



July 12, 2004

The Honorable Dr. Mark McClellan
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1428-P
P.O. Box 8010
Baltimore, MD 21244-1850

Ref: CMS—1428-P Medicare Program; Changes to Inpatient Prospective Payment System and FY 2005 Rates; Proposed Rule (69 *Federal Register* 28195), May 18, 2004.

Critical Access Hospitals

Dear Dr. McClellan,

On behalf of Iowa's 58 critical access hospitals (CAHs), the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the FY 2005 inpatient prospective payment system (PPS) published May 18, 2004 in the *Federal Register*. This notice proposes implementation of a number of positive provisions contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), including some regulatory changes. IHA would like to take this opportunity to raise concern on several proposed policies and seek clarification on other items contained in the notice.

Payment Amounts

Prior to the enactment of the MMA, Medicare provided payment to CAHs for inpatient, outpatient and skilled nursing facility services on the basis of costs. Section 405(a) of the MMA provides for payment at 101% of the reasonable cost of the CAH in providing these services, effective for services furnished during cost reporting periods beginning on or after January 1, 2004. The rule proposes to revise regulations to incorporate the change in the payment percentage made by the MMA. IHA supports this provision and the corresponding regulatory changes. **However, the Association is concerned that the cost report revisions to implement this provision have only recently been issued and specific instructions to Medicare fiscal intermediaries directing them to revise interim rates to pay at 101% of costs are still forthcoming.** The lack of timeliness in addressing the operational aspect of this provision appears as contrary to congressional intent to provide CAHs with increased reimbursement on a more immediate basis and it appears CAHs will not receive this benefit until cost report settlement that occurs substantially after the services were provided. **IHA recommends CMS take immediate steps directing fiscal intermediaries to calculate interim rates for CAHs to reflect 101% of the cost of providing inpatient, outpatient, and swing bed services.**

Building a healthier Iowa for 75 years!

Condition of Application for Special Professional Service Payment Adjustment

The Social Security Act provides for two methods of payment for outpatient CAH services. A CAH will be paid under a reasonable cost method unless it elects payment under an optional method, also known as method II. Under this option, the CAH submits bills for both facility and professional services to the fiscal intermediary and Medicare makes payment for the facility services at the same level that would apply under the reasonable cost method (increasing to 101% for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115% of the amount that would have otherwise been paid under the physician fee schedule. Section 405 of MMA amended the Social Security Act by specifying that CMS may not require, as a condition for a CAH to make an election of the optional method of payment, that each physician or other practitioner providing professional services in the CAH assign billing rights to the CAH with respect to the services.

CMS proposes to revise regulations to implement the changes made by section 405(d)(1) of the MMA by specifying that a CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method II option. The agency also proposes to clarify that such an election must be made at least 30 days before the start of the cost reporting period for which the election is made. Further, the provision would apply to all services furnished to outpatients during that cost reporting period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with Medicare reassignment regulations.

IHA supports this change to allow flexibility in the method II option. In fact, 31 Iowa hospitals with June 30 fiscal year ends elected this option and began billing under this provision as of July 1. However, IHA is concerned that a number of operational aspects of this option have yet to be clarified and in absence of more specific instructions, these facilities may run afoul of requirements to ensure proper payment of claims. Further, there remains a great deal of uncertainty about whether payments for both hospital and professional services will be processed correctly. Some of the outstanding billing questions regarding this method include the following:

1. Do the entire Medicare Part B physician billing and coding rules still apply? In other words, has the physician fee schedule along with the physician reimbursement methodology been loaded on to the fiscal intermediary claims processing system? For example, physician services are subject to correct coding initiative edits (CCI) that are different than the ones applied to the outpatient PPS but CAH outpatient services are not subject to these edits since they aren't paid on the basis of APCs. Further, will all the modifiers still be required and accepted? Physician services use modifiers such as -26 for radiology professional fees, -22 for unusual circumstances, -57 for a surgery consultant on the same day as the surgery, etc. Further there are other edits such as only one E&M code per day for physicians. All these items affect billing and reimbursement.
2. Is the physician billing number (not the UPIN) still required on the UB-92 and if so, where should it appear? This question relates back to one previously raised about the need to complete an 855R for emergency room physicians. Since the CAH is now doing the billing for the physician for CAH outpatient services, it shouldn't be necessary to complete an 855R for the facility to receive a billing number in order to bill those physicians' services to the Medicare carrier. Further, if more than one physician specialty is provided, how should or how will multiple practitioners be reported?
3. How should CAHs bill for Locum tenens? Is it acceptable to bill for those services under the physician's UPIN for which they are substituting?

4. What local medical review policies/local coverage decisions will apply to the professional services billed on the CAH claim? How will medical review occur?
5. Do the same supervision requirements for PAs and NPs still apply which require a supervising physician?
6. Does the opportunity exist for interim payments for both hospital and physician services if the claims processing system fails to promptly and accurately pay claims under the method II election?

In addition to responding to the above questions, IHA recommends CMS keep CAHs **and** the fiscal intermediaries informed of physician billing changes. **It should be a routine matter for CMS to consider how CAHs will be impacted by all policies and instructions the agency issues and IHA encourages CMS to specifically address this fact in all its communications.**

Coverage of Costs for Certain Emergency Room On-Call Providers

Under existing regulations, Medicare payments to a CAH may include the costs of compensation and related costs of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the reasonable cost of outpatient CAH services. Section 405(b) of the MMA expands the reimbursement of on-call emergency room providers beyond physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services furnished on or after January 1, 2005.

CMS is proposing to revise current regulations to include the expanded list of emergency room on-call providers for whom reimbursement for reasonable compensation and related costs in a CAH would be available. In addition, the agency is making a conforming change to regulations governing the standard for emergency room personnel who are on call under the CAH conditions of participation to **include** clinical nurse specialists. IHA supports these changes because they will allow CAHs the additional flexibility of using non-physician practitioners for emergency room coverage and to receive cost-based reimbursement for these expenses. IHA also supports the proposed conforming change to 42 CFR 485.618(d) governing the standard for emergency room personnel who are on call under the CAH conditions of participations. Further, IHA requests CMS include a comma to the proposed regulations after "clinical nurse specialist", to clarify that this is **not the only clinician required to be trained or to have experience in emergency care** but rather **all** the provider-types listed in this section must be qualified in this manner.

In the April 2004 version of the CAH interpretive guidelines many of proposed regulations pertaining to CAHs were incorporated, including this proposed rule. This version omitted clinical nurse specialist. While IHA **does not support** the issuance of interpretive guidelines inclusive of **proposed regulations** (see Interpretive Guidelines section), IHA is concerned this provision will be and has already been misinterpreted with the omission of the comma after "clinical nurse specialist" and requests CMS clarify this issue.

Authorization of Periodic Interim Payments

IHA supports the MMA provision that amends the Social Security statute by adding the ability for Medicare to provide for payments for inpatient services furnished by CAHs on a periodic interim payment (PIP) basis, effective for payments made on or after July 1, 2004. In implementing this provision

IHA understands CMS is using the existing regulations allowing for other providers to receive PIP and therefore, CAHs would operate under the same rules. IHA is concerned however that direction provided by the CMS regional office on the election of PIP would limit it to the beginning of the CAH cost reporting period, rather than to allow the flexibility of the CAH to chose PIP at any point during the year in which the facility determines the need exists to request stabilized payments from the Medicare program. In addition, the regional office has suggested PIP is only available to those CAHs that have at least one full twelve month cost report under cost-based reimbursement. Again, this direction causes concern because it does not appear to be consistent with congressional intent to extend PIP to CAHs to allow them to establish flexibility in the timing of their payments. IHA recommends CMS provide direction to its regional offices, fiscal intermediaries, and CAHs that is consistent with the objective behind the MMA provision to allow for PIP to these facilities, and to minimize the administrative burden associated with this option.

Revision of Bed Limits

Prior to the enactment of the MMA, CAHs were restricted to 15 acute care beds and a total of 25 beds if the CAH had been granted swing-bed approval. The number of beds used at any time for acute care inpatient services could not exceed 15 beds. Section 405(e) of the MMA amended the Social Security Act to allow CAHs a maximum of 25 acute care beds for inpatient services, regardless of the swing-bed approval. This amendment is effective on January 1, 2004 and applies to CAHs designated before, on, or after this date. **IHA requests CMS clearly state in the final rule that the only change section 405(e) of the MMA made to the counting of CAH beds was to expand the CAH program to allow a maximum of 25 acute care beds for inpatient services. Any other interpretation of this provision would be contrary to congressional intent.**

Interpretive Guidelines

IHA would like to take this opportunity to raise the issue of CMS releasing revisions of Interpretive Guidelines inclusive of proposed rules, **prior to the release of final regulations.** As with the proposed rule to change reimbursement for certain emergency room on-call providers, IHA has learned the proposed rule to change the CAH bed limit was incorporated into the Interpretive Guidelines by CMS via a survey and certification letter issued in December 2003. However, this provision is just now going through the notice of proposed rule making (NPRM) process. **IHA requests CMS address this issue immediately and instruct surveyors to forgo enforcing any regulation that is currently under going the NPRM process.**

Further, these guidelines go far beyond congressional intent. Under the standard for the number of beds [42 CFR 485.620(a)], the agency's interpretation indicates that the CAH may not have more than 25 beds that could be used for inpatient care. The guidance goes on to state that any hospital-type bed located in area adjacent to any location where the bed could be used for inpatient care counts toward the 25 bed limit. The guidelines list the types of beds that do not count toward the 25 bed limit, including examination or procedure tables; stretchers; operating room tables located in the operating room, beds in surgical recovery that are used exclusively for surgical patients during recovery from anesthesia; beds in an obstetric delivery room that are used exclusively for observation of OB patients in active labor and delivery of newborn infants; newborn bassinets and isolettes used for well baby boarders; stretchers in the emergency department; and beds in Medicare certified distinct part rehabilitation or psychiatric units.

Particularly troubling, the guidance addresses observation patient services and states "beds, used by patients on observation status, that conform to the hospital-type beds previously discussed in this requirement, will be counted as part of the maximum bed count". This interpretive guidance to CMS surveyors is contrary to the legislative intent of the MMA to expand the CAH program. Although

interpretive guidelines are not definitive for individual state behavior, they are frequently applied in a strict manner which would prevent most Iowa hospitals currently evaluating CAH status from moving forward, meaning greater financial hardships for those institutions that are struggling to survive under the Medicare prospective payment systems for inpatient and outpatient services. There is no compelling reason to treat observation beds differently than the other types of beds identified in the guidelines, particularly given the fact that observation patients are not considered inpatients of the hospital. IHA recommends CMS reissue this guidance upon release of the final regulation and to allow for the flexibility in the CAH program intended by Congress. Further, IHA recommends address of the guidance on observation services which prohibits observation patients from being commingled with inpatients. Forcing CAHs to maintain a separate, distinct unit for observation only patients, separate from inpatients, creates additional staffing requirements, and only adds to the cost of providing care and thus the expenditures of the Medicare program.

Again, IHA reiterates the only change the MMA made to the counting of CAH beds was to allow a CAH to have at any one time 25 acute care patients, rather than 15.

Authority to Establish Psychiatric and Rehabilitation Distinct Part Units

IHA is supportive of section 405(g)(1) of the MMA to modify the statutory requirements to allow CAHs to establish distinct part inpatient rehabilitation and psychiatric units of up to 10 beds each, exclusive of the 25 CAH bed count, effective for the cost reporting periods beginning on or after October 1, 2004. Although these units will be reimbursed under existing applicable payment methodologies for inpatient rehabilitation facilities and inpatient psychiatric facilities, and be required to meet the same conditions of participation, this provision should allow access to these types of services within rural communities.

IHA requests CMS provide clarification to the following outstanding questions:

- When can a hospital that is pursuing CAH status decertify beds in an existing DPU to meet the 10 bed criteria?
- IHA requests CMS clarify that a hospital can continue to operate an inpatient psychiatric or rehabilitation DPU during the conversion process to CAH.

Although CMS has issued instructions to implement this provision, those instructions stop short of addressing how a hospital that is in the process of becoming a CAH maintains existing DPUs.

Waiver Authority for Designation of CAH as a Necessary Provider

Section 405(h) of the MMA adds language to the Social Security Act that terminates a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. Currently, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under this provision, after January 1, 2006, States will no longer be able to designate a CAH based upon a determination it is a necessary provider of health care. In addition, the MMA included a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this provision, any hospital that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, will be permitted to maintain its necessary provider designation. The proposed rule revises the existing regulations to incorporate the MMA amendments.

Given the fact that all Iowa CAHs were granted CAH status through the state's ability to designate the facility as a necessary provider, IHA is very supportive of the grandfather provision to allow these hospitals to maintain their status, and for this provision to continue until January 1, 2006. IHA also requests CMS clarify that hospitals that have been granted necessary provider designation by January 1, 2006 may stay the course to complete the CAH certification process until it is licensed as such.

Payment for Clinical Diagnostic Laboratory Services

IHA continues to **strongly oppose** the CMS policy change from the FY 2004 inpatient PPS final rule and reiterated in the proposed FY 2005 rule which "clarifies" that payment to a CAH for clinical diagnostic laboratory tests for outpatients is made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH and are physically present at the CAH at the time specimens are collected. Otherwise, payment for these tests is made on a fee schedule basis. Although CMS has stated its belief that extending reasonable cost payment in these instances is inconsistent with Medicare law and regulations and duplicates existing coverage and creates confusion for beneficiaries and others by blurring the distinction between CAHs and other types of providers, IHA believes the agency has repeatedly failed to understand the delivery of laboratory services in rural communities. The Association and challenges the assertion that the absence of this policy created increased cost to provide care to Medicare patients without enhancing either the quality or the availability of that care. Although CMS has invited the public to submit further comments on actual, rather than merely potential or anticipated access problems and IHA is aware of CAHs that have ceased providing lab services to Medicare patients in nursing facilities, the fact remains that this is not occurring in a widespread manner because community hospitals have once again chosen to continue to subsidize the Medicare program by making these services available at far less than what it costs to provide them. In order to avert a crisis and to maintain access to services, Iowa CAHs are continuing to serve Medicare beneficiary needs for lab services, despite the lack of funding, and are using more profitable areas or reserves to cover these losses. However, this situation cannot continue indefinitely. As this becomes a more permanent interpretation and the losses on these services increase, CAHs will have to make difficult decisions to eliminate lab services in nursing facilities. **IHA implores CMS to reverse this policy interpretation and minimally, allow for cost-based reimbursement for lab services at provider-based clinics and rural health clinics associated with CAHs.**

Redefinition of Geographic Areas

Although the use of labor market areas is not an applicable concept for CAHs that are reimbursed at cost, IHA is concerned about a proposal by CMS to redefine the labor markets used to determine the wage index for the inpatient PPS. For the purpose of applying the Medicare wage index, CMS currently defines geographic areas using Metropolitan Statistical Areas (MSAs) based on 1990 census data. The Office of Management and Budget (OMB) released new definitions last summer based on the 2000 census. The OMB definitions replace MSAs with Core-Based Statistical Areas (CBSAs). Although CMS is not required to update the definitions for wage index areas using the more recent census data, the agency has proposed in the FY 2005 rule to adapt the new OMB definitions beginning October 1.

The result of this proposal is the creation of 49 new MSAs as well as significant reconfiguration of existing MSAs throughout the country. Some hospitals with special rural status, such as sole community hospitals (SCHs), rural referral centers (RRCs), Medicare dependent hospitals (MDHs) or critical access hospitals (CAHs) would be relocated from rural to urban under the new geographic definitions. This proposed change affects 10 Iowa CAHs. However, CMS does not address this issue in the proposed rule so the impact of existing CAHs moving into an urban area is unknown at this time. **IHA requests clarification on the application of this new census data to the CAH program and clarify that**

existing CAHs as well as other specially designated rural providers that were located in rural areas at the time of their designation remain eligible for CAH payment.

It should be noted that one Iowa CAH that is located in an existing MSA successfully applied for, and received redesignation as rural based on the Goldsmith Modification contained in 42 CFR 412.103(a)(1). IHA's research of the Office of Rural Health Policy's material to determine the Goldsmith Modification areas has revealed that the agency continues to use the list of metropolitan areas that was issued in 1999 while they study the 2000 census information. Each of the Iowa CAHs that will be located in a CBSA based on the OMB's 2000 census data as applied by CMS for Medicare payment purposes will continue to meet the Goldsmith modification and should retain CAH status. This information supports IHA's request to clarify that these facilities maintain their special Medicare CAH designation. When addressing the applicability of the metropolitan areas for CAHs, CMS must also provide clarification on several related issues. One, if a CAH located in an urban area is grandfathered to maintain its rural status or receives special treatment under 412.103, CMS must provide direction on whether these facilities are deemed rural for all purposes of the Medicare program such as the CRNA pass-through. Further, what wage index will apply to CAHs that choose to operate distinct part psychiatric or rehabilitation units? It is unclear whether the facility will receive the urban wage index from the area in which the CAH is located, or if the redesignation as rural for CAH purposes will require the rural Iowa wage index to be applied in these payment systems.

Again, IHA reiterates its request to make it a routine matter to consider how CAHs will be impacted by CMS policies and instructions even though there may not be an apparent connection to this group of hospitals.

Conditions for Participation-Discharge Planning

The MMA requires CMS to make publicly available to hospitals discharge planners, the public, and Medicare beneficiaries information on skilled nursing facilities (SNFs) that are participating in the Medicare program. The agency states it has fulfilled this requirement and is now proposing to require hospitals to make this list available to Medicare beneficiaries who upon discharge will be admitted to a SNF. Hospitals will be required to keep documentation of the list provided to the beneficiary in the medical record.

CMS is also re-proposing a rule issued December 19, 1997 requiring hospitals to make available to Medicare beneficiaries that are discharged to home health, and to keep documentation of in the medical record, a list of Medicare certified home health agencies (HHA) that have requested to be placed on the list and that serve the geographic area in which the patient resides.

IHA seeks clarification on the applicability of this provision to CAHs.

The proposed rule revises 42 CFR 482.483 which provides the condition of participation for discharge planning for acute care hospitals but does not make a corresponding change to the conditions of participation for CAHs. IHA requests CMS provide direction in the final rule on whether CAHs are obligated to abide by this provision regarding the delivery of information about post-acute care services to patients upon discharge.

Thank you for your review and consideration of these comments. If you have any questions please contact Heather Olson or Tracy Warner at the Iowa Hospital Association at 515/288-1955.

Sincerely,

Page 8

IHA Comments: Medicare Inpatient PPS NPRM-CAH Provisions

July 12, 2004

A handwritten signature in black ink that reads "J. Kirk Norris". The signature is written in a cursive, slightly slanted style.

J. Kirk Norris

President

Cc: Iowa congressional delegation
IHA Board of Trustees
Iowa hospitals
CMS Kansas City regional office