

Section 4205(a) of the BBA amended section 1833(f) of the Act. It now holds provider-based RHCs to the same payment limit and all-inclusive payment methodology as independent RHCs. This provision also provides an exception to the payment limit for those clinics based in small rural hospitals with fewer than 50 beds.

Expanding Access to Rural Health Clinics

Under the BBA, the independent RHC all-inclusive payment methodology and annual payment limit was also used for provider-based RHCs. This BBA provision also provided an exception to the RHC payment limit for those RHCs based in small "rural" hospitals.

Section 224 of BIPA expanded the eligibility criteria for receiving an exception to the RHC annual payment limit, effective July 1, 2001. Specifically, this section of BIPA extends the exemption to RHCs based in small urban hospitals. Thus, all hospitals of less than 50 beds (see section 1833(f) of the Act) are now eligible to receive an exception from the per visit payment limit for their RHCs.

Payment for Certain Physician Assistant Services

Sections 4511 and 4512 of the BBA removed the restrictions on the types of areas and settings in which the Medicare Part B program pays for the professional services of nurse practitioners, clinical nurse specialists, and physician assistants. This provision also expanded the professional services benefits for nurse practitioners and clinical nurse specialists by authorizing them to bill the program directly for their services when furnished in any area or setting. However, these BBA provisions maintained the current policy that payment for physician assistant services can be made only to the physician assistant's employer regardless of whether the physician assistant is directly employed or serving as an independent contractor.

Section 4205(d)(3)(B) of the BBA amended section 1842(b)(6)(C) of the Act to provide that payment for physician assistant services may be made directly to a physician assistant under certain circumstances. As an exception to the payment requirement under the physician assistant professional services benefit, this provision permits Medicare to pay a physician assistant directly who was the owner of an RHC (as described in section 1861(aa)(2) for a continuous period beginning before the date of the enactment of the BBA and ending on the date the Secretary determines the RHC

no longer meets the requirements of section 1861(aa)(2) of the Act, for those services provided before January 1, 2003).

Section 222 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) (Pub. L. 106-554, enacted on December 21, 2000) amended section 1842(b)(6)(C) of the Act to permit physician assistants who owned RHCs, and subsequently lost RHC status, to receive direct Medicare payment for their services, effective December 21, 2000. This BIPA provision eliminates the January 1, 2003 sunset date.

Quality Assessment Program

Currently, quality of RHC care is addressed in § 491.11, which requires a clinic to evaluate its total program annually. The evaluation must include reviewing the utilization of the clinic's services, a representative sample of both active and closed clinical records, and the clinic's health care policies. The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed. The clinic's staff considers the findings of the evaluation and takes the necessary corrective action. These requirements focus on the meeting and documentation of the clinic's evaluation of its quality care and do not account for the outcome of these activities. Section 4205(b) of the BBA amended section 1861(aa)(2)(I) of the Act to authorize us to require that an RHC have a quality assessment and performance improvement program. A quality assessment and performance improvement program enables the organization to systematically review its operating systems and processes of care to identify and implement opportunities for improvement.

We recognize that some RHCs are already incorporating a QAPI program into their normal operating activities. Others will begin to search for guidance in developing an appropriate QAPI program as they transition from complying with the current annual evaluation requirement. For some time now, professional and governmental organizations have been engaged in formulating guidance and in providing samples of QAPI related activities to entities interested in developing QAPI programs. In addition, state offices of rural health are excellent resources at a local level.

The Department of Health and Human Services has previously contracted with the National Association of Rural Health Clinics to develop technical assistance

materials for Rural Health Clinics to provide guidance in complying with QAPI requirements. The Department, working through the Health Resources and Services Administration's Office of Rural Health Policy (<http://www.ruralhealth.hrsa.gov>), will make those materials available widely and develop other technical assistance material as needed to help RHCs make the transition to the quality requirements of the final rule.

There are additional on-line resources that offer a wide range of support services to RHCs. Some of the more well known are as follows: The Rural Assistance Center (<http://www.raconline.org>), The National Rural Health Association (<http://www.nrharural.org>), The Rural Policy Research Center (<http://www.rupri.org>), and The National Association for Rural Health Clinics (<http://www.narhc.org>).

We expect RHCs that have no experience with QAPI programs to take advantage of the resources that are available. RHCs are encouraged to explore a variety of resources so that they can become familiar with the variety of approaches that exist to develop a QAPI program. An RHC that chooses to implement the QAPI resources (that is, model QAPI programs) provided by the Department and other on-line resources mentioned in this regulation will be considered to meet the QAPI condition for certification (CfC) provided that the model program chosen is one that is relevant to the RHC and its patient population.

II. Provisions of the Proposed Rule

On February 28, 2000, we published a proposed rule in the **Federal Register** (65 FR 10450) to implement the BBA amendments concerning the participation of RHCs in Medicare or Medicaid programs.

Definition of Shortage Area for RHC Certification

Section 6213 of OBRA '89 amended 1861(aa)(2) of the Act to expand the types of shortage areas eligible for RHC certification. Until then, the eligible areas included only those designated by the Secretary as areas having a shortage of personal health services and those designated as geographic health professional shortage areas under section 332(a)(1)(A) of the PHS Act. The OBRA '89 amendment expanded the eligible areas to also include high impact migrant areas designated under section 329(a)(5) of the PHS Act; areas containing a population group HPSA designated under section 332(a)(1)(B) of the PHS Act; and areas designated by