



**American Hospital
Association**

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June 15, 2010

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1498-P2, Medicare Program; Supplemental Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Supplemental Proposed Fiscal Year 2011 Rates; Proposed Rule (Vol. 75, No. 105), June 2, 2010

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) supplemental hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2011. We will submit comments separately on CMS' supplemental proposed changes to the long-term care hospital PPS.

While we support a number of the proposed rule's provisions, including the frontier state wage index floor changes, we have concerns about the average hourly wage criteria for reclassifications, the data and methodology for calculating payments to "low-cost" counties, and the low-volume adjustment. Our detailed comments are below.

RECLASSIFICATIONS AVERAGE HOURLY WAGE CRITERIA

In accordance with the *Patient Protection and Affordable Care Act of 2010* (PPACA), CMS proposes to decrease the thresholds necessary for a hospital to reclassify to another wage area, setting them at FY 2008 levels. This change will remain in effect for FYs 2011 through 2013. However, CMS states that the PPACA does not change the statutory deadline of September 1, 2009 for hospitals to submit applications for reclassification for FY 2011.



While we acknowledge that the PPACA did not change the statutory reclassification application deadline, we believe that a major change in average hourly wage (AHW) criteria such as this warrants the use of CMS' administrative discretion to open an additional, short window for FY 2011 applications. We are aware that some hospitals did not meet the AHW criteria in effect as of September 1, 2009 and, thus, did not apply for reclassification for FY 2011; however, they meet the revised criteria. Yet these hospitals, through no fault of their own, will not be able to benefit from this important statutory provision. **In order to provide these hospitals with a fair and equitable opportunity to reclassify to an area that is more reflective of the wages they offer their employees, we urge CMS to reopen the FY 2011 reclassification application window for a short time.** We believe that a fairly limited number of hospitals would apply, making the workload for CMS and the Medicare Geographic Classification Review Board manageable. If CMS does not reopen the application window, we fear that the agency is inviting every hospital in the nation to file an application every year in order to preserve the right to reclassify if the regulations change at a later date.

FRONTIER STATE FLOOR

The PPACA establishes, for FY 2011 and beyond, a wage index floor of 1.0 for Medicare inpatient and outpatient PPS payments to hospitals in frontier states, as well as a geographic practice expense index floor of 1.0 for Medicare payments to physicians in frontier states. The law defines frontier states as those states where at least 50 percent of counties have fewer than six people per square mile; under the provision, Alaska and Hawaii are not eligible for the floors. CMS used Census Bureau data to propose the following states as eligible: Montana; Nevada; North Dakota; South Dakota; and Wyoming. The agency clarifies that all hospitals geographically located in the state, regardless of reclassification status, will benefit from the floor. **We support CMS' proposal on the frontier state floor.**

ADDITIONAL PAYMENTS FOR QUALIFYING HOSPITALS WITH LOWEST PER CAPITA MEDICARE SPENDING

The rule implements a PPACA provision that provides \$400 million total in FYs 2011 and 2012 to hospitals in counties that rank in the lowest quartile of Medicare per-beneficiary spending, adjusted by age, sex and race. CMS proposes to distribute a smaller amount of funds in the first year (\$150 million in FY 2011 and \$250 million in FY 2012) so that the public can review its proposed and final policy and notify the agency of any possible revisions to the list of qualifying hospitals so that it can adjust payments for FY 2012. The agency states that this will ensure that it correctly identifies qualifying hospitals and their proper payment amounts without exceeding the program's funding. CMS also proposes to identify eligible counties, qualifying hospitals and their payment amounts only once to ensure that it does not exceed the fixed amount of money and to ensure predictability of payments.

The AHA appreciates CMS' efforts to ensure that it accurately identifies qualifying hospitals. However, we do not understand why CMS would only adjust payments for FY 2012 if revisions to the list of qualifying hospitals are identified. If, in fact, CMS leaves

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hospitals off the list in the final rule, the agency cannot penalize them by only providing them with their share of the FY 2012 payments and not their share of the FY 2011 payments.

Accordingly, we urge CMS to commit to provide each qualifying hospital with the proper amount of payments for both FYs 2011 and 2012, regardless of when the qualifying hospital is identified.

In addition, we certainly understand that the agency needs to ensure it does not exceed the amount of funding Congress has provided for this program. However, even if it distributes the same amount of funds in FY 2011 as in FY 2012, and even if it discovers it has left hospitals off its list of qualifying hospitals, the agency can still ensure that it does not exceed its funding while at the same time providing each hospital with the proper amount of payments for both FYs 2011 and 2012. **Therefore, we urge CMS to distribute an equal amount of funding under the program for both FYs 2011 and 2012.**

Data Used to Calculate Additional Payments. The AHA is disappointed that CMS has not made available all of the data files it used to determine which hospitals qualify for payments, including those used for the risk-adjustment regression model, calculation of county-level Parts A and B spending and application of the age/sex/race adjustment to Parts A and B county spending. The AHA also is disappointed at the lack of transparency about CMS' methodology as laid out in the proposed rule. Although the rule contains a description of the methodology used, the text is unclear and lacking in sufficient detail.

In addition, to calculate Medicare Parts A and B spending by county, CMS used an average of five years of data (2002 through 2006) to calculate average geographic adjusters (AGAs) reflecting the county's expenditure relative to that of the nation. The agency then applied the AGA to the 2009 United States Per Capita Cost Estimate to estimate 2009 Medicare Parts A and B spending for each county.

While we understand that it is appropriate to average county spending from different years to account for fluctuations in year-to-year expenditures, a three-year average may more appropriately reflect recent spending patterns. In addition, and more importantly, CMS should use the most recent data available to rank county spending. It appears from looking at the data files at http://www.cms.gov/MedicareAdvtgSpecRateStats/05_FFS_Data.asp#TopOfPage that 2008 data are the most recent. If this is the case, then **we urge CMS to use an average of 2006 through 2008 data to calculate the AGAs.**

Technical Corrections. In addition, we discovered certain technical issues with the counties and hospitals CMS identified as being in the lowest quartile. Some of these technical issues may affect the aggregated risk scores, list of eligible counties, and list of qualifying hospitals and their payments, while others may not. **In the interest of accuracy, we ask CMS to fix these issues.** Specifically:

- CMS assigns Social Security Administration (SSA) county codes of both 06064 and 06060 to Boulder County, CO, and each county code has a different adjustment factor. As a result,

county code 06064 is listed as a qualifying county, but 06060 is not. CMS' "County Crosswalk File" lists the SSA county code for Boulder County as 06060.

- Similarly, CMS assigns SSA county codes of both 12020 and 12030 to Honolulu County, HI, and each county code has a different adjustment factor. As a result, county code 12020 is listed as a qualifying county, but 12030 is not. CMS' "County Crosswalk File," lists the SSA county code for Honolulu County as 12020.
- CMS lists Washabaugh County, SD (SSA county code 43650), as a qualifying county. However, this county was incorporated into Jackson County, SD, on January 1, 1979 and should not be listed as a separate county.
- CMS lists South Boston City, VA (SSA county code 49867), as a qualifying county. However, this county and the hospital it contains (Halifax Regional Hospital, provider number 490013) was incorporated into Halifax County, VA, effective June 30, 1995 and should not be listed as a separate county.
- CMS lists Augusta County, VA (SSA county code 49070), as a qualifying county. However, CMS does not list Augusta Medical Center (provider number 490018) as a qualifying hospital although both the Provider of Services (POS) file and the 2010 AHA Guide show this hospital as being located in Augusta County.
- CMS lists North Hawaii Community Hospital (provider number 120028) as being located in Kauai County, HI (SSA county code 12040). However, both the POS file and the 2010 AHA Guide show this hospital as being located in Hawaii County, HI (SSA county code 12010).
- CMS lists both Cibola General Hospital (provider number 320037) and Acoma Canoncito Laquna PHS Hospital (provider number 320070) as being located in Valencia County, NM (SSA county code 32300). However, both the POS file and the 2010 AHA Guide show these hospitals as being located in Cibola County, NM (SSA county code 32025).

PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

The PPACA improved the low-volume adjustment for FYs 2011 and 2012. For these years, a low-volume hospital will be defined as one that is more than 15 road miles from another comparable hospital and has up to 1,600 discharges of individuals entitled to, or enrolled in, Part A. CMS proposes to apply the percentage add-on for the low-volume adjustment in increments of 100 discharges. For example, hospitals with 201 to 300 Medicare discharges would receive a percentage add-on of 23.3333 percent, and hospitals with 301 to 400 Medicare discharges would receive a percentage add-on of 21.6667 percent.

However, the PPACA specifies that the add-on payment must be determined using a "continuous linear sliding scale" ranging from 25 percent for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with 1,600 or more Medicare discharges. **CMS' proposal to use increments of 100 discharges clearly does not meet these specifications. Thus, we request that CMS comply with the law and modify its proposal so that the low-volume adjustment is determined using a continuous, linear sliding scale.** The formula for such an adjustment (only applicable to hospitals with 200 or greater discharges – those with fewer than 200 discharges automatically receive an adjustment of 25 percent) is:

$$\text{Add-on Percentage} = (4 / 14) - (\text{Medicare discharges} / 5600)$$

In addition to complying with the law, determining the low-volume adjustment in this manner will avoid the phenomenon whereby a hospital's Medicare discharges can increase by only 1 or 2 from one year to the next, yet its percent add-on will decrease by a substantial amount. Such a steep decrease could be detrimental to hospitals' ability to effectively plan and budget for the following year.

Under the *Social Security Act* section 1886(d)(12)(A), all subsection (d) hospitals are eligible for the low-volume adjustment. To make this abundantly clear, we request that CMS explicitly state that sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs), in addition to hospitals paid under the federal standardized amount, are eligible for the adjustment. In addition, the same section of the *Social Security Act* states that the percentage add-on shall be made to a hospital's payment as determined under 1886(d). Again, to make this abundantly clear, we request that CMS explicitly state that the percentage add-on will be applied to the higher of a SCH's or MDH's federal or hospital-specific rate, as both these payments are 1886(d) payments.

If you have any questions, please feel free to contact me or Joanna Hiatt Kim, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President