

Hours/Estimated Salary/Number of RHCs	One-time cost	Annual cost
1 clerical staff at \$6/hr × 5 hrs × 3,300 clinics	99,000	
1 mid-level practitioner at \$28/hr × 4 hrs × 3,300 clinics for data collection and analysis		369,600
1 mid-level practitioner—3 hrs training	277,200	
Totals	3,907,200	369,000

In developing our estimates, we obtained information on the salaries and wage estimation from the American Medical Association.

OBRA '89 reduced the nonphysician staffing requirement for RHC qualification from 60 percent to 50 percent. This reduction should have a positive effect on RHCs by providing them more flexibility in satisfying their overall staffing needs.

Effects on Other Providers

We are aware of situations in which an RHC and a physician's private practice occupy the same space and Medicare is billed for the service, either as an RHC or physician service, depending upon which payment method produces the greater payment. Our revision requires an RHC to be a distinct entity that is not used simultaneously as a private physician office or the private office of any other health care professional. As a result, private physicians or other practitioners who have used this approach under the Medicare program may experience some change in the operation of their practices from an administrative standpoint.

Effects on the Medicare and Medicaid Programs

As a result of this final rule, most provider-based RHCs are subject to payment limits and some RHCs will lose their RHC status and cost-based payment rates. Although these changes will likely result in program savings, we believe the aggregate amount is negligible for both programs. We cannot accurately estimate the payment differential between the new payment system for provider-based RHCs and the previous payments because the old system made payments without considering the number of patient visits. Without these data, we cannot precisely determine the fiscal impact.

However, in light of the fact that total expenditures for this program represent a small fraction of the Medicare and Medicaid total budget and that less than half of all RHCs will experience changes to their payment rates, we believe any aggregate savings will be insignificant. We also believe an insignificant amount of Medicare and Medicaid program savings will result from the provision

that will terminate RHC status for certain providers. Less than 5 percent of all participating RHCs could lose their status, and these affected clinics will continue to participate under Medicare and Medicaid and receive payment for their services on a fee-for-service basis.

Alternatives Considered

Section 4205 of the BBA imposes new requirements that an RHC program must meet. We considered some of the following alternatives to implement these provisions:

- *“Essential” RHCs.* Since the statute mandates an exception process for essential clinics, we considered using a national utilization test to recognize clinics that are accepting and treating a disproportionately greater number of Medicare, Medicaid, and uninsured patients, compared to other participating RHCs, for the purpose of addressing the situation of RHC clusters. For example, using an aggregate threshold based on the average Medicare, Medicaid, and uninsured utilization rates of participating RHCs, applicants will have to demonstrate that their utilization rates exceed the threshold.

Although this test would be administratively feasible, we concluded, based on our analysis of available Medicare and Medicaid RHC data, that it would not accurately determine “essential” clinics at the community level because of the wide variability in the percentage of services furnished to Medicare and Medicaid patients by RHCs. Despite our rejection of a national utilization test, we are open to suggestions on developing a minimum national percentage, which could be integrated with our major community provider test. We also considered the option of establishing less generous tests for identifying RHCs as essential clinics to the delivery of primary care. That is, the establishment of tests narrowly focused on a few extreme cases, such as an exception test for only sole community providers for a very rural community. We rejected this option because of concern that the disqualification of a clinic from the RHC program could harm access to primary care for the entire community. We believe a comprehensive set of tests is

needed to avoid harming access to care for rural areas.

- *QAPI Program.* Because the statute mandates that an RHC have a QAPI program, and appropriate procedures for review of utilization of clinic services, no alternatives for the requirement were considered. However, in the preamble of the February 28, 2002 proposed rule, we described alternative ways of satisfying the “minimum level requirement” for the QAPI program and asked for comments. Among the alternatives that we considered were the following:

- Require RHCs to engage in an improvement project in each domain annually.
- Require a minimum number of improvement projects in any combination of the domains annually.
- Require a minimum number of projects annually based on patient population.
- Rather than requiring a minimum number of projects, require RHCs to demonstrate to the survey agency what projects they are doing and what progress is being achieved. After considering the public comments, which were not conclusive, we decided not to establish a minimum requirement. We did consider alternatives for the final rule. One alternative was to take a more rigid approach to QAPI whereby the final rule would be more prescriptive in the process RHCs must follow to develop the QAPI program including setting forth specific performance measures to be utilized, the frequency and number of QAPI “interventions” that must be done, as well as the type and frequency of data to be collected. While a more rigid approach would increase RHC burden, we realize there would be no assurance that it would result in better or more predictable outcomes.

We decided to promote a more flexible and less prescriptive approach to the QAPI condition. We are more concerned with an RHC identifying its own best practices and the outcomes of an agency individualized QAPI program than in specific steps one takes to achieve the improvement. A more moderate QAPI requirement will allow an RHC the flexibility to utilize staff and other resources in ways that more directly supports its needs. An RHC can design a program to analyze its own