American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

June 28, 2016

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

RE: Critical Access Hospital Reimbursement

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 the Department of Health and Human Services' fiscal year 2017 budget proposal to reduce critical access hospital (CAH) reimbursement from 101 percent of reasonable costs to 100 percent of reasonable costs. **Reducing CAH reimbursement would have a significant and detrimental impact not only on these hospitals, but also on their patients and communities. The AHA continues to strongly advocate to maintain cost-based reimbursement of at least 101 percent of reasonable costs, as currently required by law.**

The Balanced Budget Act of 1997 created the CAH certification to ensure that hospital care would be accessible to Medicare beneficiaries in rural communities. As part of this program and as mandated by law, Medicare pays CAHs 101 percent of their reasonable costs for inpatient and outpatient services. **The reality is, however, that CAHs are currently reimbursed far less than 101 percent of reasonable costs; any additional reductions would threaten and limit their ability to provide necessary health care in rural communities.**

The current sequestration policies, originally set forth in the Budget Control Act of 2011, decreased Medicare payments to CAHs by 2 percent. This cut has been extended on several occasions, and will now be in effect through at least 2025. As a result, CAH reimbursement is actually only 99 percent of reasonable costs. In addition, only a portion of CAH costs qualify for reimbursement. These "allowable costs" do not capture some of the patient- and physician-related costs incurred by CAHs when caring for Medicare beneficiaries, including, but not limited to, certain emergency department services, standby/on-call costs for certified registered nurse anesthetists, diagnostic tests and laboratory procedures, preventive community health services, and services provided at off-campus CAH clinics. This leaves CAHs with a

reimbursement rate of even less than 99 percent of reasonable costs when considering their full scope of expenses.

Even if CAHs received 101 percent of reasonable costs for all of the costs they incur to treat Medicare beneficiaries, this 1 percent margin does not provide CAHs with the capital needed to make much-needed improvements to equipment and their physical facilities or to expand services offered to their communities. This 1 percent also does not go far enough to account for the challenges CAHs face as rural hospitals – including low volumes, a case mix that is more reliant on public program and more vulnerable to Medicare payment cuts and health care provider shortages.

CAHs play an important role in delivering health care to their communities, and we must continue to maintain the viability of these important hospitals going forward – that begins with maintaining cost-based reimbursement of 101 percent of reasonable costs. These hospitals provide essential high-quality medical care to the 19.3 percent of the U.S. population that resides in rural area, including many vulnerable patients. CAHs are often the only source of care in the area and, in total, treat approximately 7 million patients in their emergency departments and an additional 38 million in their outpatient departments. Yet, they account for less than 5 percent of total Medicare payments to hospitals.

Moreover, we urge the Centers for Medicare & Medicaid Services (CMS) and its Rural Health Council to reframe and broaden the scope of its work related to CAHs and other rural hospitals. Specifically, we urge the agency to move away from simply evaluating cuts to existing payment programs and instead toward developing integrated and comprehensive strategies to reform health care delivery and payment. The AHA is exploring this issue as part of its Task Force on Ensuring Access in Vulnerable Communities, which is examining emerging models and strategies to ensure access to health care services in vulnerable rural and urban communities. The work of the task force is ongoing, but the task force members have been clear that there is no "one-size-fits-all" solution that will work for all communities. To that end, we anticipate that the task force will present a variety of models that communities may choose to preserve access to essential health care services. We look forward to sharing additional insights with CMS in the coming months.

Thank you for reviewing these concerns. We look forward to working with CMS on this and other issues of importance to rural hospitals in the future. 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