

exception as a major community provider was not intended to be a routine occurrence. We examined the issue of using an absolute Medicare, Medicaid and uninsured payer mix threshold for defining a major community provider and we rejected this idea because it may not accurately determine essential clinics at the community level due to wide variability in population composition and utilization. However, for those clinics applying as major community providers, CMS would require the RHC applicant to have, at a minimum, Medicare, Medicaid and uninsured utilization rates reasonably consistent with the national average.

The Office of Rural Health Policy, within the Department of Health and Human Services, recently conducted a national RHC survey. Their survey-based data indicate that the average RHC utilization rates are as follows: Medicare (30 percent), Medicaid (25 percent) and uninsured (15 percent). An RHC applicant would be required to demonstrate under the major community provider test that their combined utilization rates for low-income patients (Medicaid and uninsured) would, at a minimum, equal or exceed 31 percent to even be considered eligible to apply for a major community provider exception. An RHC applicant could also meet a combined minimal utilization rate for Medicare, Medicaid and uninsured patient threshold of 51 percent to satisfy this screen. CMS believes the above minimal national utilization patient threshold is reasonable in light of the national average utilization rates and necessary to ensure consistency and fairness with respect to identifying major community providers.

*Comment:* A commenter suggested that priority be given to clinics that provide a real medical home for their patients. For example, clinics that have a full time physician with hospital admitting privileges and provide 24-hour coverage for their patients should be granted priority as essential clinics.

*Response:* The proposed tests for identifying an essential clinic are based on whether the RHC is the sole or major source of primary care for Medicare beneficiaries and low-income patients (Medicaid beneficiaries and uninsured). Although we believe that an after hours coverage system and full time physician care are important factors, the clinic must still demonstrate that it has an open door policy regarding low-income patients. As discussed above, CMS is requiring that these essential provider tests must take into account the willingness and resources of other

providers to accept and treat Medicare and Medicaid beneficiaries and the uninsured.

*Comment:* Several commenters believe clinics that have lost their rural status should be allowed to apply for an exception as an essential clinic. The regulation could exclude some RHCs that are still in medically underserved communities but fail to meet the rural location requirement. The CMS proposed policy could result in the loss of an essential RHC for uninsured and Medicaid patients.

*Response:* We agree with the commenters that an RHC that has lost its rural status but is still located in a valid shortage (geographic and population-based HPSAs, MUAs, and areas designated by the Governor of the State) area should be permitted an opportunity to apply for an exception from RHC disqualification. CMS recognizes that there may be some RHCs located in small, isolated urbanized service areas that are marginally above the minimum population threshold for qualifying as non-urbanized but represent the sole or major source of outpatient physician care for outlying rural areas designated as medically underserved. Consequently, we are revising § 491.5 to allow RHCs located in medically underserved "urban" service areas to apply for an exception as a sole, major, or specialty community provider. However, we believe that these clinics should also be required to demonstrate that they are an essential provider of primary care for patients residing in a rural area. The RHC program was established for the purpose of improving and maintaining access to primary care for "rural" underserved communities. In order to retain RHC status, CMS believes every RHC must be able to show that it continues to satisfy this basic program objective. It would be inconsistent with Congressional intent to grant exceptions from RHC disqualification to clinics non-essential to the delivery of primary care for rural patients. Consequently, CMS is requiring that at least 51 percent of the applicant's clinic patients reside in rural areas. We believe that a rural patient origin threshold of 51 percent is very reasonable in light of the statutory objective of the RHC.

*Comment:* Two commenters suggested that we conduct an extensive needs assessment of each community before rescinding the clinic's designation. If RHC status is removed, it may diminish the quantity and quality of health care services to an already underserved population.

*Response:* We believe that an extensive needs assessment is unnecessary in light of the fact that

HRSA already has made a determination that the area is no longer medically underserved. Furthermore, the purpose of granting essential provider status to RHCs is to ensure that access to quality care for Medicare, Medicaid, and uninsured patients is preserved despite the fact that the area is no longer considered rural or medically underserved.

*Comment:* A commenter suggested that the grandfather protection regarding essential provider status should be extended to rural clinics that lose their medically underserved designation. The commenter believes that if protection cannot be provided to these clinics in this manner, we should amend the exception process by including poverty level and access problems to transportation as eligibility factors.

*Response:* Section 4205(b) of the BBA requires us to determine whether a clinic is essential despite the fact that its area is no longer considered rural or medically underserved. We believe it would be inconsistent with congressional intent to provide an automatic exception to every clinic no longer located in a designated shortage area without making a determination whether the clinic is essential.

*Comment:* A commenter believes that any clinic that received its underserved designation to establish an RHC should be able to retain its status. Providers that have established clinics in very rural areas and successfully recruited physicians to these areas should receive an exception.

*Response:* We believe clinics that can demonstrate that they are essential based on the proposed conditions should be granted an exception. With regard to expanding the exception process to include clinics located in very rural areas, we believe this suggestion merits consideration. Please see the discussion below on how we intend to address this concern.

*Comment:* A commenter pointed out that some of the proposed exception tests may not be based on community need. Some of the tests do not distinguish between clinics with one physician and clinics with several physicians.

*Response:* We agree that the proposed tests need to take into account the willingness and resources of other providers to accept and treat Medicare, Medicaid, and uninsured patients. In light of this, we are requiring that the essential provider test must take into account the willingness and resources of other providers to treat and accept Medicare and Medicaid beneficiaries, and the uninsured.