) and Governor's designations, did not have a statutory requirement for regular review and were not systematically reviewed and updated for some time. As a result, some new RHCs may have been certified in areas that would no longer be designated as underserved if reviewed with current data. In response, as discussed below, the Congress amended the legislation by requiring that only those clinics located in shortage areas that were recently designated or updated will qualify for purposes of the RHC program.

Commingling

The growth of RHCs has also been stimulated by industry practices that are designed to maximize Medicare payment by obtaining RHC status for an integrated practice that submits both RHC and non-RHC Medicare claims. We define the term "commingling" to mean the simultaneous operation of an RHC and another physician practice, thereby mixing the two practices. The two practices share hours of operation, staff, space, supplies, and other resources.

Commingling occurs in RHCs that are an integral part of another provider, such as a hospital, as well as in RHCs that are independent.

A common approach taken by independent RHCs is to operate a private physician practice in the RHC at the same time the physician is furnishing RHC services to patients. We believe this could lead to incorrect billing or duplicate payments.

Government Reports

Both the GAO and the DHHS/IG concluded that the growth of RHCs is not proportional to community need and that many RHCs no longer require cost-based reimbursement as a payment incentive. They also concluded that the payment methodology for provider-based RHCs lacks sufficient cost controls and recommended establishing payment limits and screens on reasonable costs for these providers. (A provider-based RHC is an integral and subordinate part of a Medicare participating hospital, skilled nursing facility, or home health agency, and is operated with other departments of the provider under common licensure, governance, and professional supervision. All other RHCs are considered to be independent.) For more information on these reports see "Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas" (GAO/HEHS-97-24, November 22, 1996), and "Rural Health Clinics: Growth, Access and Payment" (OEI-05-94-00040, July 1996).

B. Legislation

Refinement of Shortage Area Requirements

Refinement of the shortage area requirements involves two phases.

1. *Phase I.* Section 4205(d)(1) and (2) of the BBA pertain to the requirements in the second sentence of section 1861(aa)(2) of the Act that RHCs must be located in a nonurbanized area as defined by the Bureau of the Census, as well as in a health professional shortage area (HPSA), an MUA, or in a shortage area designated by a State governor. The Congress amended those provisions to state that the rural area must also be one in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. This BBA change will be addressed by our sister agency, the Health Resources and Services Administration (HRSA), under separate rules. The Congress also amended that sentence to specify that, to be used in RHC certification, shortage area designations made by the

Department or by a State governor must have been made within the previous 3-year period.

2. *Phase II.* Section 4205(d)(3)(A) of the BBA, which amended the third sentence of section 1861(aa)(2) of the Act, the Congress revised the "grandfather clause" that permitted an exception to the termination of RHC status for a clinic located in an area that is no longer a rural area or a shortage area. This revision amended the grandfather clause to specify that an exception is available only if the RHC is determined to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the RHC. These amendments were made effective upon issuance of implementing regulations that the Congress directed us to issue by January 1, 1999.

Staffing Waiver

Previous to the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Pub. L. 101-508, enacted on November 5, 1990), an RHC was required to employ a physician assistant, nurse practitioner, or certified nurse midwife who must furnish their services 50 percent of the time the RHC operates. Section 4161(b)(2) of the OBRA added section 1861(aa)(7) to the Act to provide us with the authority to grant a 1-year staffing waiver of this requirement if the clinic can demonstrate that it has been unable, in the previous 90-day period, to hire one of these non-physician primary care providers.

Section 4205(c) of the BBA amended section 1861(aa)(7)(B) of the Act to restrict our authority to waive RHC staffing requirements. Under section 4205(c) of the BBA, a staffing waiver may only be granted to an RHC that is qualified and participating in the Medicare program.

Payment Limits for Provider-Based RHCs

Before the BBA, the payment methodology for an RHC depended on whether it was "provider-based" or "independent." Payment to provider-based RHCs for services furnished to Medicare beneficiaries was made on a reasonable cost basis by the provider's fiscal intermediary in accordance with our regulations at part 413. Payment to independent RHCs for services furnished to Medicare beneficiaries was made on the basis of a uniform all-inclusive rate payment methodology in accordance with part 405, subpart X. Payment to independent RHCs was also subject to a maximum payment per visit as set forth in section 1833(f) of the Act.