

the area is very remote and has limited health care resources. Because our proposed tests target these situations, we see no reason for changing the regulation.

Comment: Several commenters indicate that we should automatically recognize essential provider status for clinics affiliated with critical access hospitals (CAHs), Medicare dependent hospitals (MDHs), and sole community hospitals (SCHs). The criteria for essential provider status are extensive, ranging from shortage area status to treating the uninsured. Consequently, it would seem appropriate and consistent with essential provider status for the RHC program.

Response: Although we agree that some of the criteria for CAH and SCH status are consistent with essential provider status for the RHC program, clinics applying for this special status should not automatically receive an exception because of their hospital affiliation. There could be cases where the clinic of the CAH or SCH would not satisfy the requirements for being an essential RHC. Therefore, the RHC should be required on its own to demonstrate compliance with the essential provider conditions.

Comment: Several commenters suggested that we should reduce the time and distance standard, for example, change it to 20 minutes or 15 miles. Many Medicare and Medicaid patients have a barrier to transportation services in rural areas. Furthermore, some rural communities have special populations, such as prison, indigent, or Medicaid.

Response: We agree that the proposed tests for identifying essential providers should address the issue of inadequate transportation services. However, regarding this specific issue, we believe it more appropriate and effective to grant an exception to more than one RHC in a given service area under the major and specialty provider tests than reducing the time and distance standards. Consequently, we are revising § 491.5 to clarify that we will, for the major and specialty provider tests, grant multiple exceptions within a specific service area as long as each RHC meets the conditions for receiving an exception.

Comment: A commenter suggested that we should establish a special population exception criteria to reflect certain populations (for example, the Amish) and rural communities with a high proportion of elderly or low-income residents. Additionally, rural areas designated as a low income HPSA or MUA should also qualify for the special population exception.

Response: The proposed essential provider tests already address the issue of special populations. All of the tests focus on the clinic's devotion to treating Medicaid, Medicaid, and uninsured patients. For establishing a special population exception for low-income HPSAs or MUAs, rural clinics located in service areas that have a current (within the previous 3 years) designation of this type are not in jeopardy of RHC disqualification.

Sole Community Provider Test

Comment: Several commenters suggested that the sole community provider test should be applied to clinics that are the sole source of primary care for their small rural town that are 8 to 10 miles apart from other small rural towns. The commenter believes that, under the proposed 30-minute test, the time and distance of the roundtrip may deny access to care for Medicare and Medicaid patients.

Response: Although we believe the time and distance standards in the proposed rule are reasonable, we acknowledge the need to preserve RHC status for sole community clinics located in small rural towns. The residents of these rural towns, especially those who lack access to transportation, may experience difficulty obtaining needed health care if the clinic cannot remain financially viable. Consequently, we are revising proposed § 491.5(b) at § 491.5(b)(1)(ii) to clarify that we will, when appropriate, grant an exception to more than one RHC within a specific service area, as long as each RHC meets the conditions for receiving an exception. We believe this will allow RHCs that are the major or primary source of health care for their small rural town to receive an exception.

Comment: A commenter believes the our proposed 30-mile test is inconsistent with published HPSA criteria of 25 miles.

Response: We agree that HRSA applies a 25-mile test for areas connected by interstate highways. We are revising proposed § 491.5(b)(1)(iii) to correct this inconsistency.

Comment: A commenter asked how the distances would be measured for determining the sole community provider test. The commenter questioned, for example, whether the distance will be based on actual driving time or on results from a mapping software program.

Response: For administrative efficiency, we will apply the time and distance test using a mapping software program.

Comment: A commenter pointed out that using the RHC as the geographic center does not take into account the distance a large percentage of patients travel in the opposite direction of the "other" primary care practice.

Response: We believe the proposal to use the RHC as the geographic center for identifying sole community provider status is reasonably accurate and feasible from an administrative standpoint. We have applied this method for the SCH and CAH programs. Therefore, we believe it is also appropriate for the RHC program.

Comment: A commenter believes that we need to provide a standard definition under this rule for the terms such as "secondary roads" and "primary roads." The use of these terms without providing a clear definition could lead to misinterpretation.

Response: HRSA has consistently applied the definitions in the Rand McNally Road Atlas for identifying primary, secondary, and interstate highways for purposes of the 30-minute travel test. We will also apply these standard definitions when reviewing essential provider applications.

Comment: A commenter recommended that RHCs requesting exception status should be immune from the 30-minute test if they have a formal sliding fee scale in place and 10 percent or more of their encounters are indigent patients.

Response: The sole community provider test already requires the applicant to demonstrate that it accepts Medicare, Medicaid, and uninsured patients that present themselves for treatment. Therefore, to waive the 30-minute test would simply make the sole community provider test a weakened form of the major community test, and would mean that it would no longer be focused on clinics that are the sole source of primary care for Medicare and Medicaid patients in their community.

This specific essential provider test recognizes clinics as sole community providers for Medicare beneficiaries and low-income patients (Medicaid beneficiaries and the uninsured). For example, a clinic could receive this sole clinic status if it is the sole source of primary care for Medicaid and uninsured patients. If the clinic is not the sole source of care for Medicare, Medicaid, or uninsured patients, it can qualify as a major community provider by demonstrating it is a significant source of health care for indigent patients, such as Medicaid and uninsured patients.

Comment: A commenter recommended that the "participating primary care provider" language under