

integrity for the RHC benefit is to require that RHC physicians and nonphysician practitioners remain devoted to the RHC and its patients during clinic hours of operation as stated in § 405.2401(b)(1).

*Comment:* Several commenters suggested that an exception to the commingling rule should be granted to all rural hospitals or at a minimum to small rural hospitals with less than 50 beds. Rural hospitals, other than critical access hospitals (CAHs), experience difficulty recruiting sufficient staff to cover the RHC and emergency room simultaneously.

*Response:* We wish to clarify that the sharing of staff between hospital and the RHC is not commingling. We agree that any rural hospital with limited resources should be allowed to share staff between its RHC and emergency room. As discussed above, the primary purpose of § 405.2401 is to preclude physicians and nonphysician practitioners working for the RHC from operating a private Medicare or Medicaid practice during RHC hours of operation, using RHC space and resources. Therefore, it is permissible for any hospital-based RHC to share its health care practitioners with emergency rooms, as long as the clinic continues to meet RHC certification requirements and sufficient documentation is provided to allocate costs on consistent and rational basis.

*Comment:* A commenter expressed belief that the CAH exemption should be expanded to include rural hospitals that meet CAH requirements, but have chosen not to participate in the CAH program.

Also, several commenters suggested that in proposed § 405.2401, we should consider exempting RHCs located in extremely rural communities, such as frontier areas (less than six persons per square mile). These facilities face limitations on their available medical resources similar to CAHs.

*Response:* We agree that any rural hospital with limited resources should be allowed to share staff between its RHC and emergency room. We removed references to CAH and have clarified the purpose and scope of § 405.2401 to address both concerns.

*Comment:* Two commenters raised concerns about the necessary documentation to receive an exception to the commingling rule. The commenters suggested that the documentation should be done through the cost reports instead of through detailed practitioner logs, which can be very burdensome.

*Response:* We revised the regulation to clarify that any rural hospital with

limited resources should be allowed to share staff between its RHC and emergency room. With regard to the documentation issue, we will delegate to our intermediaries the decisions regarding acceptable accounting methods for allocation of staff costs between the RHC and other entities to be used in this documentation. We agree that maintenance of detailed practitioner logs on an ongoing basis is very burdensome, and other alternatives exist to achieve the desired results of assuring a proper allocation of costs, on a consistent and rational basis.

*Comment:* Several commenters recommended that RHCs be allowed to have nonclinic providers and medical specialists in their establishments during RHC hours of operation as long as all expenses are deducted out of the cost report.

*Response:* We never intended to restrict or preclude these arrangements. We are revising the regulation to clarify that physicians and nonphysicians who are employed to furnish RHC services are precluded from billing fee-for-service under Medicare and Medicaid during RHC hours of operation. Medical specialists who lease or rent space from the clinic can bill for their services during the clinic's hours. RHCs are also allowed to share common space (for example, waiting room), staff, and other resources with these specialists as long as the RHC appropriately removes the costs from its cost report.

*Comment:* Two commenters asked us to clarify whether RHC physicians who are on-call with an emergency room would violate the commingling rule. RHC physicians who provide on-call services, as opposed to being on-duty, should be allowed under this rule. Failure to amend the regulations to clarify this issue could reduce the availability of emergency room care for many rural communities.

*Response:* We agree that RHC physicians who provide on-call services for an emergency room should not be considered in violation of the commingling rule. It is clearly permissible for RHC physicians to provide on-call services for an emergency room as long as the clinic continues to meet RHC certification requirements and costs are appropriately excluded from the RHC cost report.

*Comment:* A commenter believes that sole community providers also need to commingle staff and equipment for financial and operational reasons.

*Response:* We agree with the commenter. We are revising proposed § 405.2401 to state that any hospital-based RHC is allowed to share its health

care practitioners with the emergency room as long as sufficient documentation is provided allocating costs.

*Comment:* A commenter believes providers should be allowed to operate an RHC and an emergency room in the same facility (especially small rural hospitals). There should be no sharing of staff during the hours of RHC operation, but we should acknowledge there are instances of common resource sharing. For example, it is customary for providers to share medical supply cabinets.

*Response:* We agree that providers should be allowed to operate an RHC and an emergency room in the same facility. In the case of shared storage space (shared medical supply cabinets), patient care supplies should be clearly distinguishable from those of any other entity in every respect.

Payment for Rural Health Clinic Services and Federally Qualified Health Clinic Services (§ 405.2462)

*Comment:* Several commenters suggested that the United States Department of Agriculture (USDA) Urban Influence Codes 5 through 7 should also be considered for rural hospital eligibility for the exception. There are many smaller rural communities surrounding cities, but they do not fall within the codes of 8 or 9.

*Response:* In defining rural for the Medicare program, we have consistently used the definition of Metropolitan Statistical Area (MSA) as established by the Office of Management and Budget (OMB). The available bed definition at § 412.105 is also a longstanding definition used in the Medicare program. We believe that these definitions are reasonable and appropriate for identifying eligible RHCs based in small rural hospitals. The alternative definition of bed size and rural was proposed to accommodate, based on industry concerns, extremely rural hospitals operating under extenuating circumstances. Communities that fall in the levels 5 through 7 are considerably less rural than those in level 8 or level 9. For example, a level 5 is a rural county with a city exceeding a population of 10,000 adjacent to a metropolitan area where a level 8 is a rural county that has a city with a population of less than 10,000 not adjacent to a metropolitan area. In light of the stark differences in rurality of these areas, we see no basis for changing the standard.

*Comment:* Several commenters strongly urged the adoption of the