American Hospital Association

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July 12, 2004

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Room 443-G
Washington, DC 20201

**Ref: CMS-1428-P — Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 *Federal Register* 28196), May 18, 2004**

***RE: Rural Hospital and Critical Access Hospital Provisions***

Dear Dr. McClellan:

On behalf of the American Hospital Association (AHA), its 4,700 member hospitals and health care systems, and 31,000 individual members, we appreciate the opportunity to comment on the provisions specifically related to rural hospitals and critical access hospitals in the Centers for Medicare & Medicaid Services'(CMS) proposed rule for hospital inpatient services for fiscal year (FY) 2005. This letter follows three previous letters filed on the FY 2005 inpatient rule.

**Revised Metropolitan Statistical Areas (MSAs)**
In our July 2 comment letter, we expressed concern about those critical access hospitals (CAHs) that would be designated as urban due to the new geographic boundaries proposed by CMS. We believe it is essential that these facilities maintain their CAH status. Even though they may no longer be located in "rural" counties, their physical location has not changed and these areas still have health care access concerns that can be adequately addressed only through protecting the local hospital's CAH status.

Our data indicate that approximately 90 CAHs would be affected by the new MSAs, including those hospitals located in "Lugar counties" (rural counties that are deemed urban). In the proposed rule, CMS is silent regarding the impact of the new MSA designation on a hospital's CAH status. It does not appear that CMS is considering that these hospitals would become prospective payment system (PPS) hospitals beginning October 1, given that their data were not included in CMS' calculation of the wage index or the corresponding standardized amount for PPS hospitals. The AHA would like this to be made clear in the final rule.

We believe it would be very difficult to immediately convert these facilities to PPS. For example, CAH wage indexes would not be accurately adjusted for the occupational mix of their employees because they were exempt from collecting this data (and their information also was not included in the average occupational mix adjustment for the nation, affecting all hospitals' data).

Further, we believe it would be incredibly burdensome and expensive for CMS, its fiscal intermediaries and CAHs to have CAHs convert back to PPS status beginning October 1, given that these facilities would likely apply, and be granted, a State waiver allowing them to once again become a CAH. Based on our analysis of the statute, redesignation of a county from rural to urban would not jeopardize a hospital's status as a critical access hospital, provided that either the area or the hospital is designated as rural by the State as provided by 1886(d)(8)(E)(ii)(II). While we are unsure how many of these 90 CAHs are deemed a "necessary provider" by their State, given that all are within 35 miles of the nearest facility, we believe it is the majority.

Given the short time-frame, however, we are concerned that these hospitals may not have time to become designated by the State as a "necessary provider." **Thus, we urge CMS to use its administrative authority to "grandfather" all CAHs as rural so they may seamlessly retain their current CAH status and maintain other benefits they receive for being rural (such as grant funding, health professional shortage areas (HPSA) bonuses, etc.)**

**Rural Community Hospital Demonstration**
Section 410(a) of the Medicare Modernization Act (MMA) requires CMS to create a demonstration project to test the feasibility of establishing a new special payment status for certain hospitals, called rural community hospitals, where inpatient hospital services would be paid reasonable cost under Medicare. The law specifies that the demonstration would apply to 15 qualifying hospitals in "states with low population density." CMS has arbitrarily restricted this selection process to the 10 states with the lowest population density. Elsewhere in the rule, CMS limits a sole community hospital provision to six low population density states, yet the definition of "low population density" has a number of interpretations. Given this, we are concerned that limiting the demonstration to 10 states is against congressional intent, as it would constrain geographic and regional variability in the selection of the demonstration sites. **The AHA recommends that CMS revise its criteria to permit hospitals in "areas of any state with low population density" to be eligible for the demonstration. A revised deadline of 30 days after publication of the final rule should be provided so all interested hospitals may apply.**

**Low-Volume Hospital Adjustment**
Section 406 of the MMA provides for a new payment adjustment under the inpatient PPS to account for the higher costs per discharge of low-volume hospitals. The increase in payment is to be determined based on "an empirical relationship between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental cost (if any) that are associated with such discharges." Further, the law specifically defines a low-volume hospital as one that "has less than 800 discharges during the

fiscal year." CMS, however, is proposing to base the count of discharges for both the purpose of meeting the qualifying definition and determining the amount of the payment adjustment on 500 discharges, stating that there is not an empirical relationship between costs and discharges at a level of more than 500 discharges.

The AHA is concerned that this interpretation would deny needy – and deserving – hospitals of a congressionally mandated payment adjustment. While CMS discusses the negative inpatient Medicare margins for hospitals with up to 500 discharges, it does not provide any data for those with between 501 and 800 discharges. Our analysis of FY 2002 Hospital Cost Reporting Information System (HCRIS) data indicates that there are approximately 120 hospitals with more than 500 but less than 800 discharges, and that 40 percent of these hospitals have negative inpatient Medicare margins. These small hospitals need additional Medicare payment to cover the cost of caring for Medicare beneficiaries. **We urge CMS to provide a payment adjustment for all hospitals with less than 800 discharges, even if that adjustment is minimal for those hospitals with between 500 and 800 discharges.**

**Critical Access Hospitals**
While we are very pleased that Congress continued to recognize the special needs of critical access hospitals in Section 405 of the MMA, we are concerned with CMS' interpretation and corresponding implementation instructions.

- **Payment Amounts for Inpatient CAH Services.** Section 405(a) of the MMA provides payment equal to 101 percent of reasonable cost for Medicare inpatient, outpatient and skilled nursing facility (SNF) services beginning for cost reporting periods on or after January 1, 2004. We are concerned that this provision has not been implemented, as a number of qualifying CAHs have indicated that they have not yet received the increase in payment. We understand that implementing instructions were released to the fiscal intermediaries (FIs) under change request 3052 on January 16. **We encourage CMS to investigate whether there has been a delay in the increased payment rate and require the FIs to make immediate, retroactive correction to CAH payments if necessary.**

- **Special Professional Service Payment Adjustment.** For outpatient services, CAHs may elect to be paid under an optional method, frequently referred to as "Method II," that allows the hospital to receive payment equal to 101 percent of costs for facility services plus 115 percent of the physician fee schedule for professional services rendered. Section 700 of the MMA provides a 5 percent bonus on professional services in either primary care or specialty care in physician scarcity areas (PSAs). This bonus will improve the incentive for physicians to serve Medicare beneficiaries in areas with a shortage of physicians, and make it easier to recruit and retain physicians to these areas.

  CAHs that have elected Method II billing should be eligible for these bonuses just as they are eligible for Health Professional Shortage Area (HPSA) bonuses. Thus, the maximum a CAH could receive for a specific service would be the 101 percent base rate for CAHs, plus 115 percent of the physician fee schedule for professional services under Method II billing,

plus 10 percent for the HPSA bonus, plus 5 percent for the PSA bonus. CMS' systems, however, had trouble implementing the HPSA bonuses under Method II, and some providers have waited more than two years for the increased Medicare payments. We are concerned that that FIs' systems will be unable to process the requests for the enhanced PSA bonus. **We encourage CMS to work diligently to ensure that their systems, and that of their intermediaries and carriers (if necessary), are ready to process enhanced payments beginning July 1 to ensure a smooth implementation of this provision.**

- **Periodic Interim Payment.** Section 405(d) of the MMA also provides for periodic interim payments (PIP) to CAHs, specifically stating, "the amendments made by paragraph (1) shall apply to payments made on or after July 1, 2004." CMS appears to reiterate this sentiment in its preamble to the inpatient proposed rule stating: "We also are proposing to establish a new paragraph (d) under 413.70 to provide that, for payments on or after July 1, 2004, a CAH may elect to receive PIP for inpatient services furnished by CAHs, subject to the provisions of Sec 413.64(h)." Yet the inclusion of "subject to the provisions of Sec 413.64(h)" is problematic, as it contains language that suggests that payment of PIP would be for *cost reports* on or after July 1, 2004. We believe this is an error, as the statute clearly states that these payments should be made on or after July 1, with no mention of cost reporting periods. **Given that some intermediaries have indicated that existing CAH facilities will not be able to receive PIPs until the start of their first cost reporting period beginning on or after July 1, 2004, we urge CMS to clarify that all CAHs are eligible for these payments <u>effective</u> July 1, 2004.**

- **Revision of the Bed Limit.** Section 405(e) of the MMA revises the bed limit for CAHs by allowing these facilities to operate up to 25 acute care beds, an increase from 15 acute care beds, beginning January 1, 2004. In late May, however, CMS revised its State Operations Manual and "updated" its interpretative guidelines regarding CAHs. We are deeply concerned about these revised guidelines, especially CMS' explanation of how it will count beds. Specifically, we are troubled by language that suggests CAHs may not operate outpatient observation beds adjacent to inpatient acute care beds, without them counting toward the 25-bed maximum. It is unreasonable and too costly for these very small hospitals to set up separate units to treat observation patients, and observation patients often require similar nursing care and monitoring equipment. **The AHA will be submitting a separate comment letter on the Revised Interpretive Guidelines shortly, and will be requesting a meeting with CMS to discuss this critical issue further.**

- **Waiver Authority for Designation as a Necessary Provider.** Beginning January 1, 2006, Section 405(h) of the MMA will eliminate a State's ability to designate a facility as a "necessary provider" of health care, and thus as a CAH, even if they are located within 35 miles of another hospital (or within 15 miles in areas of mountainous terrain). The law includes a grandfathering provision for CAHs that are certified as "necessary providers" prior to January 1, 2006. We are concerned that some hospitals may receive the necessary provider designation by the State prior to January 1, 2006, but would not have had enough time to complete, for example, state survey and certification, in order to be fully converted

to CAH by January 1, 2006. **The AHA recommends that CMS grandfather a *hospital* that is certified as a necessary provider by January 1, 2006 as long as that hospital is continuing the process toward conversion to a CAH.**

- **Payment for Clinical Diagnostic Laboratory Tests.** The proposed rule reiterates the policy change CMS made last year that dictates a patient must be "physically present in a critical access hospital" when a laboratory specimen is collected in order for the hospital to receive cost-based reimbursement. Previously, CAHs were reimbursed on a reasonable cost basis if the patient was an outpatient of the CAH at the time the specimen was collected. **The AHA continues to believe that this change is poor policy and against congressional intent.**

  The CAH program was created to ensure that isolated rural communities have access to critical health care services. We believe it was Congress' intent that CAHs be paid based on their costs, regardless of whether or not a patient is physically at the facility for clinical diagnostic lab services. As there are frequently few or no reasonable alternatives to care, CAHs often are the sole source of essential health care services for their communities. Thus, CAHs often provide laboratory services to Medicare beneficiaries in other rural settings, such as rural health clinics, skilled nursing facilities and patients' homes. Because of the way care is provided in rural areas, CAH staff go into these other settings and provide services such as drawing blood for lab specimens. This is especially important when the off-site services are provider-based and owned by the CAH. We are concerned that payment based on the laboratory fee schedule for these services may necessitate that these facilities stop providing lab services in the community, thus denying Medicare beneficiaries access to these necessary services. CAHs are not operating reference labs, as CMS may believe, they are merely meeting the health care needs of their patients. **CMS' policy is shortsighted, not in the best interest of rural beneficiaries or hospitals, and must be retracted.**

The AHA appreciates the opportunity to submit these comments on the inpatient proposed rule's impact on rural hospitals and CAHs. If you have any questions about these comments, please feel free to contact me or Ashley Thompson, senior associate director for policy, at (202) 626-2340.

Sincerely,

Rick Pollack
Executive Vice President