June 17, 2010

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

***RE: CMS-1498-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals Under Age 21; Proposed Rule (Vol. 75, No. 85), May 4, 2010***

Dear Ms. Tavenner:

The New Hampshire Hospital Association (NHHA), on behalf of our 26 acute care member hospitals, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2011 and our comments on specific areas are identified and discussed below.

While we support a number of the proposed rule's provisions, including those affecting Medicare-dependent hospitals and certified-registered nurse anesthetists, we have concerns about the documentation and coding adjustment, many of the new hospital quality measures, the specific calculation for New Hampshire of the rural floor (RF) area wage index (AWI) and the provider tax proposal affecting critical access and other hospitals. We are also in agreement with comments submitted on the rule by the American Hospital Association.

**MS-DRG DOCUMENTATION AND CODING ADJUSTMENT**

The proposed rule includes a 2.9 percent cut – $3.7 billion – to recoup half of the payments made in FYs 2008 and 2009 that CMS claims were due to documentation and coding changes that did not reflect real changes in case mix. In combination with other policy changes, this cut results in hospitals actually being paid less in FY 2011 than in FY 2010. **However, we understand that AHA conducted multiple analyses that found only a 0.45 percent reduction is warranted to recoup half of the overpayments made in FYs 2008 and 2009. These analyses indicate that much of the change CMS found is actually the continuation of historical increases in the case mix index (CMI), not the effect of documentation and coding changes due to the implementation of the Medicare-Severity Diagnosis-Related Groups (MS-DRGs). Thus,**

**CMS' proposed cut of 2.9 percent to recoup half the overpayments made in these years is excessive in light of these historical trends in CMI change and *should not* be implemented.**

**NHHA believes there is a fundamental flaw in CMS' methodology for determining the effect of documentation and coding changes on the FY 2008 and FY 2009 CMIs.** Specifically, in its analysis, CMS states that the increase in payments it found could not be due to "real" case mix change because its analysis looks at only one year of patient claims. However, we assert that the increase cannot be deemed documentation and coding change either, because, again, the analysis looks at only one year of patient claims.

The AHA analysis, which used multiple years of patient claims, clearly shows that a significant portion of the change CMS found is actually the continuation of historical trends, rather than the effect of documentation and coding changes due to implementation of MS-DRGs. This analysis found a documentation and coding effect of 0.9 percent for FYs 2008 and 2009. **Therefore, NHHA has significant concerns about the CMS proposed cut and urges CMS to limit the payment reduction to no more than 0.45 percent to fulfill the agency's proposal to recoup half of the overpayments made in FYs 2008 and 2009.**

### HOSPITAL QUALITY DATA

**While the hospital field has long supported reporting quality measures for consumers' and payers' use, the proposed rule would dramatically increase the reporting burden on hospitals by requiring them to report a large number of new pieces of data. In addition, the NHHA believes that the Secretary of the Department of Health and Human Services does not have the authority to include in the quality reporting program many of the measures that CMS has proposed.** Our review of the *Deficit Reduction Act of 2005* indicates that the Secretary is authorized only to require hospitals to submit the necessary data to calculate "the set of measures that the Secretary determines to be appropriate for the measurement of quality of care furnished by hospitals in inpatient settings." It does not authorize the Secretary to use data submitted to CMS or its contractors for reasons other than the measurement of quality of care, nor does it authorize the Secretary to request additional data that are unrelated to the chosen quality measures. NHHA supports the comments submitted by AHA on Hospital Quality Data.

### CRITICAL ACCESS HOSPITALS

CAH Optional Method Election for Payment of Outpatient Services. CMS proposes to modify how it handles CAH election of the "optional payment method" (also known as "Method 2"). Specifically, effective for cost-reporting periods beginning on or after October 1, 2010, once a CAH has elected to receive payments under the optional method, the election will remain in place until it is terminated. CAHs no longer will have to re-elect the optional method annually. CMS also proposes that, if a CAH is being paid under the optional method and wishes to terminate that election, it must submit a request in writing to its fiscal intermediary or Medicare Administrative Contractor at least 30 days prior to the start of the next cost-reporting period. **NHHA supports this proposal, which we believe will help ensure continued CAH access to these vital payments, as well as decrease their administrative burden.**

## Costs of Provider Taxes as Allowable Costs for Critical Access Hospitals

Under the proposed policy, CMS would permit its contractors to offset against the tax expense the Medicaid or other state payments that the hospitals receive from the state. **NHHA strongly objects to this proposed policy because of the tremendously negative impact it would have on our hospitals and the communities they serve.** If implemented, this new policy would come at precisely the time other public and private organizations are working to strengthen critical access hospitals, the vital health care safety net providers in their rural communities. This new policy would serve only to weaken the often-precarious financial condition of those critical access hospitals

**NHHA strongly opposes this policy.**

**CMS's Proposal**. CMS stated that, under the reasonable cost principles, CMS must exclude "costs found to be unnecessary in the efficient delivery of needed health services." CMS further stated that the statute and the Medicare regulations at 42 C.F.R. § 413.98 require that allowable reasonable costs be "related" to the care of Medicare beneficiaries and the costs be actually "incurred." CMS acknowledged that, in § 2122 of the Provider Reimbursement Manual (PRM), the Agency discussed taxes levied on providers that are allowable costs and that it provided a list of taxes that are considered unallowable. CMS further acknowledged that the general rule is that taxes assessed against a provider are allowable costs and that provider taxes are not included in the list of taxes for which reimbursement is not available. Nevertheless, CMS stated that that manual was last updated in 1979 and that it is "incomplete now, as it does not reflect the variety of provider taxes imposed by States."

CMS concluded that in circumstances "in which payments that are associated with the assessed tax are made to providers specifically to make the provider whole or partly whole for the tax expense, Medicare should . . . recognize only the net expense incurred by the provider." Continuing, CMS stated that "while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as reasonable cost the net tax expense; that is, the tax paid by the provider reduced by payments the provider received and that are associated with the assessed tax." Thus, CMS proposed to "clarify" its policy set forth in the PRM to state that Medicare contractors are to "determine the allowability of provider taxes on a case-by-case basis . . . and will determine if a reduction of the allowable tax expense is proper to account for payments providers receive that are associated with the assessed tax." Finally, CMS stated there would be "no financial impact [as a result] of the proposed change," which change it termed a "clarification of longstanding policy."

**As discussed below, we strongly object to the proposed change in policy. We further disagree that the proposed change will have no financial impact.**

**Proposal is Bad Policy**. The policy that CMS has proposed is bad policy. It is contrary both to congressional authorization of the use of provider taxes to fund Medicaid payments and to congressional actions that seek to protect the financial stability of critical access hospitals.

Provider taxes are a fact of life. Congress has authorized States to use provider taxes to fund Medicaid expenditures, and States have been imposing them for years consistent with the authority found in 42 C.F.R. § 433.68. States often use these taxes to aid their funding of the delivery of health care services to their citizens. The payments made by hospitals to the states are not voluntary donations; they are, instead, absolute requirements and constitute real costs to the hospitals. The taxes constitute a cost of doing business, and exemptions to the taxes are not legally available. Thus, under Medicare's general cost reimbursement principles as well as the provisions of PRM § 2122.1, these taxes qualify as reimbursable costs: they are "assessed against providers in accordance with the levying enactments" of the states and they constitute an expense for which exemptions are not available. PRM § 2122.1.

In addition, the taxes are not among those that are expressly excepted from reimbursement in § 2122.2 of the PRM. All of the taxes listed in the PRM as not allowable relate to (1) the cost of ownership (income related taxes and owners' self-employment taxes), (2) taxes that should be capitalized and amortized rather than recognized as a period expense (capital structure related or special land assessments), (3) taxes specifically related to non-covered services, (4) taxes that the provider was not required to pay, and (5) taxes the provider only collects and remits like sales tax. Everyone would agree that these broad classifications of taxes are not allowable when incurred, and that list seems quite complete. Provider taxes, as described above, do not fit into any of these broad categories of taxes that are not allowable. These taxes are a cost to hospitals of doing business, just like other administrative and general costs. They therefore should be allowed.

The fact that there may be payments made by the state to the provider – or the fact that these payments from the state may be funded by the provider taxes – does not change this result. Taxes, by their very nature, are imposed to generate income for states to allow them to furnish goods and services to the individuals and entities that pay the taxes, as well as to others. In other words, taxes are paid with the obvious expectation of someone receiving some benefit or service that is funded by the tax.

To focus the proposed rule on critical access hospitals is particularly problematic. Critical access hospitals are, as CMS is aware, reimbursed on a cost basis. These hospitals are small and serve a particularly vulnerable population who often lack access to other hospitals. Critical access hospitals typically have low operating margins. If Medicare does not reimburse the cost of these taxes, the critical access hospitals will find themselves with even fewer resources to deliver the critically important care upon which their patients depend.

**The Policy is New, Not a Clarification**. A further problem with the proposed regulation is its having been labeled a "clarification." The CMS policy is not a clarification. Here, it is plain that the position taken by CMS is new for the Agency. CMS has never described these taxes as non-reimbursable, nor that amounts received from the State must be offset against the amount of the taxes, in the PRM or in any other guidance. And, although the CMS has had opportunities to do so in the past when addressing provider tax issues at the Provider Reimbursement Review Board and through Administrator review, it has never articulated a policy akin to what is being proposed here.

**Financial Impact**. There simply is no basis for CMS to conclude, that the new policy would have "no financial impact." To the extent Medicare Administrative Contractors (MACs) will now disallow provider taxes by offsetting revenue on cost reports they are currently auditing, critical access hospitals will be negatively impacted in a significant way, which will result in a negative impact in their financial condition and on the patients and the communities they serve.

**Recommendation**. CMS's proposed policy would harm public and private efforts across the country, including half of the hospitals in New Hampshire that are Critical Access Hospitals, aimed at strengthening rural health care and rural safety net providers. **We respectfully, but emphatically, request that CMS not adopt its proposed policy.**

**New Hampshire Rural Floor Area Wage Index (AWI)**

The rural floor (RF) area wage index (AWI) in New Hampshire appears to be suppressed. Analysis indicates that this suppression in the RF AWI is caused by the fact that Concord Hospital (30 0001) was not considered as being reclassified to the Manchester-Nashua, NH CBSA (31700) (see the FFY 2010 final rule Federal Register August 27, 2009, Table 9A, page 44168) This treatment results in a suppression of the RF AWI for New Hampshire in FFY 2011 by nearly five percentage points which should be corrected.

Concord Hospital is located in Merrimack County NH and this county was one of several counties that were "deemed" to be urban in the original 1983 amendments to the Social Security Act (which created the Inpatient Prospective Payment System). Several years ago as a by-product of the implementation of the Core Based Statistical Areas, the Centers for Medicare and Medicaid Services (CMS) determined that it would place Merrimack County NH in rural New Hampshire; but, in order to comply with the original statute's intent would treat the hospital as a "Lugar" reclassification which has been the case since CMS' treatment of Merrimack County as rural. Failure to treat Concord Hospital as a Lugar reclassified hospital results in a suppression of the RF AWI in New Hampshire for FFY 2011 by approximately five percentage points.

Through our consultant we have previously alerted CMS staff of this issue via email and they have responded that the situation would be addressed and corrected in the FFY 2011 final rule. Nevertheless, we take this opportunity to provide formal comment on this situation.

If you have any questions, please contact me or Paula Minnehan, VP, Finance and Rural Hospitals, at (603) 225-0900 or pminnehan@nhha.org.

Sincerely,

Steve Ahnen
President