



Arizona Hospital and Healthcare Association

June 29, 2009

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

RE: CMS-1406-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payments System and Rate Year 2010 Rates

Dear Ms. Frizzera,

On behalf of the Arizona Hospital and Healthcare Association (AzHHA), thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed FY 2010 Inpatient Prospective Payment System (IPPS) rule. We are particularly concerned about the proposed documentation and coding adjustment and market basket revisions, as well as proposed capital, sole community hospital (SCH) and critical access hospital (CAH) payment cuts. In total, Arizona hospitals stand to lose over \$728 million under the payment cuts proposed by CMS. We submit the following comments for your consideration.

Documentation and Coding Adjustment

The proposed rule includes a 1.9 percent reduction to operating and capital payments for FY 2010 and beyond to correct the base rate for payments made for FY 2008 that the CMS claims are the effect of documentation and coding changes and that do not reflect actual changes in case mix. In its analysis, the CMS concludes there was a real case mix decline from FY 2007 to FY 2008. However, an alternative analysis by the American Hospital Association (AHA) found a historical pattern of steady annual *increases* from 1.2 to 1.3 percent in real case-mix change. For this reason, we are concerned the CMS' conclusion is incorrect. Furthermore, this conclusion is an inference based on an analysis of documentation and coding related increases. As such, the 1.9 percent proposed cut may be inaccurate and overstated.

We appreciate that the CMS attempted to mitigate the effect of their proposed documentation and coding adjustment by not applying it to the current fiscal year, nor did the agency propose to recoup potential overpayments for FY 2008. However, we remain concerned about the accuracy of the 1.9 percent adjustment as stated above. **With this in mind, we urge the CMS to reconsider the proposed 1.9 percent documentation and coding cut, given the severe impact of the cut and the fact that AHA's analysis shows real increases in patient acuity.**

Market Basket Rebase

The Medicare Modernization Act of 2003 requires the CMS to revise the weights used in the hospital market basket every four years to reflect the most current data available. Accordingly, the CMS proposes to rebase the market basket from FY 2002 to FY 2006 and revise certain categories and price proxies. These changes result in an overall projected 2.1 percent increase to the hospital market basket rate. Historical methodology and data sources, however, produce a projected 2.3 percent increase. According to the CMS, the difference results primarily from its proposed revision to the price proxy used for the chemicals cost category, *a price proxy which is not required to be part of the market basket rebase.*

Due to the recent volatility of the market and potential period of inflation that vary likely could come on the heels of federal stimulus funds making their way into the economy, we urge the CMS to reconsider its proposed methodology. **Specifically, we request CMS to rebase the data and weights used in the market basket calculation only, and not revise the price proxies used in the calculation.** This will result in a more stable estimate of the market basket increase, and is a more prudent approach given the on-going volatility of the economy.

Capital Inpatient Payments

In the FY 2008 final IPPS rule, the CMS reduced payments to hospitals under the capital PPS. This reduction included a two-year phase-out of the indirect medical education (IME) adjustment for teaching hospitals, beginning FY 2009. Congress prevented the FY 2009 cut from occurring in the American Recovery and Reinvestment Act. However, the CMS announced in the proposed FY 2010 IPPS rule it will continue with its plans to eliminate the IME adjustment in FY 2010.

Teaching hospitals are an integral component of the healthcare safety net in Arizona. They provide the clinical education and support needed to train our state's medical students and resident physicians, and they are the backbone of our state's trauma and burn care. We are very concerned that the proposed IME cut will impact the ability of these hospitals to provide high quality care for the patients they serve. According to MedPAC, overall Medicare margins for teaching hospitals were 1.1 percent for FY 2007.

Margins are projected to be negative or flat for FY 2009. **With this in mind, we urge the CMS to restore the capital IME adjustment.** The proposed cut has not been directed by Congress, and is fully under the discretion of the Administration. Restoring these funds would do much to mitigate the loss of capital payments hospitals are projected to experience for FY 2010.

Sole Community Hospitals

Under the inpatient PPS, SCHs are provided certain payment protections. Specifically, they are paid the greater of their PPS payment or their hospital-specific rate from 1982, 1987, 1996 or 2006, adjusted for inflation. Under the proposed rule, the CMS would provide a cumulative retroactive budget-neutrality adjustment to the FY 2006-based SCH hospital-specific rates, which would lower those rates by 2.3 percent. According to the AHA, the impact would be \$81 million for FY 2010.

The CMS states the application of the retroactive budget neutrality adjustment is statutorily necessary to meet the requirement that DRG reclassification changes and relative weights recalibration are budget neutral. In comments submitted to the CMS, the AHA lays out a compelling argument for why this is not the case. We agree with the AHA, and support their position that the application of the adjustment is mathematically incorrect. Given that MedPAC has projected that overall Medicare hospital margins will reach negative 6.9 percent in FY 2009, it is imperative that CMS properly fund SCH payments. **We urge the CMS to revise its instructions to Medicare Administrative Contractors on calculating the FY 2006-based SCH hospital-specific rate to exclude the proposed cumulative retroactive budget-neutrality adjustment.**

Critical Access Hospitals

The CMS proposes to reduce, from 101 percent of reasonable cost to 100 percent of reasonable cost, outpatient payments made to CAHs under the optional (“method 2”) methodology. The CMS states this change is necessary to conform regulation to statutory language enacted by the Medicare Modernization Act of 2003. We believe this proposed change contravenes congressional intent. While the statutory language erroneously did not specify that CAHs electing method 2 payment receive 101 percent of reasonable cost, the accompanying conference committee report is clear that Congress intended this be the case. The report describes both types of payment when discussing current law, and in reference to proposed change states “outpatient ...services provided by a CAH will be reimbursed at 101 percent of reasonable cost.” In short, the summary of the agreement to increase reimbursement to 101 percent of reasonable cost does not distinguish between the two methodologies.

We are further concerned that CMS did not conduct an economic impact analysis of the proposed change, which could be significant for those hospitals electing method 2

payment. **We urge the CMS to withdraw the proposed change to method 2 CAH reimbursement. Should CMS choose to move ahead with its proposal, we urge it to reissue the proposed change with a thorough economic impact analysis and with an additional opportunity for public comment. Additionally, CMS should specify a delayed effective date so that hospitals have adequate time to make an informed decision regarding election of the standard or optional payment methodology.**

EMTALA

The CMS proposes to refine regulations that allow waivers to certain sections of the Emergency Medical Treatment and Labor Act (EMTALA) during a public health emergency. We support the CMS' intent to align the regulations more closely to the language of the *Social Security Act*. Under CMS' proposal, we agree that the waiver of EMTALA sanctions should apply only if a hospital did not discriminate based on an individual's payment or ability to pay. We also agree that granting explicit authority to the CMS to target EMTALA waivers to specific hospitals during an emergency may be useful, as the CMS may be able to expedite such waivers for hospitals needing the most flexibility.

We are concerned, however, about one portion of the proposed regulation, which does not conform to statutory language and may have the unintended consequence of limiting the CMS' waiver authority. Specifically, the proposed rule states that transfers will not be subject to sanctions if the transfer "arises out of" the circumstances of the emergency. The statute, however, states that the transfer will not be subject to sanctions if the transfer is "necessitated by" the emergency. We can envision transfers that arguably do not "arise out" of the circumstances of the emergency but may be necessary for purposes of the hospital's emergency response, and are therefore "necessitated by" the emergency. Thus, there is an argument that transfers that "arise out" of an emergency is more limited than transfers "necessitated by" an emergency. The CMS can eliminate this concern by simply cross-referencing the implementing statute. If the CMS believes that regulations are necessary, then we request that it use the language set forth in the statute to ensure maximum flexibility.

As a general comment, AzHHA believes that CMS' "applicability of sanctions" regulations should be as flexible as possible given the myriad of emergency situations that may occur and the various state and hospital responses to emergency or disaster situations. Emergency situations are by their nature unpredictable, and there may be state or hospital actions that are critical for an effective emergency response, but may technically violate EMTALA. Accordingly, we request that CMS adopt the EMTALA Technical Advisory Group's high priority recommendation with respect to the expansion of the EMTALA waiver provisions. (See EMTALA TAG Final Report, Recommendation #18.)

Finally, we note that Section 1135 is subject to change. A simple regulatory reference to the statutory requirements will eliminate the need for CMS to have to continuously update the regulation after each statutory change (as it has had to do on previous occasions). The CMS can address the waiver approval process, and the factors that it deems important in that process, in the EMTALA Interpretive Guidelines, as needed.

Pay for Reporting

The CMS proposes to add four new quality measures to the pay-for-reporting requirement, none of which have been adopted by the Hospital Quality Alliance (HQA). Only two have been endorsed by the National Quality Forum (NQF). While we appreciate the CMS limiting the number of new measures that would require chart extraction in the proposed rule, we are troubled that CMS continues to choose measures that are not fully vetted through the NQF/HQA process. The Deficit Reduction Act requires that chosen measures represent “a consensus among affected stakeholder.” This requirement helps to ensure that reported measures are reliable, accurate, and effectively assess meaningful aspects of patient care. **Because the CMS has failed to fully vet the four new measures through the rigorous, consensus-building process of the NQF and HQA, we do not support their inclusion in the pay-for-reporting program. We urge CMS to withdraw the measures.**

Thank you again for the opportunity to comment on the proposed rule. If you have any questions or would like further information regarding our comments, please call me.

Sincerely,



John R. Rivers, FACHE
President and Chief Executive Officer

/gmh