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To the Editor:

Critical Access Hospitals Are Essential To Rural Communities

We take exception with many of the characterizations included in “Comparing Costs for Outpatient Care” and “New Risks at Rural Hospitals” published in the Dec. 25, 2015, edition of The Wall Street Journal.

The Medicare program’s premise is to provide beneficiaries, regardless of where they live, access to high quality, efficient care. CAHs are key to that principle — including the 266 CAHs in our states.

Historically, CAHs have received cost plus one percent reimbursement. Today, that isn’t the case. All Medicare hospital payments, including those for services at CAHs, have been reduced by 2 percent through “sequestration.” As a result, CAHs are paid less than the cost of providing care for Medicare beneficiaries.

Moreover, CAHs face manifold challenges, include serving an older, poorer and sicker population with lower rates of commercial insurance coverage. Many of the nation’s hospitals can cost shift Medicare or Medicaid losses to commercial payers; few CAHs have enough commercial payer volume to offset these losses. And, as many rural providers will point out, this “unbalanced” payor mix demands efficiency.

Although most CAHs are exempt from participation in quality reporting programs, some CAHs voluntarily participate. In many cases, even CAHs that choose to report don’t have the volume of patients to accurately benchmark their quality against all hospitals. Moreover, CAHs know their capabilities and transfer patients to tertiary hospitals, when necessary, to provide safe, efficient care.

The services CAHs provide are essential to rural communities — they support rural economies, provide basic and lifesaving health care services and allow rural residents to seek care locally and age in place. The innovation taking place in CAHs reflects the traditional spirit of rural living — surviving and thriving on limited resources.

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