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June 20, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATT: CMS – 1500 – P
Post Office Box 8011
Baltimore, MD 21244-1850

Re: CRITICAL ACCESS HOSPITALS-Comment Regarding Proposed Rule RN 0938AN57

Dear Sir/Madam:

We write to provide comments to the Inpatient Prospective Payment System (IPPS) proposed rule regarding critical access hospitals, published in the Federal Register in Vol.70/No.85/Wednesday May 4, 2005/Proposed Rules under the listing of RN 0938 AN57.

As you know, the Critical Access Hospital (CAH) Program was created by Congress to provide cost-based reimbursement to limited service hospitals in rural areas to support the fragile health care delivery systems that exists in many rural communities. In order to qualify for CAH eligibility, a hospital must not be located within 35 miles of another hospital or must be designated by the state as a "necessary provider" of health care to its community, among other requirements.

The Medicare Modernization Act (MMA) prohibits a state from designating a hospital as a "necessary provider" after January 1, 2006. Congress's intent was to limit the states' ability to designate necessary providers because of the proliferation of CAHs that might not fulfill the goals of the program—to support rural hospitals serving a distinct population. The MMA did not intend to impact the existing CAHs that are necessary providers.

The proposed rule addresses whether presently designated CAHs that renovate and/or relocate facilities may retain the "necessary provider" designation. Two provisions of this rule are problematic, and actually work to undermine access to health care in rural communities.

The first provision provides that CAHs that renovate facilities may only be considered a "replacement facility" and retain their necessary provider designation if they renovate their current building or construct a new building within 250 yards of the current building. This proposed rule is unduly restrictive and fails to serve the goals Congress envisioned in designing the Critical Access Hospital program. CAHs exist to provide residents in rural areas access to quality, affordable health care. This rule undermines that goal because it prevents CAHs, many of which are older facilities, from expanding and updating their facilities to provide quality care to their residents. Many of these facilities exist on land that restricts their ability to renovate or expand. In these cases, it

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simply is not feasible for CAHs to renovate or expand their facilities on their physical locations. This rule assumes that existing hospitals have geographic land to expand on site. In some instances, the hospitals may have been given donated land on which to expand. Under this rule, hospitals that wish to renovate and relocate to donated land and serve the same community would lose their necessary provider status.

The second provision provides that for a Critical Access Hospital to maintain its "necessary provider" status and to be considered to be "relocating" according to PL 106-173, the facility must demonstrate construction plans were "under development" by December 8, 2003 (RN0938 AN57 – 5(B)(3)(a)). This date limits the plans of CAHs that commenced renovation plans after this date but before this proposed rule was published, and thus were unaware that their necessary provider designation would be in jeopardy when they initiated plans to rebuild their hospitals. In Colorado, two CAHs with necessary provider designations began plans to rebuild and invested substantial resources in the planning stages. This rule will endanger their designation if they proceed with their moves. Conversely, if they chose to remain at their current locations, they will be unable to renovate and modernize their facilities to provide quality care to the rural communities they serve.

Ultimately, this policy could mean less medical care for rural areas. We suggest a more flexible rule that grandfathers all CAHs with "necessary provider" designations provided they continue to meet the same needs of the population they were previously serving with substantially the same staff. We leave CMS to outline these guidelines, with the objective to promote the original intent of the CAH "necessary provider" designation—to promote the health care delivery systems in rural areas to provide quality, affordable health care to their residents. Necessary providers should not be forever foreclosed from modernizing their facility. Health care delivery is dynamic, incorporating technological advances that promise to improve quality and reduce the costs of health care. Necessary providers in Colorado and nationwide should be given flexibility to promote technological advances. Our state's rural areas count on these facilities and we must assist them in meeting the health care challenges of tomorrow.

Thank you for your careful consideration of these comments.

Ken Salazar
United States Senator

Wayne Allard
United States Senator

Marilyn Musgrave
United States Representative