AHANews®

American Hospital Association www.ahanews.com Vol. 43, No. 19 • September 17, 2007

Critical access hospitals welcome changes to CMS' relocation policy

By Matthew Malamud

The AHA and critical access hospitals (CAH) last week welcomed the Centers for Medicare & Medicaid Services' (CMS) recent announcement that it has significantly revised its "interpretive guidance" for CAHs seeking to rebuild or relocate their facilities. The new policy, put in effect Sept. 7, reflects many of the policy changes recommended by the AHA and CAH leaders.

"The critical access hospital program makes a huge contribution to improving care in these underserved rural communities," AHA Executive Vice President Rick Pollack said. "We took our members' concerns directly to CMS and to Capitol Hill, and made the case that its overly prescriptive relocation criteria would weaken a program that is vital to rural health care. By issuing these new guidelines, the agency has told rural America that it finally got the message."

CMS implemented the original guidelines in November 2005 to help state survey agencies interpret a provision of the fiscal year 2006 inpatient prospective payment system rule allowing "necessary provider" CAHs to relocate. Necessary providers are designated by states to be an essential source of care in their communities.

The interpretation of a "75% threshold" for relocation drew the most ire from CAH executives, largely because CMS applied the requirement to all CAHs, not just those with necessary provider status. The guidance said that one year after a CAH opens at a new location, the agency would review whether the CAH continued to serve 75% of the same population, provide 75% of the same services and employ 75% of the same staff.

The guidelines also specified that CAHs must submit a letter of attestation to justify their relocation plan so the agency could determine whether they still would be eligible for CAH status. But the agency would not make a final determination on eligibility until after the CAH's move – overlooking, CAH leaders said, the considerable financial risk of relocating without some assurances that the hospital could remain in the program.

Under the changes announced earlier this month, the 75% threshold only applies to necessary provider CAHs, but also gives these hospitals more flexibility in demonstrating that they are complying with the 75% test. In another important change, the new policy grants preliminary approval for the move. The agency will give its final approval once the hospital has relocated and provides evidence that it is in compliance with program requirements. The agency also is requiring less paperwork from CAHs seeking approval to build near their current facilities.

Hill

"These rules will make our lives a little bit easier," said Jeff Hill, CEO of Galena-Strauss Hospital, the sole hospital in Illinois' Jo Daviess County and designated a necessary provider. Galena-Strauss plans to open its doors this December at a site less than three miles from its current location. Hill expressed confidence that the hospital will retain its CAH status under the revised guidelines.

CMS also revised another serious area of concern: the definition of "mountain terrain" and "secondary roads," which made it hard to retain CAH designation. The agency had defined mountainous terrain as an elevation above 3,000 feet and stated that roads must consist of "extensive" sectors with grades greater than 5% or "frequent changes in elevation or direction." The safe speed limit on road had to be no more than 35 miles per hour.

The new policy recognizes that these standards were too restrictive. CMS now relies on the each state's definitions of mountainous terrain, and allows hospitals to count non-continuous secondary road mileage in order to demonstrate that the new facility is no less than 15 miles from another hospital.

Nearly 1,200 rural hospitals are certified as CAHs so they can receive cost-based reimbursement for Medicare. The program pays 101% of reasonable costs for services provided to Medicare patients, which include costs for salaries, equipment and essential building projects. A CAH must be certified by the state as a necessary provider of health care services in the community or be located more than 35 miles from another hospital – 15 miles in the case of mountainous terrain or areas with only secondary roads.

"The CAH program has been essential in allowing us to build our new hospital and continue to serve our communities," said Galena-Stauss CEO Hill. "Without the program, I believe we would be in a position to either have to shut our doors or pare back on services."

The new relocation policy also brings "good news" to Rural Bayside Community Hospital in Anahuac, TX, said hospital CEO Robert Pascasio. Under the old criteria, he wouldn't consider seeking lenders to help finance a new facility because "there was no way to assure them that there would be a new revenue structure until after a project was completed."

Rural Bayside overlooks Galveston

Bay, and Pascasio worries about hurricanes – like Hurricane Rita in 2005 – roaring over the bay and battering the hospital He said the new guidelines give him a green light to look for a new site a few miles closer to the town's commercial center and major roads in an effort to improve the community's access to its only hospital.

He also was pleased to see CMS shift more of the responsibility for assess program compliance from state surveys to regional offices. "Delegating authority to the regional offices is an intelligent move," Pascasio said. "We have a day-to-day working relationship with them. They know how to work with us."

CMS' 2005 relocation criteria not only troubled the AHA and rural hospital leaders, but also irked rural lawmakers on Capitol Hill. In separate letters to CMS, 36 senators and 60 representatives last year urged the agency to reconsider the relocation criteria. They contended that the policy threatened the financial viability of CAHs and would hinder rural patients' access to health care services.

A big win for rural care

"Regulatory overkill." That is how the AHA and critical access hospitals (CAH) described the "interpretive guidance" the Centers for Medicare & Medicaid Services (CMS) implemented in November 2005 for CAHs that wanted to rebuild or relocate their facilities.

So we were delighted to see the agency reach the same conclusion by announcing on Sept. 7 that it was revising and relaxing its criteria and immediately putting into effect much more realistic CAH relocation policies – common sense changes that reflect many of our recommendations.

EDITORIAL

The agency issued its original guidelines to help state survey agencies "interpret" the fiscal year 2006 inpatient prospective payment system rule's provisions allowing "necessary provider" CAHs to relocate. These hospitals – determined by CMS or the state to be an essential sole source of care in their community – must continue to care for at least 75% of the same service area, offer at least 75% of the same services and retain 75% of the same staff as they did in their previous location. The 75% threshold is fair. But in a breathtaking example of regulatory overreach, CMS applied the guidelines to all CAHs, regardless of whether they were designated necessary providers.

CMS overlooked the considerable financial risk of relocating without some assurances that the hospital can still remain a CAH. A small rural hospital cannot put everything on the line and a lender cannot be expected to put up funds toward a project with no indication as to whether CMS would approve the move.

In assessing compliance with the 75% test, the agency ignored a host of issues, like expected changes in medical staff, closures of area hospitals and other providers, natural disasters, disease patterns – such as a heavy flu season – and demographic changes that can affect a hospital's patient volume and characteristics.

Heeding our concerns, CMS revised the guidelines so they no longer require CAHs that are not necessary providers to comply with the relocation criteria. The new policy grants a CAH preliminary approval for the move and relaxes other requirements that placed in jeopardy the CAH status of many hospitals (see our story on page 1).

We've met regularly with agency officials and with our CAH champions on Capitol Hill to help convince CMS that its overly restrictive relocation criteria would weaken a program that is vital to rural health care. On Sept. 7, CMS told rural America that it finally got the message.