August 30, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Berwick:

On behalf of the Texas Hospital Association (THA), we are commenting on proposed regulations for the fiscal year 2012 hospital outpatient prospective payment; ambulatory surgical center; hospital value-based purchasing program; physician self-referral; and provider agreement regulations on patient notification requirements. **The file code for these comments is CMS-1525-P. The comments are in reference to proposals in Section II, item 4, C, "Proposed Wage Index Changes."**

PROPOSED WAGE INDEX CHANGES

THA urges CMS to take action to avoid an inequitable redistribution of funds that would result from misapplication of the rural floor policy in circumstances that are clearly not within the original intent of the policy. CMS' proposed use of the FY 2012 IPPS wage index as the wage index for the calendar year 2012 outpatient payment system, as manipulated through one hospital in one state, is flawed and distorts wage rates and ultimately prices across the nation. Although it can be argued that the wage index, as currently constructed, is imperfect in measuring prices paid for wages in various parts of the country, the use of the rural floor, as manipulated by a few hospitals, makes it even more imperfect.

While CMS does not have authority to revise the rural floor policy for the Inpatient Prospective Payment System (IPPS), CMS has more discretion under the Outpatient Prospective Payment System (OPPS). In this regard, THA appreciates the four policy options that CMS requesting input on in the proposed rule for addressing the OPPS wage index:

- continue the current policy and use the inpatient wage index for the OPPS in its entirety, including the rural floor, geographic reclassifications, and all other wage index adjustments;
- use the inpatient wage index in its entirety except when a small number of hospitals set the rural floor for the benefit of all other hospitals in a state;
- use the inpatient wage index in its entirety except apply rural floor budget neutrality within each state instead of nationally; or
- adopt another decision rule for when the rural floor should not be applied in the OPPS when CMS has concerns about disproportionate impact.

THA opposes the option to continue the current rural floor policy. The Medicare wage index has a tremendous impact on the level of payment providers receive from Medicare. Over time, the wage index methodology has become increasingly complex and in many instances does not adjust Medicare payments equitably or accurately. THA supports systematic reform of the currently inequitable and flawed Medicare wage index system. However, CMS should not wait for reform of the overall wage index system to address obvious and significant immediate problems. The current issue with the application of the rural floor is a problem that should be addressed immediately. CMS estimates that the conversion of the CAH to IPPS status raised IPPS payments for all hospitals in that state by approximately 8%, while decreasing payments to

hospitals in all other states by more than 0.4% due to budget neutrality requirements. **This change would negatively impact Texas' hospitals by a total of $35 million**.

THA supports modification of the current outpatient rural floor policy to address specific circumstances where the result is clearly not within the intent of the policy due to the disproportionate impact it has within a state. Therefore, we support a modified version of the CMS option to not apply the rural floor policy when a small number of hospitals set the floor for the benefit of all other hospitals in the State. Rather than providing strict definitions of when this option should apply, we suggest that CMS consider the specific circumstances where it might apply and follow principles consistent with the intent of the rural floor policy.

THA opposes application of budget neutrality for the rural floor at the state level rather than the national level and urges CMS to reject this option. The Medicare PPS methodologies are national systems, based on national rates and payment policies. A state-level budget neutrality adjustment would contradict the logic of this system. In addition, all other neutrality adjustments are set at the national level and it would be inequitable to single out the rural floor adjustment for special treatment. Finally, this option would affect a large number of states where the rural floor applies. Instead, CMS should implement a targeted policy change that addresses the specific problem that has been identified.

CMS is also considering, for both the IPPS and the OPPS, whether to determine the rural wage index floor using only data from those hospitals geographically rural under the Office of Management and Budget and the Census Bureau's Metropolitan Statistical Area designations, and excluding wage data associated with the hospitals reclassified from urban to rural status. According to CMS, this policy would "eliminate the incentive to reclassify from urban to rural status primarily to increase rural floors across a state, and would ensure that the rural floor is based upon hospitals located in rural areas." **At this time, THA does not have enough information available to make an informed comment.**

THA does oppose the suggestion that the rural floor calculation should exclude data for hospitals reclassified from urban to rural status. These reclassified hospitals are considered rural for all payment policies. They are paid using the rural wage index and their data is included in the calculation of the rural wage index. In addition, exclusion of their data from the rural floor would lead to instances where a state's rural floor is less than its rural wage index which directly contradicts the intent of the rural floor.

If CMS elects to move forward with a modified wage index system for the CY 2012 OPPS payment system, THA would strongly ask that CMS include in the final rule the following discussions and impacts:

1. Establish and publish a state-by-state impact table, similar to the table included in Appendix A in the final IPPS rule; and
2. Discuss, model and publish the impacts on Medicare beneficiaries for not only the CY 2012 OPPS rule, but also the final FY 2012 IPPS rule (both for beneficiaries enrolled in fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans).

Thank you for your consideration and if you have questions or need additional information, please contact me at (512) 465-1012 or dstultz@tha.org.

Sincerely,

Dan Stultz, M.D., FACP, FACHE
President/CEO