American Hospital Association

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April 1, 2005

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Dear Mr. Hackbarth:

At your upcoming meeting, the Medicare Payment Advisory Commission (MedPAC) will conclude its discussions of its draft June report on critical access hospitals (CAHs). The CAH program is essential for maintaining adequate access to health care services in rural communities and we are concerned that information presented at the last meeting may have overlooked and undervalued the importance of this program to the Medicare patients served by these critical providers.

Growth in the CAH Program
Since 1997, the number of CAHs has in fact grown substantially. But this growth is a testament to the inadequacies of the prospective payment systems (PPS) used to pay hospitals for inpatient, outpatient, skilled nursing and home health services. Small rural hospitals with low Medicare volumes find it nearly impossible to succeed under payment systems designed to balance gains and losses on average costs over larger volumes of patients. **MedPAC's analysis of overall Medicare margins clearly demonstrates the inadequacy of payment for smaller hospitals, with a *negative* 6.2 percent overall Medicare margin for rural hospitals in 2003.**

In addition, current prospective payment systems inadequately address the different mix of services provided in rural versus urban hospitals. MedPAC's March 2005 report showed that while inpatient PPS payments represent 77 percent of all Medicare payments to hospitals, it represents only 67 percent of all Medicare payments for rural hospitals (see chart 1). Outpatient and skilled nursing payments represent a higher proportion of Medicare payments to rural hospitals – two prospective payment systems that reimburse significantly less than cost (see chart 2). These significant differences in Medicare reimbursement by service type place rural hospitals at a distinct disadvantage.

Chart 1:
Medicare Payments to Rural PPS Hospitals 2003

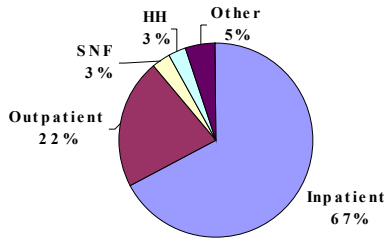
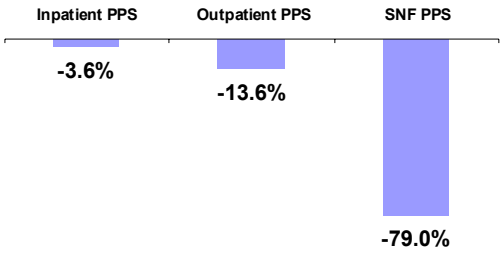


Chart 2:
Medicare Margins for Rural PPS Hospitals by Type of Service, 2003



These data clearly explain why many small rural facilities have converted to CAH status. They also show the importance of maintaining cost-based reimbursement for their inpatient, outpatient, and swing-bed services. Critical access hospitals are the safety net, integrated delivery system, and primary source of health care for the communities they serve. Cost-based payments for the full continuum of care they provide is essential for maintaining needed health care services in rural areas.

Distances between CAHs and Other Hospitals

MedPAC staff expressed concern about CAHs that are relatively "close" to other hospitals – less than 35 miles. We urge MedPAC to deliberate carefully when considering this issue. When the CAH program was created, it allowed states to waive the requirement that CAHs be at least 35 miles from another hospital. There was recognition that a federal mileage requirement was a blunt tool for identifying rural communities struggling to maintain a hospital and its vital emergency services. In the Medicare Modernization Act, Congress acted again to assist CAHs by expanding the size and service offerings for CAHs and increased payment to 101 percent of costs for inpatient, outpatient and swing bed services. Even though the program's original demonstration was intended to help more remote rural providers, the purpose of this program was legitimately expanded to ensure access to care in rural communities across the country.

It is shortsighted and inappropriate to apply a rigid federal mileage requirement without considering other factors such as geographic barriers between hospitals, seasonal affects on driving times, physician availability and practice patterns, community health plans involving the hospital, availability and type of emergency transport services, etc. These decisions, we believe, are best made at the local level. But unfortunately, the ability of states to waive the 35-mile requirement ends in January 2006. Given that CAHs would, in 2006, have to meet a strict mileage test, applying a new, more restrictive mileage policy on existing CAHs is unnecessary and likely would lead to closures and reduced access for Medicare beneficiaries living in those communities.

Cost Containment Incentives for CAHs

MedPAC staff has also raised concerns about incentives for cost containment when hospitals receive cost-based reimbursement. However, with an average total margin of only 2.2 percent, CAHs have significant pressures to contain costs for both Medicare patients and all other

patients. **With lower patient volumes, just one patient can mean the difference between operating in the black, or the red.**

Like other hospitals, CAHs face many cost increases for skyrocketing liability premiums, physician recruitment, pharmaceuticals and workforce shortages. Other cost increases are unique to CAHs whose financial situation improves with conversion, like giving nurses and other caregivers long overdue wage increases, updating antiquated equipment and Hill-Burton era facilities that are decades beyond their intended use, and purchasing administrative and clinical information systems. While there are increases in costs after conversion to CAH status, much of this is necessary "catch up" spending after years of barely getting by on inadequate Medicare payment. Making these types of changes was an anticipated outcome and expectation of CAHs as they strive to shore up and improve access to care in rural areas.

CAH Program Costs

MedPAC staff estimate that total Medicare payments will be nearly $4 billion in 2005 for the more than 1,000 CAHs across the country. This is a serious overstatement of the cost of the CAH program. The "cost" of the CAH program is only that spending above *what would have been paid* to these hospitals under Medicare's inpatient, outpatient and SNF prospective payment systems. That difference between cost-based payments and PPS payments is a relatively small amount for the Medicare program – but the impact on small CAHs and the people living in those 1,000 rural communities is tremendous.

The CAH program has been extremely successful in preserving health care access for Medicare beneficiaries living in rural America. The sustainability of rural health care access relies on protecting and preserving this essential, rural safety net program.

Thank you for your thoughtful work on the upcoming report. If you have any questions, please contact me or Danielle Lloyd at 202-626-2340.

Sincerely,

Carmela Coyle
Senior Vice President

cc: Mark Miller