Submitted Electronically

September 26, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1716-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System and Quality Reporting Programs (CMS-1716-P), July 29, 2019

Dear Ms. Verma:

The Florida Hospital Association (FHA), on behalf of its nearly 200 member hospitals and health systems, welcomes the opportunity to comment on the proposed rule from the Centers for Medicare & Medicaid Services (CMS) entitled "Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System and Quality Reporting Programs, etc." published in the *Federal Register* on July 29, 2019. The proposed rule would revise the hospital outpatient prospective payment system (OPPS), the ambulatory surgical center (ASC) payment system, and quality reporting requirements for specific providers.

In this letter, we are submitting comments on the following proposals:

- Continued reductions in payments for clinic visit services in excepted off-campus departments;
- Reduction in payments for 340B-acquired drugs in non-excepted off-campus departments;
- Transparency and charge posting; and
- Wage index provisions tied to the rural floor.

Continued Reductions in Payments for Clinic Visit Services in Excepted Off-Campus Departments

Citing "unnecessary" increases in the volume of clinic visits in hospital provider-based departments (PBDs), CMS again proposes to pay for visits furnished in excepted off-campus PBDs at the same rate that they are paid in non-excepted off-campus PBDs. CMS proposes to pay for clinic visit (evaluation and management) services in excepted PBDs at the physician fee schedule-equivalent payment rate of 40 percent of the OPPS payment amount, continuing a multi-year reduction to achieve the 40 percent target. This proposal would be implemented in a non-budget neutral manner, resulting in an estimated CY2020 cut to hospital payments under the OPPS by nearly $10 million for hospitals in Florida.

The FHA believes that this proposed policy misinterprets Congressional intent by proposing to reduce payment for services in excepted off-campus PBDs that Congress explicitly protected from site-neutral cuts in Section 603 of the Bipartisan Budget Act of 2015 (BiBA). Under the BiBA Section 603, existing off-campus provider-based departments in place as of November 2, 2015 were deemed "excepted" or grandfathered and were protected from rate reductions established for new facilities.

In the prior year proposed rule, CMS cites the Medicare Payment Advisory Commission (MedPAC) March 2018 Report to Congress as saying, "A large source of growth in spending on services furnished in hospital outpatient departments (HOPDs) appears to be the result of the unnecessary shift of services from (lower cost) physician offices to (higher cost) HOPDs." Note the use of the word "unnecessary" in the CMS quote from the MedPAC report – which does not appear in the actual report issued in March 2018. MedPAC references a shift in site of care, but not that the shift is unnecessary. By citing a reference that is not factual, CMS bases their justification on the increase in clinic visits as being unnecessary but does not substantiate that this increase in volume is in any way inappropriate.

Blaming increases in OPPS expenditures on the unnecessary shifting of services from physician offices to PBDs ignores other factors outside of hospitals' control that are driving increases in these expenditures. This includes the skyrocketing costs of pharmaceuticals, particularly chemotherapy drugs; the impact of Medicare policies, such as the two-midnight policy and the readmissions penalty program; new and costly technology not found in physician offices; and the fact that physicians frequently refer Medicare beneficiaries to PBDs for critical services they do not provide in their offices.

While numerous providers and their representatives commented on the proposed CY2019 outpatient rule, CMS moved forward with the position that the reimbursement changes referred to a method for controlling increases in the volume of covered services provided in off-campus PBDs, rather than an adjustment that would be limited by the budget neutrality provisions of the Social Security Act and, therefore, implemented the rate reduction in a non-budget neutral manner.

In support of FHA's opinion, on September 17, 2019, the D.C. District Court held that CMS exceeded its statutory authority when it first cut the payment rate for clinic services at off-campus PBDs in CY2019. The court determined that any changes needed to be across the board (through changes to the OPPS adjustment factor) or budget neutral (where a payment reduction on one APC would be offset by an increase on another). CMS, the Court ruled, did neither, and, therefore, its 2019 payment reduction was beyond their power ("ultra vires").

As this issue continues through the appeals process, the FHA strongly believes that CMS should not take in further reductions in the clinic payments for off-campus PBDs in CY2020 or future years until the matter is resolved.

Reduction in Payments for 340B-acquired Drugs in Non-excepted Off-campus Departments

In the CY2020 proposed rule, CMS requests comments on potential remedies for the nearly 30 percent reduction in reimbursement for certain 340B hospitals that a district court judge ruled

were unlawful. Specifically, the agency seeks potential remedies for CY2018 and 2019 payments and for use in CY2020 payments in the event the agency receives an adverse ruling by the U.S. Court of Appeals.

We believe the remedy should be as follows: Refund payments should be made to each affected 340B hospital and calculated using the -JG modifier, which identifies claims for 340B drugs that were reduced under the 2018 and 2019 hospital outpatient prospective payment system (OPPS) rules, and others not adversely impacted by the reductions should be held harmless. This remedy would not disrupt the Medicare program and is consistent with those for past violations of law. Our detailed comments follow.

This is a straightforward remedy that is easy to implement, will not be disruptive, does not require new rulemaking, and is comparable to those the courts and agency have adopted to correct other unlawful Medicare payment reductions. Specifically, the agency can recalculate the payments due to 340B hospitals based on the statutory rate of average sales price (ASP) plus 6 percent provided by the 2017 OPPS rule. Hospitals that have already received partial payment should receive a supplemental payment that equals the difference between the amount they received and the amount they are entitled to, including ASP plus 6 percent plus interest. Claims that have not yet been paid should be paid in the full amount, including ASP plus 6 percent.

While the claims will be for different total amounts, the percentage of the claim that the hospital was underpaid is identical in each case. These calculations should be on a hospital-by-hospital basis. Once the total amount that each hospital was paid is calculated, that amount can be multiplied by a single factor – which will be uniform across hospitals – to determine how much should have been paid and thus how much the reimbursement was reduced. Each hospital can be compensated according to the amount that its reimbursements were reduced plus interest.

There is ample authority for the Department of Health and Human Services (HHS) to remedy the underpayments caused by its unlawful rule, including: *Cape Cod Hospital v. Sebelius*, (D.C. Cir. 2011) (HHS corrected errors for the future and past claims for which hospitals had been underpaid), *H. Lee Moffitt Cancer Ctr. & Res. Inst. Hosp., Inc. v. Azar*, (D.D.C. 2018), (HHS may make a retroactive adjustment without applying the budget-neutrality requirement to cancer hospitals that received a statutorily mandated adjustment a year later than the law required), and *Shands Jacksonville Medical Center v. Burwell*, (D.D.C. 2015), (HHS compensated hospitals for three years of across-the-board cuts with a one-time, prospective increase of 0.6 percent).

The remedy need not be budget neutral. The authority the agency cites is not applicable because such expenditures would be required by a court decision in service of fixing a prior unlawful underpayment. Moreover, the agency does not consistently apply budget neutrality to fix its missteps and in other relevant instances. For example, HHS allows for retroactive correction of the wage index without any budget-neutrality adjustment when it made the error and it was not something a hospital could have known or corrected. In addition, budget neutrality does not apply to changes in enrollment or utilization for drugs when the ASP increases.

The OPPS mandates HHS reimburse hospitals for covered outpatient drugs at ASP plus 6 percent. This was the methodology used from 2013 to 2017. HHS has now requested comments on adjusting the payment for 2018, 2019 and 2020 from ASP plus 6 percent to ASP plus 3

percent. Although the agency has some authority to deviate from this law, the agency is attempting to use a policy rationale that is inconsistent with the law itself and, therefore, it would be unlawful to reduce ASP to 3 percent.

Medicare reimburses hospitals 80 percent for covered outpatient and the remaining 20 percent is collected from the patients or their insurance. Because HHS deviated from the lawful payment rate for 2018 and 2019 with a 30 percent reduction, in theory hospitals could collect from patients or their insurance companies the difference between 20 percent of the lawful payment rate and the 20 percent copay that was actually collected. HHS has requested comments on the "most appropriate treatment of Medicare beneficiary cost-sharing responsibilities." Although the agency has raised the specter that a remedy would require patient co-pays to be adjusted retroactively, we do not believe that there is any law that would require hospitals to collect payments altered by the agency's illegal act. Neither the False Claims nor anti-kickback statutes would apply since patients would not have been induced to seek services. Patients who reasonably believe that they have fully paid for hospital care provided months, or in some cases years, ago should not have to make these payments if hospitals are willing to forego them. We urge HHS to state this clearly in the final rule.

Transparency and Charge Posting

CMS proposes to require that hospitals publicly post on the internet a machine-readable file containing both gross charges and "payer-specific negotiated charges" for all items and services. It also proposes to require hospitals to display, in an easy-to-understand format, negotiated charges and certain other information for 300 "shoppable" items and services.

Our members are deeply committed to ensuring patients have the information they need to make informed health care decisions, including timely, accurate estimates of their out-of-pocket costs. The agency's approach would confuse – not help – patients in understanding their potential out-of-pocket cost obligations, would severely disrupt contract negotiations between providers and health plans, and exceeds the Administration's legal authority. We urge CMS to abandon this proposal and instead convene providers, health plans, patients and other stakeholders on approaches to meet patient needs.

In particular, we encourage CMS to take steps to facilitate the development and voluntary adoption of patient cost-estimator tools and resources by convening stakeholders to identify best practices, recommending standards for common features of cost-estimator tools, and developing solutions to common technical barriers.

We believe the proposed disclosure of payer-specific negotiated charges is unlawful. CMS lacks the legal authority to require hospitals to make public payer-specific negotiated charges. Section 2718(e) of the Public Health Service Act (PHSA) does not provide CMS with authority to establish these requirements. CMS's proposal is contrary to the plain language of the statute, as negotiated charges are not "standard charges." By definition, a "standard charge" is not privately negotiated and does not contemplate different charges for different payers. "Standard charges" has long been understood to be a technical term that means a hospital's usual or customary chargemaster charge.

CMS's proposed definition also violates the Administrative Procedure Act (APA) because it is unreasonable. In general usage, "standard" means "usual, common or customary." Payer-specific negotiated charges are not usual, common or customary. Historically, CMS has defined "charges" to mean "the regular rates established by the provider for services rendered to both [Medicare] beneficiaries and to other paying patients. Charges should be . . . uniformly applied to all patients . . . ." If hospitals negotiated charges with various payers, they would be in violation of the Medicare long-standing requirement for "like charges for like services." The agency's rationale for seeking to require that payer-specific negotiated charges be made public undercuts the notion that charges are standard: if CMS wants payer-specific payment rates, that is what they should have proposed.

In addition, CMS's proposal would violate the First Amendment as well, by compelling the public disclosure of individual charges (interpreted here as rates) privately negotiated between hospitals and health plans. Government regulation of non-misleading commercial speech is unlawful unless it "directly advances" a "substantial" governmental interest, and is no "more extensive than is necessary to serve that interest."

CMS's stated interest in putting consumers "at the center of their health care" is unlikely to be served by the mandated disclosures. The agency's own research makes clear that when it comes to price, patients are interested in their own out-of-pocket costs; not their health plan's costs. CMS' repeated admissions that the proposed disclosures are merely a "first step" or a "step towards" the rule's stated goals make clear that the proposed rule does not "directly" and "materially" serve the stated interest.

CMS's proposal also is much more extensive than necessary to serve the proffered interest. Assuming CMS intended to propose disclosure of negotiated rates, and because hospitals rely heavily on the confidentiality of health plan-negotiated rates to permit them to negotiate arm's-length rates with other health plans, disclosure of prices negotiated with individual health plans would unduly burden hospitals' ability to enter into competitive contracts; it goes well beyond the level of regulation necessary to promote the stated government interest. The negotiated rates between hospitals and health plans are confidential trade secrets. As such, requiring their public disclosure would infringe upon intellectual property rights recognized by Congress and individual states.

Mandating the public disclosure of trade secrets protected under both federal and state law would result in extreme harm to hospitals and health plans alike. The agency has failed to demonstrate that the proposed regulation is narrowly tailored or that its interests "cannot be protected adequately by more limited regulation of . . . commercial expression."

Disclosure of payer-specific negotiated rates would harm consumers and competition. Apart from its legal infirmities, the proposed disclosure threatens competition and the movement toward value-based care. The Federal Trade Commission (FTC) has warned numerous times against the disclosure of competitively sensitive information, such as payer-negotiated prices.

Such disclosure can "facilitate collusion, raise prices and harm…patients…." That warning extends explicitly to contract terms with health plans. The FTC has urged that transparency be

limited to "predicted out-of-pocket expenses, co-pays, and quality and performance comparisons of plans or providers."

At least one commercial health insurer warned that disclosure of payer-specific negotiated charges would "impair the movement to value-based care" and allow "[d]ominant health plans to seek and use that information to deter and punish hospitals that lower rates or enter into value-based arrangements with the dominant plan's competitors."

The FHA believes that CMS vastly underestimated the proposal's operational challenges for providers. In addition to our legal and public policy concerns, we have significant operational concerns with this proposal. This proposal, if finalized, would pose excessive burden on hospitals and health systems – far exceeding CMS's estimate of 12 hours.

In summary, CMS's proposed approach would not give patients the information they need to make informed health decisions, yet would introduce significant additional burden and resource requirements into the health care system. For all of this effort, we anticipate that patients will not use this information; instead they will continue to contact hospitals and health systems directly for more accurate out-of-pocket cost estimates.

Wage Index Provisions Related to the Rural Floor

In the CY2020 OPPS proposed rule, Section II.C – Proposed Wage Index Changes, CMS proposes to use the FY2020 hospital inpatient prospective payment system (IPPS) post-reclassified wage index for urban and rural areas as the wage index for the OPPS. As a result, any adjustments for the FY2020 IPPS post-reclassified wage index, are to be reflected in the final CY2020 OPPS wage index beginning on January 1, 2020.

One change to the Area Wage Index (AWI) in the 2020 IPPS proposed and final rules is to exclude from the calculation of the rural floor the data of urban hospitals that have been reclassified as rural. We oppose this policy change and its incorporation into OPPS.

We believe that CMS lacks the legal authority to remove from the rural floor calculation the wage data of hospitals that reclassified from urban to rural under Section 1395ww(d)(8)(E). In the FY2020 IPPS proposed rule, CMS proposed that the rural floor would be calculated without including the wage data of urban hospitals that have reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at 42 C.F.R. § 412.103). CMS asserted that its proposed calculation methodology is permissible under section 1886(d)(8)(E) of the Act and the rural floor statute (section 4410 of Pub. L. 105-33) because section 1886(d)(8)(E) of the Act "does not specify where the wage data of reclassified hospitals must be included." 84 Fed. Reg. at 42332. CMS further asserted that the rural floor statute also does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Id.

As discussed below, we believe that CMS is wrong and has seriously misread the applicable law. Urban hospitals reclassified as rural must be treated as rural for all purposes related to the IPPS (42 U.S.C. § 1395ww(d)), including the wage index and the rural floor. It is the role of Congress to change the rural floor policy (should there be a need), not CMS.

Our concerns are outlined below:

A. Current Statutes Do Not Authorize CMS's New Rural Floor Policy

For both rural floor provisions (Section 1395ww(d)(8)(C)(iii) and Section 4410(a) of Public Law 105-33), CMS's position is that neither statute specifies where the wage data of reclassified hospitals must be included. In its view, because there is no specification, CMS must, therefore, have discretion to exclude the wage data of such reclassified hospitals. But this position is inconsistent with the relevant statutes. CMS attempts to read ambiguity into the Medicare Act, including Section 1395ww(d)(8)(E), because of what it does not say, instead of acknowledging and applying the plain meaning of what the statutes actually do say.

1. Section 1395ww(d)(8)(E) requires the Secretary to treat urban to rural hospitals as rural for all purposes under Section 1395ww(d)

Under current law, hospitals may reclassify from urban to rural. Section 1395ww(d)(8)(E) states that "[f]or purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the state in which the hospital is located." "This subsection" refers to Section 1395ww(d), which establishes the IPPS and the many rules that apply under that payment system for inpatient hospital services furnished to Medicare patients.

Clause (ii) of Section 1395ww(d)(8)(E) includes hospitals in an urban area that satisfy any of the following criteria:

(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the *Federal Register* on February 27, 1992 (57 Fed. Reg. 6725)).
(II) The hospital is located in an area designated by any law or regulation of such state as a rural area (or is designated by such state as a rural hospital).
(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
(IV) The hospital meets such other criteria as the Secretary may specify.

Section 1395ww(d)(8)(E) is clear that for purposes of Section 1395ww(d), "the Secretary shall treat" an urban to rural reclassified "hospital as being located in the rural area . . . of the state in which the hospital is located." This means that for all relevant provisions in Section 1395ww(d) concerning rural hospitals, an urban to rural reclassified hospital under Section 1395ww(d)(8)(E) must be treated as rural.

2. How wage data are counted under current law

When a hospital reclassifies from urban to rural under Section 1395ww(d)(8)(E), its wage and hour data are included in both its geographic CBSA and its reclassified rural CBSA. (76 Fed. Reg. 51476, 51596, Aug. 18, 2011). If a hospital reclassifies under Section 1395ww(d)(10) ("MGCRB reclassification") then the wage data will be included in both its geographic CBSA

and its reclassified MGCRB CBSA. Id. And where a hospital has both a rural reclassification under Section 1395ww(d)(8)(E) and a MGCRB reclassification, the wage data will be included in its geographic CBSA and its MGCRB CBSA. (81 Fed. Reg. 56762, 56924, Aug. 22, 2016).

3. Because the rural floor statutes are part of and tied to Section 1395ww(d), the urban to rural reclassified hospitals must be treated as rural for all purposes related to the application of the rural floors, including the inclusion of their wage data in the rural floor calculation

There are two statutory rural floors at issue which protect hospitals located in urban areas from being paid at a wage index lower than that assigned to the rural area of the state in which the hospitals are located. The first of these is established by Section 1395ww(d)(8)(C)(iii), which provides that reclassification under the Medicare statute "may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the state in which the county is located." In other words, if an urban area's wages were to fall below the wage index for rural areas in the state, due to certain reclassifications, those urban hospitals in that impacted county would receive the state's rural wage index.

The second of these rural floors is established by Section 4410(a) of Public Law 105-33, which provides that, "[f]or purposes of Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital that is not located in a rural area (as defined in Section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the state in which the hospital is located." Thus, under this second rural floor provision, an urban hospital benefits even if its wage index value was lower than that of the rural wage index before considering reclassifications.

The first rural floor provision at Section 1395ww(d)(8)(C)(iii) is clearly a provision within Section 1395ww(d). Urban to rural reclassified hospitals under Section 1395ww(d)(8)(E), therefore, must be treated as rural for purposes of Section 1395ww(d)(8)(C)(iii). This rural floor provision requires that as a result of certain reclassifications, there cannot be a reduction of any county's wage index to a "level below the wage index for rural areas in the state in which the county is located." Because reclassified hospitals are to be treated as rural for all purposes under Section 1395ww(d), the reclassified hospitals' wage data must be used to calculate this rural floor, since it is data of a hospital located in "rural areas in the state." Therefore, under this rural floor provision, reclassified rural hospitals' wage data are included for purposes of calculating and applying the rural floor.

The second rural floor provision at Section 4410(a) of Public Law 105-33 is also a provision within Section 1395ww(d), as it concerns the application of Section 1395ww(d)(3)(E). Section 1395ww(d)(8)(E) requires, therefore, that hospitals that reclassify from urban to rural under Section 1395ww(d)(8)(E) must be treated as rural for all purposes related to Section 4410(a) of Public Law 105-33 concerning the wage index statute at Section 1395ww(d)(3)(E). This rural floor provision requires that the wage index for an urban area not be less than the AWI applicable to "hospitals located in rural areas in the state in which the hospital is located."

Because reclassified hospitals are to be treated as rural for all purposes under Section 1395ww(d), the reclassified hospitals' wage data must be used to calculate this rural floor, since it is data of a hospital located in "rural areas in the state." Thus, under this rural floor provision, reclassified rural hospitals' wage data are included for purposes of calculating and applying the rural floor, as well.

Excluding reclassified hospitals from the rural floor is plainly inconsistent with the statutory language. CMS's new policy creates a distinction in the treatment of rural hospitals that does not exist, as Section 1395ww(d) does not distinguish between hospitals being geographically rural or hospitals that are rural due to reclassification under Section 1395ww(d)(8)(E).

Moreover, both rural floor statutory provisions require that the wage index for the affected hospitals not be less than the precise same AWI that applies to hospitals physically located in rural areas of the applicable state. As noted above, Section 1395ww(d)(8)(C)(iii) requires that a reclassification not result in a wage index that is "below the wage index for rural areas in the state in which the county is located." Similarly, Section 4410(a) of Public Law 105-33 requires that the wage index for an urban area "may not be less that the area wage index applicable. . . to hospitals located in rural areas in the state in which the hospital is located." We understand that, pursuant to the FY2020 final IPPS rule, CMS has included the data from reclassified urban hospitals in determining the wage index applicable to hospitals that are physically located in a rural area. Both rural floor provisions plainly require that the wage index for the applicable urban areas (those affected by a reclassification under Section 1395ww(d)(8)(C)(iii) and all urban areas under Section 4410(a)) may not be less than the wage index for hospitals physically located in a rural area. Accordingly, the rural floor must be the same as the rural wage index in the state for hospitals physically located in rural areas, and those wage indexes include data from reclassified urban hospitals.

Finally, Congress intended the term "rural area" to have the same definition when applied to the rural floor and Section 1395ww(d)(8)(E). CMS has not provided any arguments to the contrary, stating only that it believes it has discretion to make a distinction where Congress has not. However, Congress did not create a subcategory of rural hospitals that are eligible for the rural wage index but whose wages are not included in the calculation of a state's rural floor, and CMS cannot ignore the plain meaning of current statutes to establish its new rural floor policy.

B. The Geisinger Community Medical Center and Lawrence + Memorial Cases

Not only is the statutory language clear, but the Second and Third Circuits have rendered decisions in which CMS has acquiesced, doing away with a regulation that sought to create a distinction between the treatment of geographically rural hospitals and rural hospitals that reclassified under Section 1395ww(d)(8)(E), because it was unjustified under the same Statute at issue here. CMS's new rural floor policy is inconsistent with these decisions.

In Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015) and Lawrence + Memorial Hospital v. Burwell, 812 F.3d 257 (2d Cir. 2016), the Second and Third Circuits each found that a hospital that reclassifies from urban to rural under Section 1395ww(d)(8)(E) shall be treated as a rural hospital for all purposes under Section 1395ww(d), including for wage reclassification.

In Geisinger (at 391), the Third Circuit determined that Section 1395ww(d)(8)(E) is clear on its face. The court determined that the opening clause of Section 1395ww(d)(8)(E) – "[f]or purposes of this subsection" – indisputably refers to Section 1395ww(d), which establishes the IPPS and sets forth numerous rules for IPPS payment under Medicare, including the rural floor provisions. Id. at 392. The court continued that Congress intended Section 1395ww(d)(8)(E) to apply comprehensively over Section 1395ww(d), and the fact that some parts of Section 1395ww(d) are irrelevant to the reclassification permitted under Section 1395ww(d)(8)(E) does not contravene Congress's intent. Id.

The Secretary argued in Geisinger that Section 1395ww(d)(8)(E) was "silent" with regard to Medicare Geographic Classification Review Board (MGCRB) reclassification (Section 1395ww(d)(10)), but the court rejected this argument, declaring that the Secretary attempts to "read ambiguity into the statute because of what it does not say, rather than read it for what it plainly says." Id. at 393. The court continued that while "Congress did not explicitly provide that [Section 1395ww(d)(8)(E)] applies to subsection (d)(10) . . . it did explicitly provide that [Section 1395ww(d)(8)(E)] applies for purposes of subsection (d), which covers subsection (d)(10)."

Here, CMS's position with respect to the FY2020 IPPS final rule is no different than CMS's arguments in Geisinger, and the result should be the same. The two rural floor policies are part of Section 1395ww(d), and both clearly articulate how urban hospital wage index values are to be compared to the wage index values of "hospitals located in rural areas in the state in which the hospital is located." Section 4410(a) of Public Law 105-33. CMS cannot read ambiguity into Section 1395ww(d)(8)(E) because it does not specifically reference the rural floor provisions, when it does reference the broader provision of Section 1395ww(d) that includes such rural floor provisions. Further, the Geisinger court reiterated that there is only one definition of "rural" within Section 1395ww(d). Id. at 394. Thus, there is no distinction between geographically rural hospitals and those that reclassified to a rural area under Section 1395ww(d)(8)(E).

The Second Circuit in the Lawrence + Memorial case reached the same conclusion as the Geisinger court. In doing so, it considered additional arguments from the Secretary similar to those put forward in the IPPS final rule by CMS (i.e., a hospital must necessarily be treated as "rural" so it cannot receive the wage index of an urban area). Lawrence + Memorial, 812 F.3d at 265-266. The Second Circuit decided that these arguments were unpersuasive because the Secretary's reading defies the plain meaning of the Medicare statute. Id. at 266. Specifically, the court reminded the Secretary that there is no distinction in Section 1395ww(d) between "geographically rural" hospitals and hospitals with "acquired rural status." Id.

Additionally, Section 1395ww(d)(8)(E) was inserted into the Medicare statute after both rural floor provisions were added to it. Thus, Congress mandated that specified hospitals be treated as rural for the purposes of the entire Section 1395ww(d), which already included the rural floor provisions. See Id.

After the Second and Third Circuits invalidated the reclassification regulation, CMS decided not to challenge the decisions and eliminated the reclassification regulation nationally. Having accepted those decisions, CMS is now acting in a manner that is inconsistent with them by excluding the data of the reclassified urban hospitals from the rural floor.

In the IPPS final rule, CMS says the rural floor policy is consistent with Geisinger and Lawrence + Memorial because, although it is CMS policy to consider reclassified hospitals as having rural status, "the rural floor is separate from issues of the treatment of the hospital itself." 84 Fed. Reg. at 42335. However, the conclusion in Geisinger and Lawrence + Memorial is that hospitals that reclassify under Section 1395ww(d)(8)(E) shall be treated as rural for all purposes under Section 1395ww(d), which includes the rural floor provisions.

CMS also argues that the "strict reading of 'rural for all purposes'" is "neither required by the text of the court decisions . . . nor appropriate from a policy perspective." However, as discussed above, the plain meaning of Section 1395ww(d)(8)(E) is that a reclassified urban hospital must be treated as rural for all purposes related to Section 1395ww(d), and that is what the Second and Third Circuits concluded. Further, the plain, unambiguous meaning of the rural floor statutory provisions is that hospitals in an urban area may not have a lower wage index than hospitals located in a rural area of the state, which wage index includes the data of urban hospitals reclassified to rural. And regardless of whether CMS thinks Congress has created policy that is not "appropriate," it is CMS's obligation to carry out the intent of Congress as demonstrated by the plain language of the applicable statutes. CMS of course understands there are limits to its authority to change the rural floor policy, stating that it is Congress's role to amend the national budget neutrality provision under section 3141 of Public Law 111-148, should it want to eliminate national budget neutrality. (84 Fed. Reg. at 42335.) ("We agree with the commenter that [the complete elimination of the national budget neutral impact of the rural floor policy] would be difficult to achieve without legislative action.")

C. Congress, Not CMS, Has the Authority to Address any Rural Floor Policy Concerns

CMS, referencing the Office of Inspector General November 2018 report, acknowledges that the legislative intent of the rural floor was to correct the anomaly of some urban hospitals being paid less than the average rural hospital in their states. (84 Fed. Reg. at 42332.) CMS asserts that "an adjustment is necessary to address the unanticipated effects of urban to rural reclassifications on the rural floor and the resulting wage index disparities, including the inappropriate wage index disparities caused by the manipulation of the rural floor policy by some hospitals." Id. However, CMS is wrong to assert that it has the authority to change the statute. If there is something to fix, as CMS contends there is, then CMS should seek a statutory change from Congress rather than adopting a rule which contravenes the plain language of the applicable statutory provisions.

CMS does not have the legal authority to alter the rural floor policy as it contends. The relevant statutes clearly state that hospitals that reclassify under Section 1395ww(d)(8)(E) are to be treated as rural for all purposes under Section 1395ww(d); this includes the rural floor provisions. Therefore, we ask that CMS not adopt its rural floor policy in the OPPS final rule or anywhere else.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions or comments, please email me at kathyr@fha.org.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services