**A Bit of History re the Development of Critical Access Hospitals**

by Tim Size, RWHC Executive Director, 8/20/13

Re the Department of Health and Human Services OFFICE OF INSPECTOR GENERAL: "MOST CRITICAL ACCESS HOSPITALS WOULD NOT MEET THE LOCATION REQUIREMENTS IF REQUIRED TO RE-ENROLL IN MEDICARE" by Daniel R. Levinson, Inspector General, August 2013

(1) The current Medicare system for paying hospitals, the Prospective Payment System (PPS) started in 1983. It was only tested in a handful of large tertiary hospitals in New England; subsequently, following the implementation of PPS, hundreds of rural hospitals closed across the country.

Over the next 15 years, many of us worked long and hard to reform the PPS to make it work equitably for rural hospitals. Many ideas were tested and failed. Finally, with strong bipartisan support, Congress passed the Balanced Budget Act of 1997 and with it, the program for Critical Access Hospitals. The program built on existing demonstrations for remote rural hospitals and adapted it for small, rural hospitals across the country.

States were given the right to designate through the establishment of federally approved state health plans, "necessary providers" eligible to receive Critical Access Hospital funding. The purpose was deliberative, the process public–not a loophole, not a bonus, not charity. It was Congress's response to fifteen years of the country seeking an appropriate and equitable payment system.

In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act. This law removed state designation of "necessary providers" in exchange for allowing CAHs to have the flexibility to staff up to 25 beds (compared to the previous limit of 15) and to increase reimbursement from 100% to 101% of reasonable costs. This agreement has defined Critical Access Hospitals, as we have known them for the last ten years.

While the Flex Program for CAHs was technically built on a model originally designed for remote locations, **the "sense of the Congress" at**

**the time was a recognition of the failure in trying to fit the round peg of rural into the square hole of PPS.**

The FLEX program was intended not as charity but as the closest we could get to designing an equivalent and fair reimbursement system for small rural facilities.

(2) **The funding for CAHs was intended to be an equivalent form of reimbursement to PPS, not a bonus or some form of public charity.** In that light, I don't see how a CAH being x or y miles from another CAH or PPS hospital can be wrong while it is OK that I can easily walk to four hospitals (a VA, one Catholic, one community and one academic) from my home in Madison. So yes, I am defending the "ten milers."

(3) There is an ongoing and necessary tension in our country between what I think of as "the power of place" (local communities and organizations trying, however imperfectly, to make sense of their world) versus "the power of capital" (control largely going to increasingly larger organizations and government outside of those communities). I continue to believe that we get the best results when there is a "reasonable" balance in that tension. **I am totally unashamed, as I believe is most of Congress, to advocate for Keeping Local Care Local**.

(4) As long as we have "fee for service" Medicare payments as a significant part of the payment puzzle, we need to preserve the “special” rural payments, including CAHs. Even after that; we can anticipate having very similar conversation as we discuss how premium dollar and Medicare payments are shared with ACO like entities. At the same time we have to work much more effectively to support rural communities coming into the rapidly changing world-to incent "value over volume" in a manner that helps preserve, where practical, local access to care and local jobs.

(5) If we are pointing fingers, I am surprised that by now, CMS has not worked to develop more robust models for rural in that regard. I think it is because, as has so often been the case, that time to focus on rural needs and opportunities always seems to come in second.