

and uninsured patients, and continues to maintain this open door policy. Furthermore, the clinic's utilization rates for low-income patients would have to be consistent with the claim that it is a major source of primary care for its service area. For example, if there are three RHCs located in a rural town, which is no longer considered medically underserved, and two of the RHCs claim to be major community providers because their utilization rates for low-income patients exceed 45 percent, we would consider these RHCs with the higher utilization rates as major community providers if the third RHC has utilization rates of less than 10 percent for low-income patients. Also, as explained above, CMS would require the RHC applicant to have, at a minimum, Medicare, Medicaid and uninsured utilization rates consistent with the national minimal patient utilization threshold. 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 be eligible to apply for a major community provider exception.

Comment: Several commenters pointed out that multiple RHCs may be necessary to share the uncompensated and indigent care load. Multiple RHCs do not necessarily mean excess capacity.

Response: We acknowledge that there may be a situation where more than one RHC in a particular rural area represents the major source of primary care for Medicare, Medicaid, and uninsured patients. For example, there may be three RHCs located in a rural town that is no longer considered medically underserved, but only two of the three RHCs treat the Medicaid and uninsured population for that rural community. Therefore, we are revising proposed § 491.5(b)(1)(ii) to clarify that more than one RHC in a given service area can receive an exception as a major community provider. However, as discussed above, there must be supporting evidence that the applicants represent a major source of primary care for the patient population of the service area.

Comment: A commenter recommended that if we establish a national minimum utilization standard for the major community provider test, it should be set no higher than a combined Medicare, Medicaid, and uncompensated care rate of 60 percent.

Response: We rejected the idea of using a specified Medicare, Medicaid, and uninsured payer mix for defining a

major community provider because it may not accurately determine essential clinics at the community level due to a wide variability in utilization from region to region. We believe the best approach is to require the clinic to demonstrate that it represents a significant source of primary care for Medicare and indigent patients (Medicaid and uninsured).

Comment: Several commenters requested clarification of the situation when a "provider" may not be limited to one discreetly certified site.

Response: Health care entities that own and operate multiple RHCs would not be permitted to submit one application on behalf of all its clinics. The essential provider tests can only be appropriately applied on a facility specific basis.

Comment: A commenter believes we should state, for the major community provider test, that a disproportionate share of Medicare, Medicaid, and uninsured patients is defined as serving a higher percentage of these patients than the percentage in the community at large.

Response: The goal of this essential provider test is to identify clinics that are the major source of primary care for Medicare, Medicaid, and uninsured patients. We believe the test must *not* be solely based on whether the clinic is serving a higher percentage of these patients compared to other RHCs in the community, but based on whether the clinic represents a major source of primary care for these patients. The test, for example, will identify whether, without the presence of the clinic, other RHCs have the capacity or willingness to fill the void in terms of furnishing care to Medicare, Medicaid, and uninsured patients.

Comment: A commenter asked whether the RHC applying for the exception would be compared to other RHCs or all primary care providers.

Response: Clinics applying under this exception test will be compared only to other RHCs. However, in situations where the clinic is the only participating RHC, the test will compare the RHC to other primary care providers.

Specialty Provider Test

Comment: Several commenters expressed belief that the specialty provider test should be expanded to include mental health services. Recent reports have indicated a serious need for mental health services in rural underserved areas.

Response: We acknowledge that many rural areas are seriously underserved in terms of mental health services. We see

the merit of expanding the specialty provider test to include RHCs that provide mental health services. Therefore, we are revising proposed § 491.8(a)(6) to expand this essential provider test to recognize RHCs that employ a clinical psychologist or clinic social worker. We are expanding the specialty provider test in § 491.5 to grant exceptions to RHCs that represent the sole source of mental health care for their communities and that furnish these covered mental health services on-site.

Comment: Several commenters recommended that the exclusive provider language under the specialty provider test should be changed to give exemptions to specialty providers that see the majority of Medicare, Medicaid, and uninsured patients. There could be two pediatric clinics in the community, but only one clinic sees a disproportionate share of Medicare, Medicaid, and uninsured patients.

Response: We agree with the commenters that this essential provider test should take into account the possibility that there may be more than one specialty clinic furnishing primary care to Medicare, Medicaid, and uninsured patients. We share the commenters' concern that there may be two specialty clinics in the service area that equally share in treating indigent patients or, as described above, there may be two clinics and only one sees the majority of low-income patients. Consequently, we are revising § 491.5(b)(1)(ii) to eliminate the sole source of care requirement. We clarify that more than one RHC within a service area can receive an exception under this test as long as the applicant can demonstrate that it represents a major source of care for indigent patients (Medicaid and uninsured). Furthermore, the RHC applicants would be required to demonstrate that their utilization rates for low-income patients (Medicaid and uninsured) would, at a minimum, exceed equal or 31 percent to even be considered eligible to apply for a specialty clinic test as a major source of pediatric or OB/GYN care. We are making this change to be consistent with the major community provider test.

Comment: A commenter believes clarification may be needed, under the specialty test, regarding general medicine RHCs that include part-time or full-time OB/GYN or pediatric care.

Response: This test was established to specifically target clinics that exclusively provide pediatric and OB/GYN care. We believe the other tests in this final rule will give those clinics that do not limit their practice by gender or