

2000 proposed rule, but concerned the implementation of the proposed rule and the potential impact on RHCs financial viability and access to care. Specifically, the loss of RHC status and the cost of additional regulatory requirements on clinics could negatively impact providers, especially small clinics, and their patients.

We share the commenters' concerns with preserving access to care for Medicare and Medicaid beneficiaries and the cost impact of establishing additional regulatory requirements. However, we believe the clarifications and changes that we are making to the regulations will eliminate or significantly reduce negative impact on rural providers and their communities.

Several commenters raised issues unrelated to the provisions of this rule. In this final rule, we only address the comments pertaining to the RHC proposed rule published on February 28, 2000, in the **Federal Register** (65 FR 10450).

#### *Scope and Definitions (§ 405.2401)*

*Comment:* Several commenters indicated that the definition of "shared space" should be clarified. For example, can an RHC lease or rent to a specialist during RHC hours of operation? Also, can an independent laboratory operate within RHC space during clinic hours as long as the cost is not included on the clinic's cost report?

*Response:* We are revising, in § 405.2401(b), the definition of *Rural health clinic (RHC)* to state that the RHC definition applies to physicians and nonphysician practitioners working for the entity to furnish RHC services. These practitioners are prohibited from operating a private Medicare or Medicaid practice during RHC hours of operation. Therefore, a specialist and an independent diagnostic laboratory can operate practices in leased or rented space within the RHC. The RHC definition was never intended to prohibit the operation of a multipurpose facility. The operation of a multipurpose facility and the sharing of common space (for example, waiting room), staff, and other resources is permissible as long as the costs are appropriately excluded from the RHC cost report.

*Comment:* Several commenters indicated belief that the proposed rule would prohibit RHCs from performing nonprimary care services. The commenters suggested that we not force the provider to set up two separate facilities.

*Response:* As discussed above, the RHC definition was never intended to prohibit the operation of a multipurpose facility. The operation of a multipurpose

facility and sharing a common space, staff, and resources is permissible as long as the costs are appropriately excluded from the RHC cost report. Therefore, in § 405.2401(b)(1), we are revising the regulation to clarify that physicians and nonphysician practitioners working for the RHC cannot operate a private Medicare or Medicaid practice during RHC hours of operation, using clinic resources.

*Comment:* Several commenters pointed out that problems associated with commingling should be addressed by improving cost reporting. The commenters stated that we should require the fiscal intermediaries to pay close attention to the Medicare Part B services on the Medicare cost report.

*Response:* We disagree with the commenters. We believe that the issue of commingling cannot be effectively addressed through the cost reports. When a practitioner who is working for an RHC shifts from patient to patient for billing Medicare and Medicaid (for example, simultaneously operates as a private practice under Medicare Part B and as an RHC under Medicare Part A), both the provider and the Medicare fiscal intermediary would have a difficult time accurately apportioning the cost associated with RHC patients. We believe the administrative burden of accurately allocating cost for the Medicare and Medicaid programs, as well as for the provider, would outweigh the benefits derived from this type of commingling.

*Comment:* One commenter suggested that we prohibit a single health care professional from billing both Medicare Part A and Part B in the RHC setting.

*Response:* Our proposed policy was established for the primary purpose of prohibiting health care professionals assigned to the RHC from billing Medicare Part B during clinic hours, using clinic resources. Therefore, we are revising proposed § 405.2401(b)(1) to clarify that physicians and nonphysician practitioners working for the RHC cannot operate a private Medicare or Medicaid practice during RHC hours of operation, using RHC space and resources.

*Comment:* A commenter indicated that it would be extremely difficult to conduct a pediatric practice in which publicly funded patients and privately funded patients were not treated equally in the same environment at the same time.

*Response:* The RHC definition prohibits physicians and nonphysician practitioners who are working for the RHC from billing fee-for-service under Medicare and Medicaid during RHC hours, using RHC space and resources.

We do not intend to regulate clinic policies for privately insured patients.

*Comment:* A commenter suggested that we allow more flexibility in the provisions of this regulation to recognize unique rural situations. Improving or maintaining access to care in rural communities requires adaptability to local situations.

*Response:* RHCs should not be paid for professional and facility costs through the Medicare cost reports while its practitioners simultaneously use RHC space and resources to bill fee-for-service benefits, which include these costs. Furthermore, we believe that the clarifications and changes that we are making to this policy, based on public comments, will provide sufficient flexibility for rural clinics to address access problems within their communities.

*Comment:* A commenter asked us to clarify § 495.2401(b)(1) that addresses practices other than Medicare, such as Medicaid and private pay, to ensure that practitioners are able to comply with the commingling rule.

*Response:* The RHC definition will preclude RHC practitioners from operating private Medicare and Medicaid practices during clinic hours, using RHC space and resources.

*Comment:* A commenter suggested that RHCs eligible for essential provider status should be given an exception to the commingling rules.

*Response:* The proposed changes to the RHC definition are intended to remove opportunity to duplicate billing and payments. This concern applies to all RHCs. Therefore, all RHCs must comply with the definition as stated in § 405.2401(b).

*Comment:* A commenter recommended that we provide RHCs with a specific list of CPT codes that should be included in the cost report. Many RHCs provide services beyond primary care and bill these services to Medicare Part B and deduct the costs from the RHC cost report. The commenter believes that an RHC definition specifying CPT codes would resolve the current issue of commingling.

*Response:* We disagree with the commenter. We do not believe it is appropriate to dictate the scope of the RHC practice by creating a list of medical services that must be billed and paid for outside the RHC benefit. We would run the risk of creating either an incomplete or overly inclusive list for participating RHCs, which vary in size and scope. Moreover, to do so would be contrary to the statute and therefore unenforceable. We believe the best approach for maintaining program