

July 7, 2003

Thomas A. Scully  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, S.W. Room 443-G  
Washington, DC 20201

**Ref: CMS-1470-P — Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2004 Rates; Proposed Rule (68 *Federal Register* 27154), May 19, 2003.**

Dear Mr. Scully:

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the proposed rule implementing changes to the hospital inpatient prospective payment systems and fiscal year 2004 rates, published in the May 19, 2003, **Federal Register**. We appreciate your ongoing commitment to rural health care, and the NRHA looks forward to working with you in our mutual goals of improving access and quality of health care for all rural Americans.

The NRHA is a national nonprofit membership organization that provides leadership on rural health issues. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

The proposed 268-page rule is complex with significant changes in hospital payment policy. We are disappointed that CMS delayed release of the rule, and that this delay resulted in a shortened comment period for rural hospitals. By law, interested parties are to be given 60-days from notice of the proposed regulation in the *Federal Register* to submit their comments (42 U.S.C. 1395hh(b)). This shortened timeframe makes it extremely difficult to read and analyze the proposed rule, share the information with our members, and solicit their feedback, comments, and concerns. We urge CMS to ensure a full 60-day comment period in the future.

We also urge CMS to consider accepting late comment letters, given that the proposed rule had an incorrect deadline date of July 18, 2003. Moreover, the correction notice issued on June 4 also had an incorrect date of July 15, 2003, such that it was not until

June 9 that a Federal Register notice appeared with the correct date of July 8, 2003 – less than a month before the actual comment due date.

Our comments include the following:

### **FY 2004 Wage Index Proposals**

On Pages 27189 and 27190, CMS proposes to exclude paid lunch hours from the wage index, along with paid hours associated with military and jury duty leave. We do not believe these changes are necessary. These issues are likely to affect most hospitals in a similar fashion, and are not likely to be very material. We also believe many hospitals would have difficulty tracking this information. The wage index survey is already a complex worksheet, and we do not believe any purpose would be served by further complicating this process.

### **Changes to MSA Designations**

In several places, CMS mentions the new MSA designations that had not yet been published at the time this proposed rule was published. CMS states that it will evaluate those changes and determine when and how to implement them. Verbal comments made during the July 1, 2003, CMS Hospital Open Door Forum, indicate that CMS does not intend to implement these changes prior to October 1, 2004.

Due to the potential significant impact these changes may have on hospital reimbursement, both positive and negative, we understand and agree that CMS needs to analyze these changes and carefully implement them. However, rural hospitals also need the ability to analyze the potential impact these changes could have on their Medicare reimbursement. We encourage CMS to publish its proposed plans to implement these changes as soon as possible, and allow time for the industry to comment on the implementation plans. We also believe rural hospitals should be allowed to amend pending MGCRB applications and/or file new applications based on new data arising from the methodology CMS proposes to use to implement the MSA changes.

In a related issue, CMS should modify the existing regulations related to urban hospitals requesting reclassification as rural hospitals. The regulations at 42 CFR 412.103(a) should be modified to specifically list hospitals that would otherwise qualify as a Medicare dependent hospital or critical access hospital to be eligible to apply for reclassification as rural. Section 1886(d)(8)(E)(ii)(IV) gives the Secretary this latitude to expand the current regulations.

Finally, if a hospital elects to be treated as rural, it should be afforded all of the same benefits as other rural hospitals. This should include the ability to apply to the MGCRB for the use of an urban area's wage index. In the August 1, 2000, **Federal Register**, CMS describes its rationale for not allowing such hospitals to apply for an urban wage index, saying such situations would be "illogical" or "anomalous". We do not believe either word fits this situation. In the context of the very complex Medicare regulations

under which hospitals operate, it is very logical for hospitals to seek classification as a sole community hospital (SCH) or Medicare dependent hospital (MDH), which offer a number of protections and enhancements for inpatient reimbursement. However, hospitals still gain benefit from having the highest possible wage index to reflect the labor costs they incur in providing services to Medicare patients. Thus, there is nothing anomalous about a hospital seeking reclassification as a rural hospital for SCH or MDH purposes, while seeking the flexibility to retain the urban wage index they might otherwise have received. We request CMS revisit this issue and revise its policy accordingly.

### **Expanding the Postacute Care Transfer Policy**

CMS proposes to add an additional 19 DRGs to the postacute care transfer policy, subjecting hospitals to potentially lower payments depending on each patient's length of stay and discharge disposition. Postacute care helps ensure patients receive the highest quality care in the most appropriate setting.

This policy contradicts the premise of inpatient PPS. In a system of averages, there are going to be cases with an average length of stay below or above the national average. By reducing hospitals' payment for cases below the average, CMS inhibits hospitals' ability to break even in the payment system.

We believe this policy is based in part on a belief that hospitals are inappropriately transferring patients to a postacute setting early during the acute stay, for reimbursement purposes. If this is true, the current transfer policy should have resulted in an increased length of stay for the original 10 DRGs subject to the policy. However, on Page 27198, CMS notes that this is not the case, stating that its analysis "shows that these DRGs continue to contain high percentages of cases transferred to postacute care settings". Thus, it seems apparent that hospitals are transferring such patients because it is the right clinical decision for these patients, not because it offers better reimbursement. We do not believe CMS has offered sufficient justification for this expansion. If there is any such expansion, it should be implemented on a budget-neutral basis, so that any reduced reimbursement for such cases is rolled into overall DRG payments.

### **Criteria for Payment on a Reasonable Cost Basis for Clinical Diagnostic Laboratory Services Performed by CAHs**

Section 1834(g) of the Act states "The amount of payment for outpatient critical access hospital services of a critical access hospital is the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2)." The existing regulations at 42 CFR 413.70(b)(2)(iii) provide for cost reimbursement for lab services provided to CAH outpatients, as defined in 42 CFR 410.2. That definition states that "*Outpatient* means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH."

CMS is proposing to further redefine outpatient for the purpose of reimbursing CAH laboratory services to specify that an outpatient must be physically present in the CAH at the time the specimens are collected. We do not believe it is appropriate for CMS to redefine this term once again.

The definition of outpatient services has long been established in regulations and in Medicare manuals. The proposed change only worsens the problems CAHs will have trying to discern whether an individual qualifies as an outpatient or not. When taken in context of the current extremely complex provider-based rules, determining whether a patient is “physically present in the CAH” or not will be very unclear. We are concerned that this change introduces yet another chance for providers to bill inappropriately only because the regulations are unclear.

Lastly, we believe the justification for the proposed change is insufficient. There are already specific laws and regulations covering SNF consolidated billing and home health agencies are generally not allowed to bill for lab tests. NRHA strongly opposes this proposal.

#### **Labor-Related Share of DRG Standardized Payment Amount**

In responding to MedPAC’s Recommendation 2A-3, CMS states that it is not prepared at this time to revise the labor-related share of the DRG standardized payment amount. CMS described its preliminary analysis in the fiscal 2003 rulemaking process, and apparently has not yet completed this analysis. CMS does acknowledge that the latest result of the 1997 data it has analyzed would result in a labor share of 62.1%.

In its preliminary analysis, CMS describes other categories of costs that, while labor-related, are not measured through the current wage index survey. Other types of contract costs and similar costs with a labor component are frequently costs that are not “priced-out” in the local labor market. In other words, rural hospitals would purchase these specialized services in an urban area, that may or may not be close to the hospital. The labor share of the DRG should only be adjusted by those costs that are reflected in the wage index survey.

#### **Fixed-Loss Cost Outlier Threshold**

CMS has proposed a fixed-loss cost outlier threshold of \$50,645. Given the revised outlier policies published in the June 9, 2003, **Federal Register**, outlier payments will undoubtedly decrease dramatically for many hospitals. CMS should revise this threshold downward significantly, to reflect the decrease in outlier payments that will be experienced by hospitals because of the new outlier policies.

#### **CAH Data**

In the proposed rule, the agency has requested public comments on whether wage data from critical access hospitals (CAHs) should be excluded from the wage index.

Currently, the proposed FY 2004 wage index includes wage data for all facilities that were inpatient PPS hospitals in FY 2000 – even if these facilities were subsequently converted to CAH status. While CMS believes that including wage data for CAHs is appropriate to reflect the market area during the relevant past period, others have suggested that the data be removed, as these facilities are no longer operating under PPS. **The NRHA is concerned about the immediate financial impact this might have on all rural hospitals in FY 2004. Thus, we recommend that CMS examine the impact that removing CAH wage data would have and make this analysis available for notice and public comment.**

**Conclusion:**

The NRHA appreciates the opportunity to submit these comments on the proposed rule. Please do not hesitate to contact Alan Morgan, Vice President of Government Affairs and Policy at 703-519-7910 if you have any questions about these comments.

Sincerely,

Wayne Myers, MD  
*President*