

July 2, 2003

Mr. Thomas A. Scully
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.,
Washington, D.C. 20201

ATTN.: CMS-1470-P

Re: Medicare Program; Changes to the Inpatient Prospective Payment System and Fiscal Year 2004 Rates; Proposed Rule, Federal Register, Volume 68, No. 96, Monday, May 19th, 2003

Dear Mr. Scully:

On behalf of our approximately 140 member hospitals or health care systems, the Wisconsin Hospital Association (WHA) is taking this opportunity to formally comment on the proposed rules establishing new policies and payment rates for hospital inpatient services for fiscal year 2004. The Association presents the following comments for your consideration:

PAYMENT PROVISIONS:

- **Proposed expansion of the transfer rule:** CMS proposes to expand the existing transfer policy to include an additional nineteen DRG's. CMS' criteria for selection is threefold:
 1. DRG's where at least ten percent of all cases were transferred to post acute settings before the geometric mean length of stay,
 2. DRG's with at least a seven percent decline in length of stay over the past five years,
 3. DRG's with a geometric mean length of stay of at least three days.

This policy continues to contradict the original intent of the inpatient prospective payment system, which established a payment system predicated on averages. Program savings from the implementation of this provision were estimated at approximately \$160 million; Medicare payments to hospitals would be approximately 2% lower in FY 2004 versus FY 2003 because of this expansion.

The Wisconsin Hospital Association strongly opposes expansion of the transfer rule to any additional DRG's for the following reasons:

1. The Wisconsin Hospital Association maintains that application of the transfer policy to **any** DRG categories (including the original ten) penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place.
 2. There is no indication that CMS will increase other Medicare payment provisions in order to maintain budget neutrality; consequently, **WHA recommends, at the very least, that CMS include the savings (estimated at \$160 million) in future base DRG payment rates.**
 3. The statute clearly states that the Secretary is authorized, but not required, to expand the transfer policy.
- **Proposed increase to the fixed cost outlier threshold amount:** CMS has increased the fixed loss threshold used in the calculation of Medicare outlier payments from \$33,450 to \$50,645, an increase of over **50%** from FY 2003 to FY 2004. The rationale for this increase is, again, CMS' concern that, without a large increase in the threshold, the 5.1% outlier payment "cap" will be exceeded. **The Wisconsin Hospital Association opposes any increases in the fixed threshold amount, as hospitals are currently not reimbursed fully for the costs of treating these high-cost patients. Additionally, CMS recently published a separate, final rule revising several provisions of the Medicare outlier payment policy. Because this final policy will have a significant impact on the amount of Medicare outlier payments in FY 2004 and will undoubtedly impact the estimated percentage of payments, WHA recommends that this increase in the threshold be eliminated in the final Medicare inpatient rules.**
- **Critical Access Hospital outpatient clinical laboratory procedure payments:** The proposed rules include a "clarification" of existing policy that bases Medicare reimbursement to Critical Access Hospitals for outpatient laboratory tests on where the patient is located. If the patient is physically present at the hospital at the time the test is performed, that patient meets the requirement of being a "patient of the CAH," and cost-reimbursement is paid to the hospital; however, if the patient is not present at the hospital when the procedure is being performed, that patient is not considered to be a "patient of the CAH" and payment to the hospital is based upon the hospital laboratory fee schedule. CMS' justification for this provision is that it "clarifies" existing policy. **The Wisconsin Hospital Association strongly objects to the implementation of this provision.** Costs are incurred by the facility that processes the test. For example, if blood is drawn for a nursing home patient at the patient's residence (the nursing home), payment for the blood draw should be based upon the fee schedule, as the procedure was done at the nursing home, using nursing home staff and facilities. However, if the processing and analysis for that procedure were done at the hospital, using hospital staff and equipment, the payment for that testing should be based on cost. That would ensure a more accurate matching of payments with costs, and retain the original intent of the cost-reimbursement methodology that is available to critical access hospitals. Furthermore, those patients would be registered at the hospital where the testing is done. **Therefore, WHA strongly recommends that CMS not use the location of the patient as the basis for payment.**
- **Treatment of certain residency programs as normal operating costs:** In its proposed rules, CMS reiterates its distinction between those provider educational activities that are reimbursed as cost-based, educational "pass-through" costs and those continuing educational activities that are normal operating costs, the reimbursement for

which is included in bundled prospective payments. The agency, in particular, singles out one-year, Pharmacy residency programs conducted in hospitals. *“Because pharmacy students need not complete the 1-year residency program to be eligible to practice pharmacy in the hospital setting, the 1-year programs that presently are operated by hospitals would be considered continuing education, and therefore, would be ineligible for pass-through reasonable cost payment.”* Clinical pastoral education programs are also mentioned in the same vein. Therefore, effective for cost reporting periods occurring on or after October 1st, 2003, the costs of pharmacy and clinical pastoral educational programs conducted in hospital settings would be classified as “operating” costs and not “educational, pass-through costs.” **The Wisconsin Hospital Association disagrees with this treatment of those programs for the following reasons and encourages CMS to eliminate this change:**

1. **ANY** change to the methodology for calculating Medicare, educational pass through cost, at the very least, should be transitioned. Because in this situation, the dollar impact of this change is unknown, a transition period would allow hospitals to better plan for the operational changes they would have to make in anticipation of lower reimbursement.
2. There is an implication in the proposed rule that because not ALL pharmacists go through a residency program at a hospital, that residency program is not an important part of the educational process. It would appear that, in reality, the opposite is true. Hospitals, which sponsor pharmacy residency programs, are adding to the quality of the educational program, and thus are enhancing the quality of patient care. The implications that hospital-sponsored, pharmacy residency programs are essentially, “optional” underestimates their importance in the educational development of pharmacists.
3. In its regulatory impact analysis, CMS states, *“We believe that these two programs comprise a small fraction of the approximately \$230 million that are paid for all nursing and allied health education programs under Medicare.”* The fact that a regulatory change has, in its opinion, only a small dollar impact is not a valid reason for the agency to implement it.

OTHER PROVISIONS:

- **Change in counting beds for the IME and DSH calculations:** The proposed rules contain several provisions discussing, clarifying and revising the methodology of counting beds and patient days for the purposes of calculating the Medicare Indirect Medical Education (IME) and Disproportionate Share (DSH) payments. Specific provisions that are the subject of this comment letter are as follows:

1. CMS proposes that the determination of whether or not beds in a patient care unit should be counted for IME or DSH calculations be based upon whether or not those beds were used to provide patient care at any time during the preceding three months. If patient care were provided in those beds during the previous three months, those beds would be counted in the current month’s totals. CMS’ rationale for the selection of three months is weak. *“We believe 3 months, one quarter of a hospital’s fiscal year, represents a reasonable standard for determining that a unit is not being used to provide patient care and may be excluded from the hospital’s available bed count.”* **The Wisconsin Hospital**

Association requests that CMS provide more tangible evidence as to why the three-month time frame is reasonable.

2. CMS proposes a change in the definition of “available” bed. Currently, if a bed can be staffed by nursing personnel within 24 to 48 hours, that bed is classified as “available,” and subsequently, included in the total bed count. The agency proposes to revise the definition of available bed, to consider a bed “available” if a patient could be admitted to the room within 24 hours. **The Association commends CMS for this clarification of current policy.**
 3. The proposed rule restates CMS’ current policy with regards to the exclusion of “labor room days” from the total patient day count. While the agency reaffirms its policy of excluding these days, it also recognizes the cumbersome recordkeeping and reporting that would be required of hospitals. Therefore, the agency proposes that, “...*the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care during a typical month, to apply the rest of the year.*” **WHA supports this alternative reporting method suggested by CMS.**
- **Delay in the implementation of the Census 2000 data for wage index adjustments:** CMS makes reference to the Office of Management and Budget Office’s use of the Census 2000 data in the determination of national “Core-Based, Statistical Areas” (CBSA’s). These new standards will establish two categories of CBSA’s: Metropolitan Statistical Areas (MSA’s) with a population of 50,000 or more and MSA’s with a population of less than 50,000. The agency concludes that the earliest these new definitions could be used for Medicare wage index calculations is FY 2005. **The Wisconsin Hospital Association agrees with CMS’ approach to review and analyze these new designations and their impact on the Medicare wage index before implementation. WHA would also recommend that before any incorporation of changes to the current MSA’s, the industry be given sufficient lead-time, both to analyze the impact and also to formally comment on the usage and interpretation of the Census 2000 data.**
- **Revision of the process and timetable for correcting wage index data:** CMS proposes to change the timetable for the review and correction of hospital data used in the determination of the area wage indices. Essentially, the schedule for hospitals to submit changes to the Medicare fiscal intermediaries (FI) is moved **up three months**. Currently, the FI’s contact the state hospital associations in December to alert them to specific hospital wage index data issues. CMS makes each hospital’s cost report wage data information available in early January via the Public Use files, and hospitals then have approximately thirty days to review that data and submit revisions to the fiscal intermediaries. CMS proposes to make the public files available in early October and thus require hospitals to notify FI’s of changes by early November. **While the Wisconsin Hospital Association appreciates the agency’s desire to expedite the process and, at the same time, reduce the workload of its fiscal intermediaries, it is especially concerned about the additional workload these time frames would place on its member hospitals, in particular, those hospitals whose fiscal year ends on June 30th.** During October and November, the June 30th hospitals, in all likelihood, are preparing cost reports for the fiscal year just ended; this proposal would place an additional cost-reporting task on them because wage index data from a previously filed cost report would have to be reviewed during the same time period that the current report is being prepared. Given the importance of the data that is used to

prepare the wage index, **WHA recommends that CMS continue with the current process already in place for wage index data review and corrections.**

Mr. Scully, thank you again for the opportunity to comment. The Wisconsin Hospital Association welcomes the opportunity to work with your agency in the continued development and refinement of this payment system.

Sincerely,

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