

Congress of the United States
House of Representatives
Washington, DC 20515

June 12, 2015

The Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 337H
Washington, DC 20201

Dear Acting Administrator Slavitt:

We write to you in support of the Critical Access Hospitals (CAHs) that serve our constituents in rural and mountainous areas of our nation – where travel can be difficult, resources and providers limited, and population demand less than in well populated areas. While these hospitals are small, their impacts are not. Without their presence, large portions of our districts would go underserved for many miles.

In recent years, a consensus across the political spectrum has emerged that healthcare waste, fraud, and abuse needs to be addressed, including the need to rein in certain aspects of Medicare spending. We all agree that savings need to be found so Medicare can remain solvent for current and future beneficiaries. We are, however, concerned that in an attempt to find savings, the unique challenges that more rural areas of our country face are being overlooked. In fact, the rural nature of many parts of the nation was the very foundation for certifying CAHs. It is important to remember that before the CAH program was created by the 1997 Balanced Budget Act, over 300 rural hospitals closed in the 1980s and early 1990s. The higher reimbursement these hospitals receive helps to ensure that CMS supports access to healthcare for all Americans, including those in rural areas.

The recent changes in guidance for the definition of “mountainous terrain,” and mileage for CAH designation deviate quite drastically from previously established definitions and leave us with significant concerns. For example, the requirement for 15 miles of mountainous roads does not adequately provide for the actual or varying conditions of those roads. Nor does it take into consideration the distance a patient will be traveling – the rule strictly measures distance from one CAH to any other hospital or another CAH and does not consider the distances a patient, perhaps in an emergency situation, will need to travel.

Additionally, in 2006, when the ability to designate a CAH as a Necessary Provider (NP) was removed, CAHs that were designated as NPs were grandfathered into the program. Therefore, we would like to know whether all hospitals, both those that were designated as an NP or that qualified under previous rural definitions, that are currently designated as CAHs will

still be grandfathered into the program, and will new definitions to qualify only apply to hospitals attempting to join the CAH program moving forward?

Without timely access to healthcare in the rural setting, patients seeking medical care will experience a greater likelihood of negative outcomes and accrue increased costs due to delayed care. As you know, this is significantly more costly to the system than compared to seeking care earlier. CAHs provide significant amounts of service to our constituents in a cost-efficient setting and oftentimes at the beginning stages of illness. However, if CAHs were unable to remain open after losing their designation, many in rural communities would see this access to care diminished and healthcare costs may increase as a result in the long-run.

It is important that CMS approach these proposed changes to CAH eligibility with caution. The economic viability of local communities, as well as the medical safety for the individuals these CAHs serve, is also at stake. Without a CAH designation, many hospitals, with the pharmacy services they offer and the emergency care and general access to healthcare they provide, will cease to provide that care. Additionally, individuals employed at these hospitals would no longer have a job or an income with which to provide for their families. While it is imperative that we continue to look for ways to cut waste, fraud, and abuse in government spending, we must consider the long-term impacts and costs associated with disrupting these rural economies and eliminating access to care.

We would like to work with you to establish guidance that supports our rural hospitals while also partnering with you to find savings within the Medicare program. To facilitate that discussion, we request that CMS provide any plans to review the designation of existing CAHs, as well as any plans CMS is considering to grandfather existing CAHs who entered the program under the previous definitions. As the appropriations process is currently underway in the House of Representatives, we would ask that you provide this information no later than July 6, 2015, to enable the Committees of jurisdiction time to review the information prior to any floor action. We look forward to hearing from you on this important matter.

Sincerely,



Bob Goodlatte
Member of Congress



Morgan Griffith
Member of Congress



Gregg Harper
Member of Congress



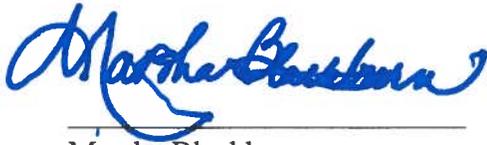
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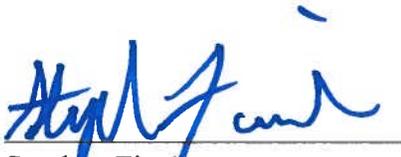
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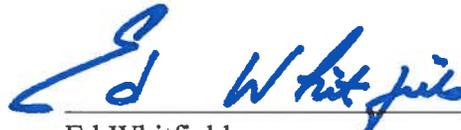
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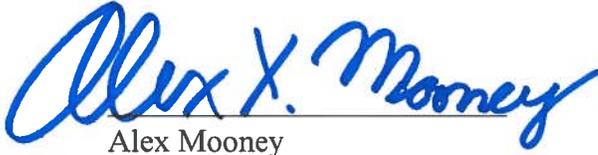
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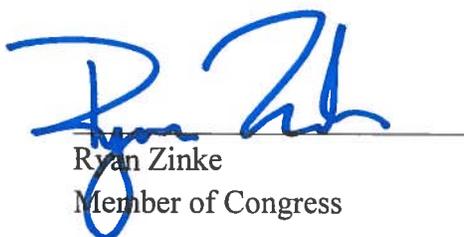
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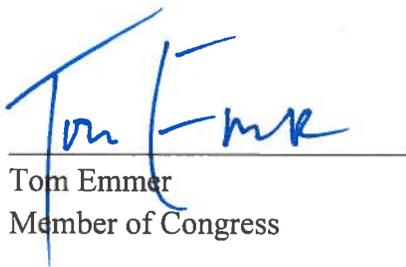
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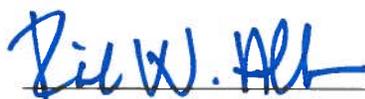
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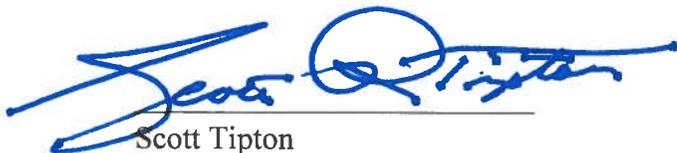
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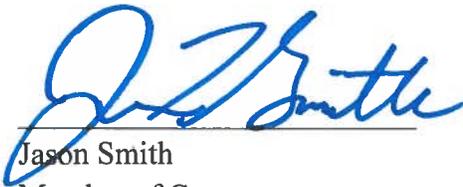
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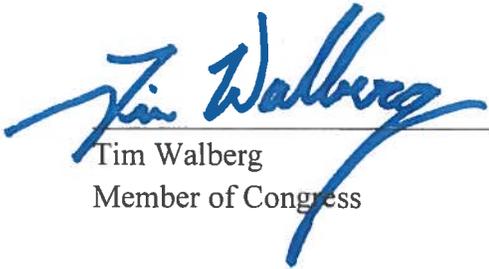
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