American Hospital Association

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November 17, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., S.W.
Washington, DC 20201

RE: Critical Access Hospital Interpretive Guidance – Transmittal 145

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) is writing to address our concerns related to interpretive guidance recently released by the Centers for Medicare & Medicaid Services (CMS) in its State Operations Manual (SOM).

We are concerned that CMS's recently articulated requirements around the documentation necessary to support a critical access hospital's (CAH) necessary provider (NP) designation are inappropriate and unnecessarily limited. They may very well have the dire consequence of causing many CAHs to lose the designation that they rightfully obtained prior to 2006. We urge CMS to immediately remedy this issue by revising its requirements to allow alternative methods of documentation.

In order to qualify for participation in the CAH program, a CAH must be located in a rural area and meet the distance or NP criteria set forth in 42 CFR 485.610(b) and (c). On Aug. 21, CMS published Transmittal 145, which included Exhibit 365 to Chapter 9 of the SOM, titled *Critical Access Hospital (CAH) Recertification Checklist: Rural and Distance or Necessary Provider Verification*. Exhibit 365 sets forth the procedures to be followed by the CMS Regional Offices (RO) and State Agencies to verify hospitals' compliance with these requirements for program participation prior to conducting a CAH recertification survey.

Specifically, for NP CAHs, Exhibit 365 indicates that the RO must review each CAH's file to determine whether there is evidence that the CAH was certified as an NP prior to Jan. 1, 2016. However, it lists only one source of evidence that will be considered sufficient – an NP designation letter issued by the state prior to Jan. 1, 2006. **However, CMS did not actually require states to issue these letters when CAHs were designated originally as NPs.** Indeed, until the agency issued Exhibit 365 in August, there had never been any sort of statute, regulation or CMS policy that required states to have issued an NP designation letter to a CAH that had

been designated as an NP. **We are extremely concerned that the agency now appears to be creating a retroactive requirement that the states had actually issued such letters, which is not the case in many instances.** The consequences of this retroactive policy change could be dire: if such a letter is unavailable, ROs have the ability to terminate a hospital's participation in the CAH program.

In contrast to its statements in Exhibit 365, CMS historically has allowed different types of documentation to serve as sufficient evidence of NP designation. For example, when the Medicare Prescription Drug, Improvement and Modernization Act of 2003 was amended to include a grandfathering provision for CAHs that were certified as NPs prior to 2006, a CAH only had to demonstrate that it had been designated as an NP in its state's rural health plan as of Jan. 1, 2006. Moreover, Transmittal 143, which was in place prior to and remains unchanged following the release of Exhibit 365, indicates that the RO should have documentation related to a CAH's original designation as an NP in its file. However, it states that, if the RO does not have this documentation, it may ask the CAH to supply copies of "the original necessary provider designation documents," implying that more than one type of document would suffice.

As a result of this broad guidance from CMS, many states did not issue NP designation letters to CAHs; we are extremely concerned that the hospitals will, therefore, obviously be unable to produce such letters. **We emphasize again that this retroactive policy change could have the very serious consequence of unfairly causing many NP CAHs to lose their CAH designation.**

By retroactively changing its requirements for documentation, CMS has created a standard that many hospitals will now be unable to satisfy, through no fault of their own. As a remedy, we believe that CMS should allow alternative documentation types to be accepted by an RO to demonstrate that a CAH has received the NP designation from its state, including, but not limited to:

1. The initial certification letter from the fiscal intermediary or Medicare administrative contractor dated prior to Jan. 1, 2006;
2. Documentation that the CAH was designated as a NP in its state's rural health plan as of Jan. 1, 2006;
3. A current or recent letter from the state attesting to the fact that a CAH was designated as a necessary provider prior to Jan. 1, 2006;
4. Any evidence used by CMS to determine or deem a CAH an NP, e.g. the documentation that the agency used to create the list of NP CAHs it provided to the Office of Inspector General for its August 2013 report: *Most Critical Access Hospitals Would Not Meet the Location Requirements If Required to Re-enroll in Medicare*; **or**
5. Any other evidence maintained by either the state or CAH that documents the state's designation of the CAH as a NP prior to 2006.

Allowing a wider variety of documentation types to serve as evidence that the CAH was certified as an NP prior to Jan. 1, 2016 would still achieve CMS's program oversight goals, while also maintaining consistency with its past policies of accepting more than one type of documentation as sufficient evidence that a CAH received the NP designation from its state.

Thank you for reviewing these concerns. We look forward to working with you to develop a reasonable solution that will ensure that those CAHs that have rightfully obtained NP designation may continue to participate in the CAH program. If you have any questions, please contact me or Priya Bathija, senior associate director, policy, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

cc: Sean Cavanaugh
Patrick Conway, M.D.
Kate Goodrich, M.D.