American Hospital Association

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Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Dr. Berwick:

In anticipation of the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the inpatient prospective payment system (PPS), and on behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) would like to comment on a specific aspect of the inpatient PPS – the rural floor budget-neutrality adjustment. As described below, we have significant concerns about this policy and we urge CMS to correct this issue in its upcoming proposal for fiscal year (FY) 2012 inpatient payments.

The rural floor budget-neutrality adjustment was the subject of a recent District of Columbia Court of Appeals decision in *Cape Cod Hospital, et al. v. Kathleen Sebelius, Secretary, United States Department of Health and Human Services*. At issue was whether CMS properly implemented the adjustment to ensure that it does not progressively reduce Medicare payments for inpatient services over time.

The Balanced Budget Act of 1997 (BBA) established the rural floor by requiring that the wage index for hospitals in urban areas of a state cannot be less than the wage index for hospitals in the rural area of a state. The BBA also imposed a budget-neutrality requirement on this provision – the annual total Medicare payments made under the inpatient PPS must equal the annual total Medicare payments that would have been made in the absence of the rural floor policy.

In FY 1999, when the rural floor was first introduced to the inpatient PPS, CMS applied the rural floor budget-neutrality adjustment to the standardized amount. Until FY 2008, CMS carried forward that adjusted standardized amount from the prior year when calculating inpatient PPS payments for the coming year. Yet, the agency also applied the full value of the coming year's budget-neutrality adjustment to the standardized amount. This reduced the total Medicare payments made under the inpatient PPS annually. The amount that payments were reduced grew

each year as the budget-neutrality adjustments carried forward and compounded. Thus, the rural floor was not implemented in a budget-neutral manner, as required by the BBA.

In FY 2008, CMS changed its methodology for applying the rural floor budget-neutrality adjustment by applying the adjustment to the wage index rather than to the standardized amount. Also in that year, CMS made a positive adjustment to the standardized amount that was intended to reverse the FY 2007 budget-neutrality adjustment. This ensured that no further reductions to the total Medicare payments made under the inpatient PPS would occur as a result of this policy. However, CMS did not make positive adjustments to reverse the FY 1999 through FY 2006 rural floor budget-neutrality adjustments, as AHA and others repeatedly urged in responding to proposed rules. Thus, while the payment shortfall to hospitals is no longer increasing, total Medicare payments made under the inpatient PPS are still less than what they would have been in the absence of the rural floor, violating the BBA's budget-neutrality requirement. Specifically, we estimate the payments are about $430 million less than what they should be.

In its ruling, the Court of Appeals mandated that the Secretary vacate the portions of its regulations challenged in the suit. It also remanded the matter to CMS to either explain why reversing all prior rural floor budget-neutrality adjustments was unnecessary to achieve budget neutrality, or, if it can provide no explanation beyond what it has previously articulated, to recalculate the payments due to hospitals under a formula that removes the effects of the prior budget-neutrality adjustments.

CMS should recalculate the standardized amount to remove the compounding effect of the improper application of the FYs 1999 through FY 2006 budget-neutrality adjustments without delay. As the Court of Appeals found, there is simply no plausible justification for either the agency's prior application of the adjustment (as it was clearly an error that has resulted in more than a decade of inappropriately low inpatient PPS payments) or its failure to reverse the effects of the prior cumulative adjustments. Because of CMS' flawed policy, as well as existing statutory requirements for FY 2012 productivity and documentation and coding cuts to the inpatient PPS, **we believe CMS has an obligation to remedy the situation promptly. In the FY 2012 inpatient PPS rulemaking cycle, CMS should increase the standardized amount, and therefore aggregate inpatient PPS payments, to what they would have been in the absence of the rural floor.**

Similar issues exist on the budget-neutrality adjustment for the imputed rural floor, a measure CMS created in FY 2005 by establishing a wage index floor for those states that do not have rural hospitals. We urge CMS to address the improper application of the imputed rural floor budget-neutrality adjustment as part of its broader rural floor policy fix.

If you have any questions, please feel free to contact me or Joanna Hiatt Kim, senior associate director for policy, at (202) 626-2340 or jkim@aha.org.

Sincerely,

Rick Pollack
Executive Vice President