

July 8, 2002

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

**Ref: CMS-1203-P - Medicare Program; Changes to the Inpatient Prospective Payment System and Fiscal Year 2003 Rates; Proposed Rule (67 Federal Register 31404), May 9, 2002.**

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 2003 rates, published in the May 9, 2002, **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.

Our comments include the following:

**Labor-Related Share:**

CMS proposes to increase the labor-related share of the DRG standardized payment amount from 71.066% to 72.495% of the payment amount. CMS estimates the labor-related share of hospital payments based on an analysis of what hospital costs are actually labor-related. **This change will significantly redistribute payments among hospitals, resulting in a 0.2 percent average decrease in per case payments for rural hospitals.** Of the total labor-related share shown in Table 7, 5.401% relates to "nonmedical professional fees," a category that has increased from 2.127% in the current payment amount. CMS defines this category to include legal, accounting, engineering and

management and consulting fees. For rural hospitals, most of these services **are not** purchased in the local labor market. At a minimum, they would be purchased from a

nearby urban area, and in many cases are purchased from a distant urban area. A similar situation would hold true for some of the items included in the “other labor-intensive services” category, weighted at 5.438% of the proposed labor-related share.

CMS also acknowledges that some of the costs in these categories **may not even be** labor-related, and is studying methods to determine this more precisely. Our concern is that CMS is adjusting the labor portion of the standardized payment amount by including costs that may or may not be labor-related, and in any case are not being measured through the existing hospital wage index, to the detriment of rural labor markets. Until CMS has completed its study of what contract costs are actually labor-related, and developed a method to measure these costs in the hospital wage index, they should be excluded from the labor-related share. This would yield a revised labor-related share of 61.656% of the standardized payment amount. **The NRHA encourages CMS to convene a workgroup with hospital representatives to review labor costs in order to determine the most appropriate methodology.**

#### **OMB Standards for Hospitals to Qualify for Redesignation:**

The implementation of Section 402 of Public Law 106-113 is discussed on Page 31437. The discussion does not address whether the reclassification of hospitals would be effective for **discharges or cost reporting periods** beginning on or after October 1, 2002. Section 402 states, “The standards described in this clause for cost reporting periods beginning in a fiscal year... (II) after fiscal year 2002 are the standards published in the **Federal Register** by the Director of the Office of Management and Budget based on the most recent available decennial population data.” Based on this wording, CMS should clarify that these provisions will be effective for **cost reporting periods** beginning on or after October 1, 2002.

The proposed rule contemplates implementing Section 402 in a manner similar to a Medicare Geographic Classification Review Board (MGCRB) decision. The redesignated hospitals would receive the reclassified wage index instead of the actual wage index for the urban area in which the previously rural hospital would be included. Since the redesignated hospitals are being treated the same as hospitals which have been reclassified to the adjacent urban area under MGCRB provisions, we believe such hospitals should also have the option to reject the reclassification as urban and continue their rural status if they wish. We do not believe that Congress intended to harm rural hospitals through implementation of this provision. Accordingly, an option to reject the Section 402 reclassification is needed. Also, since such provisions were not set out in the proposed rule, we believe that a special one-time option to reject the Section 402 reclassification should be allowed after the normal 45-day period following the proposed rule.

In the event that rejecting a Section 402 reclassification will not be permitted as discussed above, an option should be made available to sole community hospitals (SCHs) or rural referral centers (RRCs) to immediately elect rural status under 42 CFR 412.103, with no interruption of their SCH or RRC status. Under 42 CFR 412.230(5)(iv), such an election might preclude the hospital from retaining an existing reclassification for wage index purposes. 42 CFR 412.103 should specifically allow any hospital redesignated under Section 1886(d)(8)(B) to be allowed to immediately elect rural status to retain its SCH or RRC designation. 42 CFR 412.230(5)(iv) should be revised to allow such hospital to continue to receive any MGCRB reclassification for wage index purposes that was in effect at the time of the 42 CFR 412.103 reclassification.

### **Transfer Payment Policy:**

On Pages 31455-7, CMS proposes possible changes to the post-acute care transfer provision, either to include all DRGs or to add an additional 13 DRGs. This proposal would effectively reduce DRG payments for any hospital discharge that has less than the average length of stay and where the patient receives post-acute care after discharge. Post-acute care helps ensure patients receive the highest quality care in the most appropriate setting. Hospitals would be penalized across the board for making good clinical decisions in discharge planning if a patient's average length of stay is less than the average for the DRG.

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 average. By reducing hospitals' payment for cases below the average, CMS inhibits hospitals' ability to break even in the payment system.

While we understand CMS was required to develop the initial list of 10 DRGs subject to the post-acute care transfer payment policy, CMS was permitted but **not** required to expand this list. This provision would significantly reduce payments to rural hospitals that are suffering under the weight of prior payment reductions. **As CMS has no statutory requirement to implement it, we would request that this proposal be removed from the final rule.**

### **SCH Like Hospitals:**

On Pages 31458-9, CMS describes a proposed revision to the definition of like hospitals, for the purposes of determining what hospitals might qualify for SCH status. CMS proposes that if a limited-service facility provides no more than 3 percent of the services at a proposed or existing SCH, the limited-service facility will not be considered a like hospital. We applaud CMS efforts to address this particular issue. However, we are unclear how the proposed 3 percent test would be conducted, or what data would be

available to measure the level of overlapping services. We would request that CMS clarify how such data would be accumulated and presented for analysis purposes, while also expanding the test to 10 percent. If a limited-service facility did not have the capability of providing 90% of the services at a proposed or existing SCH, it certainly should not be considered a like hospital reasonably available as an alternative source of inpatient care for Medicare patients.

We would suggest that CMS consider alternative criteria to determine whether a limited-service facility would be considered a like hospital to a proposed or existing SCH. Such criteria could include reviewing whether the limited-service facility would be similar in scope of operations to a critical access hospital (CAH). CMS has determined that a CAH is not a like hospital for purposes of determining SCH status. The size criteria would be particularly applicable to the limited-service facilities. For example, if a limited-service facility has no more than 15 acute-care patients at any time during its most recent year, it should not be considered large enough to qualify as a like hospital for purposes of determining SCH status. A separate issue to evaluate would be emergency room services. If the limited-service facility does not have a 24-hour emergency room, we do not believe it should be considered a like hospital.

#### **Medicare-Dependent, Small Rural Hospitals: Ongoing Review of Eligibility Criteria:**

CMS proposes that intermediaries evaluate on an ongoing basis whether a Medicare-dependent hospital (MDH) should continue to maintain MDH status if it qualified under the provisions of Section 1886(d)(5)(G)(iv)(IV) of the Social Security Act. We appreciate CMS' concern in this area. We realize the statutory language may appear vague, as to whether or not this issue should be reevaluated with more recent cost report data, once a hospital becomes an MDH based on Medicare utilization in 2 of the 3 most recently audited cost reporting periods.

We believe congressional intent was to provide flexibility for hospitals to become MDH, by effectively providing additional opportunities to become classified as an MDH. We do not believe the intent was to introduce a level of uncertainty into the process, whereby a hospital with Medicare utilization close to 60% could alternate back and forth between having and losing MDH status, based on which cost reports were the most recently audited. **We request that CMS delete these proposed regulatory revisions.**

#### **Eligibility Criteria for Reasonable Cost Payments to Rural Hospitals for Nonphysician Anesthetists:**

CMS proposes to raise the current threshold of 500 procedures to 800 procedures. This increase in the number of cases will allow rural hospitals to continue to provide surgical services to their Medicare patients. Without this proposed change in the regulations,

rural hospitals will experience serious disruptions in their delivery of anesthesia services. CRNAs are the sole anesthesia providers in 62% of rural hospitals. Without CRNAs, these rural hospitals will have difficulty in continuing to meet their patients surgical and trauma stabilization services.

However, we also wish to comment on the disparity in regulatory interpretations made by various fiscal intermediaries (FIs) in their management of the rural hospital CRNA reasonable cost pass-through application process. Due to the fact that the current Social Security Act section 1861(s)(11), (bb) allows payment to be made to the CRNA for anesthesia services and related care, some fiscal intermediaries have taken the liberty to include all the non-anesthesia ancillary services provided by the CRNAs when counting the total number of surgical procedures. If this practice continues, even with the increase in the proposed 800 case mix, the rural hospitals will not be able to qualify for the reasonable cost payment for their CRNAs. Counting these ancillary services along with the surgical procedures will surpass the 800 surgical case mix. This interpretation by some FIs is contradictory to the regulations under [42 CFR 412.113(c)(2)(i)(C)] which states, a "surgical procedure requiring anesthesia services means a surgical procedure in which the anesthesia is administered and monitored by a qualified non-physician anesthetist, a physician other than the primary surgeon, or an intern or resident...."

We recommend the CMS adopt the AANA proposed definition of a surgical procedure which is as follows:

"For the purpose of identifying the procedures to include in the 800 case-mix, a surgical procedure is defined as any procedure which involves cutting, abrading, suturing, laser or otherwise physically changing body issues and organs. Any ancillary procedures performed by the CRNA such as pain management services (including pain management for normal vaginal deliveries), emergency intubations, difficult IV starts, or other stand-alone services shall not be included in the 800 case-mix." In addition current regulations only allow for hospitals in existence as of 1987 and have met the other conditions set in the Social Security Act section 1886(d). This essentially limits the number of rural hospitals that may qualify for the CRNA reasonable cost treatment, as hospitals which were not in existence as of 1987, or may have employed more than one full-time equivalent (FTE) anesthetist, would not currently qualify for this provision. I urge CMS to review this critical issue, as this threatens new rural hospitals' ability to continue to provide surgical and anesthesia services to their patients.

**Responsibilities of Medicare-Participating Hospitals in Emergency Cases (EMTALA):**

CMS proposes several changes to the EMTALA regulation. In general, these changes are a good step toward improving implementation of the regulation. In particular, we support changes limiting application of EMTALA to only those hospital departments that function like an emergency department (ED) and permitting ambulances to transport

patients based on clinical protocols, rather than ownership by the hospital. However, further regulatory clarification is needed in several areas. The final rule should make it clear that EMTALA does not apply to non-emergency services delivered in an ED and does not apply at a site other than an ED unless emergency care services are requested.

In addition, changes are necessary in the proposed rule regarding application of EMTALA to inpatients and on call responsibilities. First, EMTALA was not intended to apply to inpatients. CMS should eliminate the application of EMTALA to an inpatient admitted through the ED. When an individual is admitted through the emergency department with an emergency medical condition that has not yet been stabilized, the assumption of responsibility for the patient and his or her care on an inpatient basis should be deemed to meet the hospital's obligation under EMTALA. The final rule should provide that EMTALA does not apply in the inpatient setting to any patient. Second, CMS should limit its review of hospitals' on call responsibility to ensure that the ED has a list of on call physicians and that services are provided by those physicians in a non-discriminatory manner. EMTALA should not be used to create redundant review of medical personnel.

Further, the final rule should provide hospitals with meaningful due process before a notice of termination can be issued. Currently, a hospital can be forced to enter into a costly and burdensome plan of correction before it can appeal the decision of a regional office – regardless of whether that decision and resulting plan are reasonable and in their patients' best interests.

### **Provider-Based Entities:**

We applaud the general effort to clarify the provider-based regulations, and extend the application date for existing entities to cost reporting periods beginning on or after July 1, 2003. However, given that new payment systems implemented under the Balanced Budget Act of 1997 have essentially eliminated most areas of true cost reimbursement, the issues that CMS seeks to resolve through the provider-based rules no longer seem to be truly relevant. We would request CMS further simplify the application process and clarify the "attestation" referred to in the revised regulations, as these areas relate to new entities. This paperwork burden should be eliminated completely for existing entities, as intermediaries, state agencies or CMS regional offices have all had the opportunity to review existing entities at the time they were established and through ongoing billing and cost reporting processes since they were established.

### **Capital Payments for New Hospitals:**

CMS details how new hospitals would be reimbursed for capital-related costs, after the end of the normal 10-year transition for existing hospitals (generally cost reporting periods beginning on or after October 1, 2001). The current 42 CFR 412.324(b)(3)

provides that for new hospitals, hold harmless payment for old capital costs “is payable for up to and including 8 years and may continue beyond the first cost reporting period beginning on or after October 1, 2000.” This CMS policy was clarified on Page 43418 of the August 30, 1991, **Federal Register**, which stated that hold-harmless payments “would extend for 8 years, even though the hold-harmless payments may extend beyond the normal transition period.” This policy was once again clarified on Page 39911 of the August 1, 2001, **Federal Register**, using similar language.

We believe this existing regulation conflicts with the proposed 42 CFR 412.304(c)(2), which provides for payment at 100% of the Federal rate after the first two full years of operations. Existing “new” hospitals have assumed that 42 CFR 412.324(b)(3) applied, providing a total of ten full years of consideration for the higher capital costs incurred by a newly-opened hospital. To effectively stop this additional reimbursement in mid-stream would be extremely unfair to those hospitals that have planned and budgeted their costs and reimbursement assuming the regulations would remain in effect as written.

We request that CMS reconsider its policy, and provide a full 10-year transition for all new hospitals, to consider the high level of fixed costs incurred in starting a hospital. At a minimum, if any change is to be implemented it should be applicable only to those hospitals opening on or after October 1, 2002.

### **Outliers:**

CMS proposes a fixed loss cost outlier threshold equal to the DRG payment plus add-ons plus \$33,450, compared to a current threshold of \$21,025. This 59% increase was determined based on a new methodology that estimates the projected change in the rate of increase in inpatient costs per case. The cost per case decreased by 2.99% in 1996 compared to 1995, and subsequently increased by 0.38% in 1997 compared to 1996, by 2.37% in 1998 compared to 1997 and by 2.42% in 1999 compared to 1998.

CMS uses this data to estimate that the cost per case is increasing at a faster pace, resulting in an estimated increase in the cost per case of 6.55% in 2002 compared to 2001 and by 7.93% in 2003 compared to 2002. In Table I on Page 31669, CMS estimates that the overall change in payments for all hospitals will be 0.4%. If CMS truly believes that costs in 2003 will increase by 7.93% while payments will be allowed to increase by only 0.4%, the rural hospital sector will be thrown into a crisis situation.

We urge CMS to reevaluate the data and methodology used to establish the fixed loss cost outlier threshold, and avoid such a dramatic change in this threshold. Until more recent actual data is available, the threshold should remain at the 2002 level of \$21,025.

### **Collection of Occupational Mix Data:**

On Pages 39860-3 of the August 1, 2001, **Federal Register**, CMS describes the requirement under Section 304(c) of the Benefits Improvement and Protection Act of 2000 to begin collection of occupational mix data for hospital employees. The first collection must be completed by September 30, 2003, for application beginning October 1, 2004. CMS indicated last year that it would develop “a survey instrument for the initial collection of occupational mix data that can be used by hospitals during calendar year 2002.” Due to the importance of this issue, we would appreciate CMS addressing the status of this data collection effort, and how it intends to comply with the statutory deadlines established by Congress.

**Impact of MGCRB Decisions:**

We request that wage data for hospitals reclassified under Section 1886(d)(8)(E) of the Social Security Act be included in both the areas to which they are reclassified and the MSA where the hospital is geographically located, for purposes of determining the wage index for each area. Because of close proximity for some small rural hospitals, hospitals can compete for health care staff.

Section 401 of the Balanced Budget Refinement Act of 1999 (BBRA) amended Section 1886(d)(8) by adding a new paragraph (E). Paragraph (E) allows an urban hospital to be redesignated to a rural area if certain criteria are met. The purpose of the legislation was to allow urban hospitals with rural characteristics to qualify under certain provisions of the Medicare regulations for special payments, such as sole community hospitals, etc. Currently, the wage data for hospitals redesignated under Section 1886(d)(8)(E) of the Act is included in the rural hospital wage index calculation and excluded from the MSA wage index calculation where the hospital is geographically located. This would appear to be an unintended consequence of Section 401, and is inconsistent with the treatment of other reclassifications as described below.

There are other provisions of the Medicare regulations that provide for the redesignation or reclassification of hospitals from one geographic area to another. In each of the situations, when a hospital is redesignated or reclassified, the applicable wage data is included in both the area to which it is reclassified and the MSA where the hospital is geographically located. Section 1886(d)(8) of the Social Security Act affords protection to certain hospitals that may be negatively impacted by reclassifications or redesignations. Under Section 152(b) of BBRA, hospitals in certain counties were deemed to be located in specific MSAs for the purposes of payment under the hospital inpatient prospective payment system. The wage index values for MSAs that contain the counties specified in Section 152(b) are calculated by including the wages of hospitals that are reclassified out of the MSA by Section 152(b). Thus, wages for hospitals reclassified under BBRA Section 152(b) are included in the MSA where they are geographically located and the MSA to which they have been reclassified. It has been CMS' position that in the case of rural hospitals redesignated to another area, the wage

index of the rural area where the hospitals are geographically located is calculated by including the wage data of the redesignated hospitals.

The intent from the legislative language and prior final **Federal Registers** is to provide a level of consistency and predictability in the wage data determination and hospital reclassification process. Excluding the data of hospitals redesignated under Section 1886(d)(8)(E) of the Social Security Act has a significant impact on the wage index of the MSA in which the hospital is geographically located. The exclusion of hospitals redesignated under Section 1886(d)(8)(E) in calculating the wage index values is also contrary to the expectations of the hospital prior to the enactment of BBRA Section 401.

### **CAH All-Inclusive Billing:**

We recommend that the advanced notice period for Critical Access Hospitals (CAH) to elect the all-inclusive billing option be set firmly at 30 days, rather than allowing fiscal intermediaries (FIs) to choose a time frame ranging from 15 to 60 days. Currently, CAHs may elect an “optional payment method” to receive reasonable costs for facility services associated with an outpatient visit plus a professional fee based on 115 percent of the Medicare physician fee schedule. Currently, CAHs are required to inform their FI 60 days before the start of each affected cost reporting period that they would prefer this option. By allowing each FI to determine this time period, which may be as short as 14 days but no longer than 60 days, we are concerned that confusion will arise, as well as the creation of different policies across the nation. **The NRHA shares the key concern of the American Hospital Association, that CAHs that have already elected this option have not received payments under the option because CMS systems have been unable to implement the provision.** Under BIPA, the provision was to be effective for cost reporting periods beginning on or after July 1, 2001. The NRHA recommends that the all-inclusive billing provision be made retroactive to July 1, 2001, as mandated by statute. We also encourage CMS to immediately publish specific implementation instructions via a program memorandum to clarify proper implementation of this payment option.

### **Elimination of the MDS for CAHs:**

The NRHA applauds CMS’s decision to eliminate the requirement that CAHs complete a lengthy patient assessment form (often called the minimum data set) for skilled nursing facility patients.

**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,

Val Schott,  
*President*