



June 12, 2017

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

RE: Proposed Change to Volume Decrease Adjustment for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)(§ 412.92) published at 82 Fed. Reg. 19796, 19933-19935 (April 28, 2017).

Dear Ms. Verma,

Thank you for the opportunity to provide comments on behalf of the Maine Hospital Association regarding the FFY 2018 proposed IPPS Rule and specifically the proposed changes related to the calculation of the Volume Decrease Adjustment.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals in Maine including 33 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital. In addition to acute-care hospital facilities, we also represent 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices. Several of our acute care hospitals are negatively impacted by the current approach used by CMS and the MAC to calculate the Volume Decrease Adjustment.

Comments Related to: *C. Proposed Change to Volume Decrease Adjustment for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)(§ 412.92) published at 82 Fed. Reg. 19796, 19933-19935 (April 28, 2017).*

BACKGROUND:

CMS’ “Current Approach”:

In the proposed rulemaking, CMS described its “current approach” in calculating volume decrease adjustments as “the MACs calculate the volume decrease adjustment by subtracting the hospital’s total MS-DRG revenue for inpatient operating costs, including outlier payments and IME and DSH payments in the cost reporting period in which the volume decrease occurred, from fixed costs in the cost reporting period in which the volume decrease occurred, minus any adjustment for excess staff.” 82 Fed. Reg. at 19934.

The MAC’s VDA Calculation Process in Maine (and Elsewhere):

The MHA notes this “current approach” is not the approach consistently used by the MAC in Maine (and elsewhere) for over 25 years.

The MAC for Maine hospitals has applied a consistent approach for over 25 years that faithfully followed the plain language of the statute, regulation and PRM. The MAC determined a lump sum adjustment that did not exceed the difference between the hospital's Medicare inpatient costs and the hospital's total MS-DRG revenue for inpatient operating costs, and taking into consideration the individual hospital's needs and circumstances, the hospital's fixed (and semi-fixed) costs, and the length of time the hospital experienced a decrease in utilization. In addition, the MAC applied an excess staffing adjustment as required by the PRM. However, in 2016, the MAC began issuing VDA final determinations using the "current approach" described in the proposed rulemaking. In addition, the MAC reopened previously issued VDA final determinations for at least five Maine hospitals, and then applied the new "current approach" to substantially reduce the amount of the VDA payment. The MHA understands that the MAC undertook a similar reopening process for a large number of hospitals located in New Hampshire, Vermont and New York.

The MHA believes that CMS' "current approach" actually represents a brand new approach that has only recently been adopted.

The Problem with CMS' "Current Approach":

CMS has recognized a significant flaw in its "current approach." Specifically, CMS acknowledged that "if the hospital's total MS-DRG revenue for treating Medicare beneficiaries for which it incurs inpatient operating costs (consisting of fixed, semi-fixed, *and* variable costs) exceeds the hospital's fixed costs, the calculation by the MACs results in no volume decrease adjustment for the hospital." 82 Fed. Reg. at 19934. This flaw occurs because the CMS' newly implemented "current approach" requires the MACs to adjust the hospital's total Medicare inpatient operating costs (to remove "variable" costs), but does not require corresponding adjustment to total MS-DRG revenue (which reimburses fixed, semi-fixed and variable costs). As a result, the MAC is comparing adjusted Medicare inpatient costs to total Medicare inpatient payments. Such an "apples" to "oranges" comparison understates the volume decrease adjustment payment, and therefore violates the plain language of the applicable statute – that the required payment adjustment "fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." 42 U.S.C. § 1395ww(d)(5) (D)(ii) and 42 U.S.C. § 1395ww(d)(5)(G)(iii).

COMMENTS REGARDING SPECIFIC CMS' VDA PROPOSALS:

Variable Costs:

The MHA appreciates CMS' proposal to "require that the MACs compare estimated Medicare revenue for fixed costs to the hospital's fixed costs..." 82 Fed. Reg. at 19934. CMS suggests this proposal will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment." 82 Fed. Reg. at 19934. However, the MHA notes that the so-called "current approach" does not simply give rise to a theoretical or "conceivable possibility" of underpayment, but instead guarantees that the resulting payment will not "fully compensate" the hospital for its fixed costs. Again, this is because the "current approach"

subtracts total inpatient MS-DRG revenue (which is reimbursement for a hospital's fixed, semi-fixed and variable costs) from the hospital's fixed costs only.

Accordingly, the MHA contends that the proposed comparison of "estimated Medicare revenue for fixed costs to a hospital's fixed costs" is the minimum required step to ensure compliance with the applicable statutory mandate.

The MHA believes a better approach would simply compare the hospital's total inpatient costs and total MS-DRG payments, and simply abandon any requirement that the MACs make adjustments to remove costs that are allegedly "variable," as opposed to "fixed" or "semi-fixed." 42 C.F.R. § 412.92(e)(3)(i)(B). Such an approach would appropriately streamline the calculation process, and avoid unnecessary disputes regarding the distinction between variable, fixed and semi-fixed costs in current-day hospital operations. Furthermore, it would appropriately preserve the longstanding regulatory mandate that the MAC consider the "individual hospital's needs and circumstances..." (as opposed to a predetermined, across-the-board determination that broad categories of costs are variable – rather than semi-fixed – costs). 42 C.F.R. § 412.92(e)(3)(i)(A). Finally, it would appropriately preserve the statutory mandate that fixed costs includes the "reasonable cost of maintaining necessary core staff and services" a phrase which demonstrates Congress' intent to broaden the payment beyond more traditional concepts of fixed costs. 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 U.S.C. § 1395ww(d)(5)(G)(iii).

However, if CMS requires the MACs to continue removing "variable" costs, the MHA agrees with the CMS proposal that a corresponding adjustment must be made to identify the MS-DRG payments related to the "fixed costs." Again, without a corresponding adjustment, the resulting payment cannot "fully compensate" the qualifying hospital as required by the plain language of the applicable statute. Within this context, the MHA supports CMS' proposed changes to 42 C.F.R. § 412.92(e)(3), which result in an adjustment to total MS-DRG payments by multiplying these payments "by the ratio of the hospital's fixed Medicare inpatient operating costs to its total Medicare inpatient operating costs" as reflected at 82 Fed. Reg. at 20161.

Cap Calculation:

CMS explained that "under the current methodology, the MAC determines a volume decrease adjustment amount not to exceed the cap calculated as the difference between the lesser of (1) the hospital's current year's Medicare inpatient operating costs or (2) its prior year's Medicare inpatient operating costs multiplied by the appropriate IPSS update factor and the hospital's total MS-DRG revenue for inpatient operating costs..." 82 Fed. Reg. at 19933. CMS referred to this as the "cap calculation." CMS has proposed to remove the cap calculation.

The MHA supports CMS' proposal "to remove the cap calculation from the volume decrease adjustment calculation methodology in future periods." 82 Fed. Reg. at 19934. The MHA agrees with CMS' observation that "a hospital could not foresee a decrease in volume from one year to the next and would therefore not plan for a volume decrease adjustment..." 82 Fed. Reg. at 19934. The MHA further notes that neither the plain language of the applicable statute or regulation support a cap based on a prior year's cost experience.

Excess Staff Adjustment:

CMS explained "we currently require a hospital, when applying for a volume decrease adjustment, to demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days but not beyond minimum

levels as required by State or local laws.” 82 Fed. Reg. at 19935. If the MAC determines that a hospital did “not appropriately adjust its number of staff, the cost of maintaining those staff members is deducted from the total volume decrease adjustment payment.” 82 Fed. Reg. at 19935. Typically, the MAC identified excess staff by comparing the qualifying hospital’s staffing levels to a regional peer group. PRM, Section 2810.1.C.6.

CMS has proposed “to modify the volume decrease adjustment process to no longer require that a hospital explicitly demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days and to no longer require the MAC to adjust the volume decrease adjustment payment amount of excess staffing.” 82 Fed. Reg. at 19935. CMS correctly recognized that “it is likely that a hospital would, in its normal course of business, adjust its staffing levels as revenue declines” rather than “maintain those staffing levels for the sole purpose of potentially having those staffing costs eventually reflected in a Medicare volume decrease adjustment payment that the hospital may or may not qualify for when it files its cost report.” 82 Fed. Reg. at 19935. For the reasons identified by CMS, the MHA supports CMS’ proposal to no longer apply the excess staffing adjustment. In further support, the MHA notes that the application of a peer group to determine excess staffing is contrary to the plain language of the existing regulation, which requires consideration of the individual hospital’s needs and circumstances, not unrelated hospitals.

Prospective Application of Proposed Changes:

CMS has proposed to apply the proposed changes “effective for cost reporting periods beginning on or after October 1, 2017.” 82 Fed. Reg. at 20161. The MHA disagrees that the proposed changes should only be applied prospectively, and encourages CMS to apply the proposed changes to all pending VDA applications, timely appeals and reopening requests.

However, at a minimum, the MHA believes that the proposal to adjust Medicare inpatient MS-DRG payments by the ratio of fixed costs to total costs must be implemented retroactively as it is necessary to “fully compensate” a qualifying hospital as required by the applicable statute. Because this proposal is necessary to comply with the existing law, this proposal must be applied to: (a) a VDA request currently pending before a MAC; (b) a timely appeal before the PRRB which involves the VDA payment; and (c) a timely reopening request by a hospital seeking to reopen the MAC revised final determination of the hospitals VDA payment.

Please feel free to contact me with any questions about this testimony and thank you again for the opportunity to comment.

Sincerely,



David Winslow
Vice-President of Financial Policy