CHARLES E. SCHUMER
NEW YORK

DEMOCRATIC LEADER

United States Senate

WASHINGTON, DC 20510

March 12, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Administrator Verma:

I write in regards to a determination by the Centers for Medicare & Medicaid Services (CMS) that significantly altered the Critical Access Hospital (CAH) eligibility requirement for location relative to surrounding hospitals. This change in criteria has potential to adversely impact at least nine of the current eighteen CAHs in New York State, as well as other rural hospitals that may seek CAH status in the future. CAH designation is vital to ensuring health care access in sparsely-populated, rural communities, and many of these hospitals would not be financially sustainable without the additional support the designation provides.

As you know, in order to qualify for CAH status, a hospital must "be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads." Under years of CMS guidance, "primary roads" were considered any road in the interstate system or a US-numbered highway, while single lane state routes were considered "secondary roads." This allowed rural hospitals across New York, which rely heavily on NYS Routes, to satisfy the lower 15-mile distance threshold in order to receive CAH status. These definitions served as the basis for eighteen hospitals in New York receiving CAH designation since the program's inception in 1997.

However, New York State officials were notified late last year that CMS began citing a 2015 CAH State Operations Manual (SOM) that changed the definition of "primary road" to include any road in the "National Highway System," which includes NYS Routes. This new definition could jeopardize the status of New York hospitals that received CAH status under the previous guidance.

According to the New York State Department of Health's (NYSDOH) review of the existing eighteen CAHs in the state, nine of the hospitals have NYS Routes – now considered primary roads and thus subject to the higher 35-mile threshold – in their markets. Consequently, those hospitals are at risk of losing CAH status during the recertification process if CMS applies the "National Highway System" criterion when evaluating the distance between them and other hospitals. Such a decision threatens the ability of these providers to maintain operations, imperils access to care for the communities they serve, and would result in an aggregate loss of more than $35 million per year in federal aid.

In advance of the CAH recertifications of at least four New York hospitals in the coming months, I respectfully request that CMS delay the upcoming recertifications until the agency can come to a resolution with our providers. Relatedly, since the loss of CAH status would impact provider payments, I urge you to not apply the policy to existing CAHs. Significant policy changes such as the one made in 2015 should go through notice-and-comment rulemaking, not altered at the sub-regulatory level, as clarified in the 2019 Supreme Court decision in Azar vs. Allina Health Services. Lastly, I strongly encourage CMS to quickly reschedule the recently cancelled meeting with NYSDOH regarding CAHs in New York State. Due to the potential financial impact on our hospitals and New York State, I appreciate CMS communicating with the NYSDOH on a regular and timely basis in regard to this issue.

The CAH designation was created by Congress to reduce the financial vulnerability of rural hospitals and improve access to health care by keeping essential services in rural communities. This change to criteria not only threatens the very goals of the program, but also the viability of hospitals across the country.

Thank you for your attention to this important matter. Please do not hesitate to contact me or my staff should you have any further questions.

Sincerely,

Charles E. Schumer
United States Senator