June 19, 2013

VIA REGULATIONS.GOV

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1599-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation [CMS-1599-P]

Dear Sir or Madam:

On behalf of the Rural Referral Center/Sole Community Hospital Coalition (the “Coalition”), please accept these comments on the Inpatient Prospective Payment System (“IPPS”) Proposed Rule for Fiscal Year 2014 (the “Proposed Rule”).

Formed in 1986, the Coalition is comprised of hospitals designated as Rural Referral Centers (“RRCs”) and Sole Community Hospitals (“SCHs”) under the Medicare Program. Member hospitals of the Coalition share the common goal of ensuring that federal hospital payment policies recognize the unique and important role of these hospitals in providing access to quality care in their communities. Consistent with this mission, the Coalition is pleased to provide the Centers for Medicare and Medicaid Services (“CMS”) with these comments.

I. MS-DRG Documentation and Coding Adjustment

Section 631 of the American Taxpayer Relief Act of 2012 (“ATRA”) requires the Secretary to “make an additional adjustment to the standardized amounts” totaling $11 billion during Fiscal Years 2014 through 2017.¹ This adjustment is required because of “the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under the [TMA, Abstinence Education and QI Programs Extension Act of 2007 (Public Law 110-90)] until FY 2013.”² In total, CMS estimates that a – 9.3 percent adjustment is required to fully recover the $11 billion. In Fiscal Year 2014, CMS proposes to begin to implement this provision

¹ American Taxpayer Relief Act of 2012, § 631 (emphasis added).
² 78 Fed. Reg. 27,504.
by applying a – 0.8 percent documentation and coding recoupment adjustment to the standardized amount.

As a potential alternative, CMS solicits comments on whether to apply a portion of the – 0.8 percent recoupment as a prospective adjustment instead. Notably, CMS states that for any portion applied as a prospective adjustment, “we also would make appropriate adjustments to the hospital-specific payment rates.”\(^3\) The Coalition objects to any proposed prospective adjustments to the hospital-specific rate (“HSP”) because CMS does not have the authority to apply the documentation and coding adjustment to the HSP.

The plain language of Section 7(b)(1) of the TMA, Abstinence Education and QI Programs Extension Act of 2007 (Public Law 110-90), as amended by ATRA, provides clear instructions from Congress that the documentation and coding adjustment is only intended to apply to the standardized amounts. The pertinent provision provides for the following:

(1) Notwithstanding any other provision of law, if the Secretary determines that implementation of [MS–DRGs] resulted in changes in coding and classification that did not reflect real changes in case mix under section 1886(d) […] for discharges occurring during fiscal year 2008, 2009, or 2010, that are different than the prospective documentation and coding adjustments applied under subsection (a) or otherwise applied for such year, the Secretary shall—

(A) make an appropriate adjustment under paragraph (3)(A)(vi) of such section 1886(d); and

(B) (i) make an additional adjustment to the standardized amounts under such section 1886(d) for discharges occurring only during fiscal years 2010, 2011, and 2012 to offset the estimated amount of the increase in aggregate payments (including interest as determined by the Secretary) determined, based upon a retrospective evaluation of claims data submitted under such Medicare Severity Diagnosis Related Group (MS–DRG) system, by the Secretary with respect to discharges occurring during fiscal years 2008 and 2009; and

(ii) make an additional adjustment to the standardized amounts under such section 1886(d) based upon the Secretary’s estimates for discharges occurring only during fiscal years 2014, 2015, 2016, and 2017 to fully offset $11,000,000,000 (which represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied).

(emphasis added). As CMS acknowledges in the Proposed Rule, Section 1886(d)(3)(A)(vi) of the Social Security Act (the “Act”) only authorizes adjustments to the average standardized amounts,\(^4\) which is entirely consistent with CMS’ previous discussion of this issue.\(^5\)

\(^3\) 78 Fed. Reg. 27,505.

\(^4\) Id.

\(^5\) See 72 Fed. Reg. 66,580, 66,886 (Nov. 27, 2007) (concluding that applying the documentation and coding adjustment to the HSP is “not consistent with the plain meaning” of section 1886(d)(3)(A)(vi)).
1886(d)(3)(A)(vi) of the Act indisputably does not permit CMS to apply a documentation and coding adjustment to the HSP. Under Section 631 of ATRA Congress specifically instructed the Secretary to make the documentation and coding adjustment under subsection (B)(ii) *only* to the standardized amount. Nothing in the language of ATRA gives CMS the authority to make an adjustment to the HSP.

CMS’s reliance on section 1886(d)(5)(I)(i) of the Act to apply the documentation and coding adjustment to the HSP is not appropriate. Although the Coalition recognizes that the authority granted under Section 1886(d)(5)(I)(i) of the Act is broad, it is not so broad that it swallows the more specific instruction at section 1886(d)(3)(A)(vi) of the Act. Moreover, section 1886(d)(5)(I)(i) of the Act only authorizes the Secretary to make such “other” adjustments she deems necessary. As CMS has repeatedly stated in multiple *Federal Register* notices, the documentation and coding adjustment it applies to the HSP is the very same adjustment – calculated in the same manner, intended to address precisely the same phenomenon in coding practices – as the documentation and coding adjustment it applies to the standardized amount. It is not an “other” adjustment, it is the same adjustment. Section 1886(d)(5)(I)(i) of the Act is therefore not a source of authority for applying the adjustment to the HSP.

Section 7(b)(1) establishes a simple *if* – *then* proposition: *if* the Secretary determines that there was a documentation and coding effect based on a review of 2008, 2009, and 2010 claims data for subsection (d) hospitals, *then* the Secretary shall do two things. First, make a prospective adjustment under 1886(d)(3)(A)(vi), which CMS agrees applies only to the standardized amount. Second, make a recoupment adjustment to the standardized amount in FY 2010, 2011, and 2012 (pursuant to (i)), or 2014, 2015, 2016, and 2017 (pursuant to (ii)).

Here, CMS has done precisely what is described in the prefatory “*if*” clause – it has identified a documentation and coding effect based on a review of claims for subsection (d) hospitals (which includes SCHs). Having made such a determination, CMS’s only options are the two steps mandated in sections 7(b)(1)(A)-(B), both of which, by their express terms, are limited to adjustments of the standardized amount. If Congress had intended for any prospective adjustment to apply to the HSP, they would have so specified. Instead, Congress twice passed legislation – through the TMA and later ATRA – that explicitly limits these documentation and coding adjustments to the standardized amount.

The Coalition is aware that several hospitals are currently involved in litigation regarding CMS’s application of the documentation and coding adjustment to the HSP in FY 2011 and FY 2012. Until the court has rendered a decision on the legality of the FY 2011 and FY 2012 adjustments, CMS should decline to adopt any documentation and coding adjustment that affects the HSP. As

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6 If CMS is going to invoke its authority under Section 1886(d)(5)(I)(i), it should do so consistently. For example, under Section 1886(d)(5)(F)(ii) Congress authorized the Medicare DSH add-on to apply only to the standardized amounts. If CMS believes it can use its authority under Section 1886(d)(5)(I)(i) to apply the documentation and coding adjustment to the HSP (absent Congressional direction), then CMS should similarly exercise its authority to apply the DSH add-on to the HSP, even though this provision also only refers to the standardized amount.
such, the Coalition urges CMS to apply the ATRA-mandated documentation and coding adjustment as a – 0.8 percent recoupment adjustment to the standardized amount in FY 2014.

II. Revised Payment Methodology for Disproportionate Share Hospitals

CMS proposes to implement Section 3133 of the Affordable Care Act, which would modify the calculation of Disproportionate Share Hospital (DSH) payment adjustments. Beginning in Fiscal Year 2014, hospitals qualifying for DSH payments would receive 25 percent of the amount they would have received under the previous statutory formula.\(^7\) The remaining 75 percent of the amount that would have been paid to each hospital will be consolidated into a separate pool that funds “uncompensated care payments.” CMS calculates the total of uncompensated care payments that will be distributed to each hospital through a three-factor formula that takes into account: (1) the difference of the estimate of the full Medicare DSH payment amount the hospital would receive in FY 2014 (prior to the 75-percent reduction) and the estimate of the total payments CMS will make in FY 2014 with the initial 25 percent payment; (2) the change in the percentage of the uninsured population; and (3) the amount of uncompensated care that each hospital provides.\(^8\)

A. The Twelve Percent Cap on DSH Payment Adjustment Percentages Should Only Be Applied to the Empirically Adjusted Amount.

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”), a twelve percent cap was placed on DSH payment adjustment percentages for certain rural hospitals, including those with SCH status (the “Cap Provision”).\(^9\) Under CMS’s proposed implementation of the revised DSH payment methodology, CMS is silent as to how it will apply this Cap Provision, but how CMS chooses to apply this cap is relevant, as explained below.

Ex. If a hospital subject to the twelve percent cap has a disproportionate share patient percentage sufficient to generate a disproportionate share adjustment percentage of 16 percent pursuant to 1886(d)(5)(F)(vii), under the proposed formula, CMS could use either 16 percent or 12 as the empirically justified amount. If the agency uses 16 percent, then the empirically justified amount portion of the formula would be 4 percent (16 * 0.25); if the agency uses 12 percent, then the empirically justified amount portion of the formula would be 3 percent (12 * 0.25).

Pursuant to the language in Section 1886(r)(1), DSH hospitals will now receive 25 percent of the amount they would have received under subsection (d)(5)(F). The Coalition understands that the reference to (d)(5)(F) incorporates the Cap Provision, and therefore calculation of the empirically justified amount will incorporate this cap. Factor one in Section 1886(r)(2)(A) likewise takes into account the amount each hospital would have received under (d)(5)(F) (i.e. includes the Cap Provision) when creating the pool for the uncompensated care payments. For these reasons, the

\(^7\) Social Security Act, § 1886(r)(1); 42 U.S.C. § 1395ww(r)(1).
\(^8\) Id. § (r)(2).
\(^9\) Id. § (d)(5)(F)(xiv).
Coalition asks CMS to clarify and confirm that the Cap Provision will not be applied again to the overall DSH payment adjustment each hospital receives.

If the Cap Provision were to apply to the overall adjustment, then in effect, SCHs would be penalized twice: once when calculating the empirically justified amount and calculating the amount placed in the uncompensated care payment pool; and again when formulating the overall DSH adjustment the hospital receives.

The Cap Provision applies to “the disproportionate share adjustment percentage otherwise determined under clause (iv) . . . .” By its instruction, the Cap Provision affects only those calculations made under clause (iv). Sections 1886(r)(1) (regarding the empirically justified amount) and (r)(2) (regarding the uncompensated care payment pool) incorporate the methodologies in Section 1886(d)(5)(F). As such, it follows these calculations should be adjusted by the Cap Provision because they take into account the calculations under clause (iv).

In contrast, there is not a provision in Section 1886(r) regarding an adjustment to the overall DSH payment percentage. Congress made specific cross-references to 1886(d)(5)(F) when constructing new Section 1886(r). Because Congress did not even create a provision in 1886(r) regarding the overall adjustment – much less cross-reference Section 1886(d)(5)(F) with respect to the overall percentage – it logically follows that the overall DSH payment adjustment under the new methodology should not be subject to the Cap Provision. If Congress had intended for the Cap Provision to apply to the overall adjustment, then it would have created an appropriate provision in Section 1886(r).

Accordingly, CMS should clarify that application of the Cap Provision is limited only to (1) the empirically justified amount received by each SCH, and (2) the calculation of factor one to determine the pool to be distributed for uncompensated care payments. The Cap Provision is not applicable to the overall DSH payment adjustment for SCHs.

B. SCHs should be paid uncompensated care payments under 42 C.F.R. § 412.106(g)-(h).

As CMS knows, DSH payments under Section 1886(d)(5)(F)(ii) are calculated by multiplying the standardized payment amount by the disproportionate share adjustment percentage. CMS has historically interpreted the statute not to apply the DSH adjustment percentage to an SCH’s or MDH’s hospital-specific payment rate. However, the uncompensated care payment statutory language in new Section 1886(r)(2) contains no such limitation. Thus, as long as a hospital is DSH-eligible under 42 C.F.R. § 412.106(c), CMS should clarify that such a hospital will receive uncompensated care payments under the new regulations at 42 C.F.R. § 412.106(g)-(h). Since such payments are not discharge-related payments, uncompensated care payments should be paid in addition to any discharge-related payments for an SCH, whether such discharge-related payments are calculated on the basis of the federal standardized amount, plus DSH payments, or on the basis of the HSP, without DSH payments. In other words, if an SCH has aggregate HSP payments that exceed the sum of federal standardized amount and DSH payments, the SCH
should still receive uncompensated care payments under 42 C.F.R. § 412.106(g)-(h), as long as they are DSH-eligible under 42 C.F.R. § 412.106(c).

C. Uncompensated care payments should not be removed from calculation of the greatest aggregate payment for SCHs.

CMS proposes to exclude uncompensated care payments from the calculations used to determine whether an SCH is paid the Federal rate or the HSP.\(^{10}\) According to CMS, because the uncompensated care payments are not discharge-driven (like payments to SCHs), it would not be appropriate to take these uncompensated care payments into account when the Fiscal Intermediary or Medicare Administrative Contractor calculates whether the SCH is paid the Federal rate or the HSP.

The uncompensated care payments cannot be excluded in calculating whether an SCH is paid the hospital-specific rate or the Federal rate. Specifically, Section 1886(d)(5)(D) of the Act states that payment to an SCH shall be:

(I) an amount based on 100 percent of the hospital’s target amount for the cost reporting period . . . , or
(II) the amount determined under (1)(A)(iii), whichever results in greater payment to the hospital.

In turn, Section 1886(b)(3)(C) of the Act defines the “target amount” as the allowable operating costs of inpatient hospital services, which are defined to include “all routine operating costs, ancillary service operating costs, and special care unit operating costs” with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis . . . and includes the costs of all services for which payment may be made under this title that are provided by the hospital.”\(^{11}\) Subsection (II) references the Federal rate, which is “the national adjusted DRG prospective payment rate.”\(^{12}\)

According to the plain language of Section 1886 of the Act, the “target amount” used to calculate the HSP must include costs for all inpatient hospital services. By removing the costs for uncompensated care from this analysis, CMS is excluding a significant category of patients from the calculation of the HSP. Moreover, this category of patients is generally more expensive, even further reducing the accuracy of the HSP calculation. In essence, an SCH would only be allowed to take into account a portion (25 percent) of its total costs to provide uncompensated care when calculating the HSP. This proposal unfairly reduces payment to certain SCHs, who might otherwise qualify for the higher Federal rate if the uncompensated care payments were included in the calculations. As such, uncompensated care payments to SCHs should be included in calculating whether the HSP or Federal rate yields greater payment for an SCH.

\(^{10}\) 78 Fed. Reg. 27,581.
\(^{11}\) Social Security Act, §§ 1886(b)(3)(C), (a)(4) (emphasis added).
\(^{12}\) Social Security Act, § 1886(d)(1)(A)(iii).
Based on these concerns, the Coalition strongly opposes CMS’s proposal to make the uncompensated care payments on an interim basis, and urges CMS to adjust hospital payments per discharge. In order to implement this change, the Coalition recommends that CMS modify the PPS PRICER to create an additional DSH line in the program to account for the per-discharge payment. This recommendation would ensure that these important payments are accounted for in determining whether SCHs will receive the Federal rate or HSP.

If CMS does finalize its proposal to exclude the uncompensated care payment in determining which rate is higher, the Coalition seeks clarification on how this will be implemented. Specifically, if the SCH qualifies for DSH payments, will the uncompensated care payments be added to aggregate federal payments when comparing to aggregate HSP payments on the cost report, or will the uncompensated care payment be made regardless of whether the SCH is paid on aggregate federal payments or HSP payments so long as it meets the DSH qualification threshold? The Coalition recommends that CMS clarify this point in the Final Rule.

III. Implementation of Revised Core-Based Statistical Areas

CMS proposes to delay adoption of the revised Core-based Statistical Areas (CBSAs) published by the Office of Management and Budget on February 28, 2013. The Proposed Rule suggests that the changes will likely be proposed in the Fiscal Year 2015 proposed rule. The Coalition supports CMS’s decision to postpone adoption of the revised Metropolitan Statistical Areas (“MSAs”) given the enormous implications these changes will have on a wide range of hospitals. The new MSAs will affect, *inter alia*, program payments, geographic-based designations, and eligibility for physician self-referral exceptions and Federal Anti-Kickback Statute safe harbors.

Due to the breadth of policies and regulations that rely on the MSAs, a three-month window between a proposed and final IPPS rule is not sufficient notice for hospitals to adapt to the potentially significant financial repercussions, even if CMS phases in the changes over time. The Coalition therefore urges CMS to delay the effective date of any proposal to implement the revised MSAs until one year following the final rule adopting these designations, and then to employ transitions comparable to those used when CMS last implemented new MSAs in FY 2005. For example, if CMS were to approve the revised MSAs in the Fiscal Year 2015 final rule, implementation of the newly adopted definitions should not be effective until Fiscal Year 2016, and even then CMS should phase in the new MSAs.

In addition, if the revised MSAs are adopted, CMS should provide a three-year “hold harmless” period for those hospitals who maintain a special status under the Medicare Program that is jeopardized by changes to the MSAs. For example, many member hospitals of the Coalition currently qualify for RRC or SCH status because they are located in a rural area. The revised MSAs will potentially change some hospitals from “rural” to “urban,” which might end a hospital’s ability to be designated as an SCH.\(^\text{13}\) The financial consequences of such a change could be profound. It is not outside CMS’ authority to provide a three-year hold harmless period

\(^{13}\) RRCs presumably would be unaffected by the new MSAs because they are subject to grandfather protection.
for groups of hospitals that would experience a more severe reduction in payment as a result of labor market revisions.14 As such, if the new MSAs are adopted for FY 2015, CMS should allow RRCs and SCHs to maintain their status for FY 2015, 2016, and 2017 so long as all other criteria continue to be met.

Finally, if CMS adopts the revised MSAs in FY 2015, the Coalition also recommends that CMS employ its policy from Fiscal Year 2005 to provide a transition period for hospitals who experience large decreases in their wage indexes as a result of the new MSAs.15 The Coalition requests that CMS extend this transition period to three years in order to allow hospitals sufficient time to develop appropriate strategies to minimize the financial impact of changes to their current wage index. CMS could develop, through the rulemaking process, a threshold for a “large decrease in wage index” so as to protect only a specifically defined category of hospitals.

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Please call me at 202.756.8148 if you have any questions about these comments.

Sincerely,

Eric Zimmerman

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14 69 Fed. Reg. 49,033 (Aug. 11, 2004) (providing a three-year transition period for hospitals transitioning from urban to rural status because “they have experienced a steeper and more abrupt reduction in their wage index due to the labor market revisions.”).