

August 27, 2007

Centers of Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P (NECESSARY PROVIDER CAHs)
P.O. Box 8011
Baltimore, MD 21244-1850

RE: NECESSARY PROVIDER CAHs

To Whom It May Concern:

This letter contains the comments of Dixon Hughes PLLC related to the notice of proposed rulemaking for Hospital Outpatient Prospective Payment System (OPPS) that includes proposals specific to Critical Access Hospitals (CAH). This proposed rulemaking was published in the Federal Register on August 2, 2007 and will be effective January 1, 2008 if implemented.

Dixon Hughes PLLC (DH) is a Certified Public Accounting and Consulting firm. DH is among the top 20 CPA firms in the country. DH has a significant healthcare practice rendering a wide range of accounting and consulting services to clients throughout the country. DH is associated with over 100 Critical Access Hospitals (CAH) in over 20 states. Consequently, we have significant experience in the financial and operational affairs of CAHs.

We are very concerned about the provisions in the proposed rule which will eliminate the potential of a necessary provider, or any CAH, to establish a provider-based location including a department, a remote (off campus) location or an off campus distinct part psychiatric or rehabilitation unit on or after January 1, 2008 that does not meet the distance criteria for CAH from another hospital or CAH. The penalty for establishing such a unit can be the loss of CAH certification. CMS proposes "...any off campus locations must satisfy the current statutory CAH distance requirements, without exception and regardless of whether the main provider CAH is a necessary provider CAH." This proposal has significant potential to create a negative situation for many CAHs and will consequently negatively impact access to care for Medicare beneficiaries in many rural communities.

We believe that potential access will be diminished in many rural communities because those areas are experiencing an increasing inability to recruit or retain physicians in private practice, non-provider-based practices. This is the result of many factors such as:

- the aging physician workforce,
- inadequate numbers of medical graduates targeted to rural areas because most graduate medical education programs are targeted to urban training,
- insufficient Medicare and Medicaid payments for free-standing physicians on the fee schedule,
- inadequate Medicare and Medicaid payments to free-standing Rural Health Clinics (RHC),

- increasing amounts of uncompensated care being provided in economically depressed rural communities, and
- other localized factors throughout the country.

In an effort to overcome these recruitment and retention challenges, many rural hospitals (including CAHs) are developing programs that will envelop the rural primary care practices within the hospital's organizational, financial and operational structure (i.e. provider-based scenario). In these cases hospitals are employing physicians or otherwise guaranteeing their income and benefits through contractual arrangements in order to attract and/or retain them in the community. In some cases, the practice locations are being expanded to provide therapy, laboratory, radiology and other diagnostic services in order to maximize access and minimize travel problems for the rural poor and elderly. Other situations develop because there is inadequate space on the CAH campus for expanded services. Therefore the CAH is required to go "off-campus" to provide much needed services. In many cases, these "off-campus" community-based sites will be within 35 miles of another hospital in the case of a necessary provider CAH.

Because Medicare cost reports require hospital overhead be allocated to the operations of the hospital-owned practices, fee-based payments are insufficient to cover both the direct cost of operations and the allocated overhead. Therefore, the cost-based reimbursement of provider-based status is necessary for the financial sustainability of both the practice and the CAH.

We have also experienced clients that are part of a controlled group or network that act with an intentional spirit of collaboration in which they seek to provide the best services and access in the most efficient and cost effective way. These enterprises have created "off campus" facilities in rural communities, within 35 miles of another CAH or hospital with the full collaboration of the neighboring entity. Under the proposed regulations, this type collaborative effort that is a goal of the Flex Program will be stymied. The result will be a continuation of inefficient, duplicative points of access to care or in worse case scenarios beneficiary access will be inhibited.

We recognize CMS has a duty and interest to protect the public from unwarranted "gaming" of the cost-based Medicare (and Medicaid in some states) payment system. However, we believe the proposed regulations are too restrictive. In an effort to create a more reasonable criterion, we believe there should be a test similar to that contained in the existing provider-based regulations that demonstrates a "high level of integration" with the main provider (i.e. the CAH or necessary provider CAH). The test contained in §413.65(e)(3)(iii) – (iv) otherwise known as the 75/75 test, is intended to demonstrate that the proposed facility or organization has or will have a high level of integration with the main provider.

We also believe that the current provider-based attestation standards contained in §413.65 should be used by the CAH to gain approval by the Intermediary of the proposed facility or organization. We believe the attestation may be filed in advance of the creation or acquisition of the off campus facility or organization if the CAH wishes to be held harmless for any subsequent adverse finding. We believe the CAH could also determine that it meets the provider-based regulations, including the high level of integration criteria, and establish the off campus facility or

organization and file the attestation after the initiation of services at the off campus site. In this case, a future adverse determination by the Intermediary would subject the CAH to the refund of the difference in Medicare, and Medicaid if applicable, reimbursement between the cost-based CAH and the applicable fee schedule.

Because we have had experiences of what we believe have been unreasonably lengthy periods of time for the Intermediary response to attestation requests, we believe that Intermediary determination of provider-based status based on submitted attestation requests should be required within a reasonable period of time (such as 60 days from the date of submission). In the event that the Intermediary fails to respond within the specified time, the approval of provider-based status should be deemed to be granted.

We also believe that moving the location of off campus physical facilities, within a reasonable proximity of an existing off campus facility that is a provider-based facility or organization, should be excluded from any future test of distance or "high integration".

We believe that "on campus" patient service functions owned and controlled by the CAH or necessary provider CAH should clearly be exempted from the tests of distance from other hospitals or high level of integration tests.

Thank you for your consideration of these matters. If you have questions concerning these comments, please contact me at 336-714-8100 or tbarnhart@dixon-hughes.com.

Sincerely,

A handwritten signature in cursive script that reads "Tommy L. Barnhart".

Tommy L. Barnhart, CPA
Member