



June 27, 2008

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1910-P2
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: CMS—1910-P2 Medicare Program; Changes in Conditions of Participation Requirements and Payment Provisions for Rural Health Clinics and Federally Qualified Health Centers; Proposed Rule (73 *Federal Register* 36696), June 27, 2008.

Dear Mr. Weems,

On behalf of Iowa's 117 hospitals, the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule to change the Conditions of Participation for rural health clinics (RHCs) and federally qualified health centers, published in the June 27, 2008 *Federal Register*.

While IHA supports CMS' efforts in continuing to promote high quality health care, it opposes some of the agency's proposals that would jeopardize the existence of Iowa's rural health clinics as the health care safety net for Iowa's citizens. The RHC designation has allowed rural and underserved areas in the state the ability to recruit and retain physicians that would otherwise choose not to practice in rural Iowa. In addition, the RHC designation has allowed many clinics to enhance the quality of services it provides to its communities, whether through hiring chronic disease specialists, implementing electronic health records, and improving overall outcomes of care. **Iowa physicians practicing in RHCs have stated they will leave the clinic if CMS adopts this proposed rule as written.**

The Iowa health care system is already on the brink of a physician supply crisis. This is a pervasive issue that affects both rural and urban communities, particularly in the recruitment of various specialists. This results in a loss of health care access for all Iowans and threatens the high quality of care ratings that Iowa has demonstrated over the past decade.

Because Iowa has one of the lowest Medicare reimbursement rates in the nation, Iowa has more difficulty recruiting and retaining physicians than most other states. The reality is that income concerns *do* make a difference in recruiting physicians. If CMS finalizes this rule as proposed, Iowa's ability to recruit and retain physicians, and Medicare enrollee access to care will continue to diminish.

The following are IHA's comments:

RHC Location Requirements

Current law requires that every RHC must have a shortage area designation made or updated within the last three years.

While the Health Resources and Services Administration (HRSA) approves these designations, states are responsible for ensuring their designations are updated on a regular basis. However, there is a disconnect between Medicare RHC policy and HRSA shortage area policy. RHC designations must be updated every three years, but HRSA requires the HPSA designation be made every four years. As a result, RHCs are in the awkward position of having to pressure their states to apply for a designation more often than they are required to under HRSA policy.

IHA urges CMS to work closely with HRSA to educate states about the proposed RHC regulations and to encourage states to post on their Web sites information regarding applications for shortage designations and the present location of the shortage and rural designations.

One criterion to become a RHC is that the clinic be in a designated shortage area either designated by HRSA or by a Governor's designation. CMS proposes that if a RHC does not meet this criterion it would be decertified within 180 days of the date the clinic no longer qualifies.

If RHCs in Iowa lose their designation, the physicians treating patients in these clinics will leave the area, leaving those patients without local access to health care. This also will result in a cyclical pattern of shortage area designation. When the RHC physicians leave the area—it again becomes a shortage area.

Because of the disruption to the rural health care safety net this proposal will create, **IHA requests CMS to allow for a grandfather clause of present RHCs.** CMS should perceive this as an investment in access to high quality, preventive health care for Medicare enrollees. Without local access to RHC services, the incident rate of Medicare enrollee visits to high-cost hospital emergency departments for care will increase.

A second criterion to becoming designated as a RHC is the clinic must be located in a non-urbanized area as defined by the U.S. Census Bureau. Three counties in Iowa do not fall into this category, threatening the viability of eight RHCs in Iowa. Further, IHA questions the appropriateness of the use of Census Bureau data because two of such counties don't even fall into CMS' definition of a Metropolitan Statistical Area.

IHA also requests CMS grandfather the existing RHCs in these counties. There is precedence for such grandfathering as provided by the Goldsmith Modification provision that allows urban hospitals to apply for rural designation based on specified criteria. One of the criteria allows redesignation if the hospital is located in a rural census tract that is part of an urban area. This is determined using the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy. The Office of Rural Health Policy has developed an updated version of the Goldsmith Modification called Rural-Urban Commuting Area (RUCAs) codes. RUCAs use urbanization, population density, and daily commuting data to identify rural census tracts in all metropolitan counties.

This same policy should apply to RHCs.

Payment Methodology for RHCs

In the proposed rule CMS implements section 1833(a)(3) of the Social Security Act, which requires that beneficiary coinsurance and deductible amounts be subtracted from reasonable costs to determine the Medicare payment amount, and which limits the Medicare payment amount to no more than 80 percent of costs which are reasonable and related to the cost of furnishing such services. Although this provision has been a part of the statute for more than 30 years—as long as the RHC provider designation has been in existence—CMS has not implemented or enforced it and has instead been paying RHCs at 80 percent of the facility's all-inclusive rate per visit, subject to a payment limit, without regard to the deductible and coinsurance amounts billed to Medicare beneficiaries.

CMS' interpretation of this statutory provision will have serious negative implications for the financial viability of RHCs, which will experience substantial reductions in Medicare payments. IHA questions CMS' motivation in implementing this new interpretation of statute after 30 years. The RHC program is not one whose rate of growth has elicited concern from federal advisory committees, federal oversight agencies or Congress. **IHA urges CMS not to implement this proposed policy and instead continue to pay RHC services using the current methodology.**

This proposal combined with the proposed changes to the location requirements will greatly reduce access to local care for Medicare beneficiaries, and other citizens that benefit from the RHC designation. Physicians working in Iowa's RHC are threatening to leave the clinics if these proposals are adopted as written, thereby further hindering Iowa's ability to recruit and retain physicians. Individuals in rural and medically underserved areas often have no other way to obtain health care, especially if they are unable to travel to urban centers for medical care.

Hours of Operation

CMS proposes that RHCs publish hours of operation on signage and clearly delineate the time the midlevel practitioners and physicians are present.

This is not a practical policy for RHCs that change their coverage from physician to midlevel on a regular basis, and for organizations that have more than one clinic and share physician coverage. **CMS should require posting of hours of operation when a practitioner is present, rather than requiring the delineation of type of practitioner.** RHCs need to be flexible in their staffing and coverage.

Authentication of Patient Health Records

CMS proposes to update its patient health record requirements to require that all entries in the medical record to require that all entries, whether electronic or hand written, be legible, complete, dated, timed and authenticated promptly by the person responsible for ordering, providing or evaluating the service(s) furnished. All entries in the record would be required to be authenticated within 48 hours unless state law designates an alternate time frame.

This proposal is unrealistic and burdensome for RHCs. There are many circumstances in which 48 hours would not be adequate to obtain physician authentication, for instance over the weekend following services provided on a Friday. Also, if there is a loss of transcription services a period longer than 48 hours would be necessary. **IHA urges CMS extend this proposal to a period of not less than 72 hours, and allow a longer time frame for extenuating circumstances.**

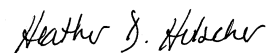
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Thank you for your review and consideration of these comments. If you have questions, please contact me at the Iowa Hospital Association at 515/288-1955.

Sincerely,

A handwritten signature in cursive script that reads "Heather D. Hulscher".

Heather D. Hulscher
Director, Finance Policy
Iowa Hospital Association

cc: Iowa Congressional Delegation
Iowa Hospitals
CMS Kansas City Regional Office