MEDPAC Medicare Payment Advisory Commission

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June 10, 2008

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1390-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: file Code CMS-1390-P

Dear Mr. Weems:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and fiscal year 2009 Rates; Proposed Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians, Federal Register Vol. 73, No. 84, pages 23528-23938 (April 30, 2008).

We appreciate your staff's ongoing efforts to administer and improve the payment system for acute inpatient services, particularly considering the agency's competing demands and limited resources. In this letter, we comment on a series of CMS actions that could affect the incentives and fairness within the inpatient prospective payment system (IPPS). We also discuss improving the disclosure of information regarding physicians' financial relationships with hospitals and device companies.

Incentives to Reduce Avoidable Readmissions to Hospitals

CMS has asked for public comment on three approaches to applying incentives to reduce avoidable readmissions: 1) public reporting of readmission rates, 2) direct adjustment to hospital DRG payments for avoidable readmissions, 3) adjustments to hospital DRG payments through a performance-based payment methodology. MedPAC supports public reporting of readmission data and has recommended financial penalties for providers with unusually high risk-adjusted readmission rates.

In its June 2008 report to the Congress, MedPAC recommends that CMS inform hospitals of their readmission rates. For the first two years, communication of readmission rates to individual hospitals should be confidential. Beginning with the third year, hospitals' readmission rates should be made available to the public.

Information disclosure alone, however, may not be sufficient to fully motivate and sustain change. Therefore, the Commission also recommends changing hospitals' payments to hold providers financially accountable for service use around a hospitalization episode. Specifically, MedPAC recommends that Medicare reduce payment to hospitals with relatively high, risk-adjusted readmission rates for select conditions. The Commission recommends that this payment change be made in tandem with a previously recommended change in law to allow hospitals and physicians to share in the savings that result from reengineering inefficient care processes (see our comments on gainsharing below). Because avoidable readmissions present a significant opportunity to improve patient care while reducing costs, we believe that a readmission policy can stand on its own rather than being only one component of a P4P composite score.

MS-DRG Case-mix Documentation and Coding Adjustment

We concur with CMS's conclusions about the need for, and application of, counterbalancing adjustments to offset the effects on payments associated with improvements in medical record documentation and diagnosis coding. The implementation of Medicare severity diagnosis related groups (MS-DRGs) in 2008 gives hospitals a financial incentive to improve medical record documentation and coding to more fully account for each patient's severity of illness. We expect documentation to improve and reported severity levels to increase. To avoid unwarranted increases in payments due to the effects of improvements in reported severity, CMS should make a counterbalancing reduction in prospective payment rates and hospital-specific rates for all hospitals paid based on their reported case mix. This includes all hospitals that are paid under the IPPS.

Refinement of cost-based weights for MS-DRGs

We commend CMS for its proposal to complete the three-year transition from charge- to cost-based weights that began in fiscal year 2007 and the two-year transition from CMS DRGs to MS-DRGs that began in fiscal year 2008. Under this proposal, MS-DRGs would be fully implemented in fiscal year 2009 and the relative weights would be based entirely on the estimated costs of furnishing care in each patient category. As we indicated in our letter in response to last year's proposed rule (dated June 11, 2007), the evidence that we have examined demonstrates that these changes will substantially improve payment accuracy under the hospital inpatient prospective payment system.

Opportunities for further refinement of cost-based relative weights

CMS has not proposed any further refinements to the data and methods that it uses to calculate and recalibrate cost-based relative weights for fiscal year 2009. However, CMS is soliciting comments on the findings described in two recent reports from RTI International, Inc., and the RAND Corporation. We believe that these reports identify significant opportunities for CMS to adopt long- and short-term refinements to the current data and methods it uses for calculating cost-based relative weights for MS-DRGs.

RTI systematically evaluated sources of, and potential remedies for, aggregation bias (also called charge compression), which occurs when groups of services that hospitals mark up differently are aggregated together. When this happens, CMS's cost estimate for a group of services—derived by multiplying the claim service charges for the group by the overall average cost-to-charge ratio

(CCR)—overstates costs for services with high markups and understates costs for services with low markups. The main problem is that the current cost report—the source for the national CCRs that CMS uses to estimate costs for different services—does not break out all of the groups of services for which hospitals use different mark ups.

MedPAC believes that improving the accuracy and fairness of the MS-DRG weights is a critically important goal. RTI's report offers strong evidence about the need to update the annual cost report by adding new revenue center lines, and make conforming changes in the breakout of claim service charges in the MedPAR file. Adding only one new revenue center line for devices and implants as proposed, however, will not ensure equity across types of services, and it may impair payment accuracy for some MS-DRGs by correcting only one source of bias among several that are now partially offsetting. In the longer-term, adding as many as seven new revenue center lines to the cost report and using conforming groups of service charges in the MedPAR file will improve both the fairness and accuracy of the weights. But these refinements will take at least three years to bear fruit. In the meantime, we believe that CMS can achieve most of the desired improvements by using RTI's regression-based estimates to determine national cost-to-charge ratios for subgroups of drugs, supplies, and radiology services.

As discussed more fully below, we recommend that you:

- Adopt the line reassignments developed by RTI to correct errors in the cost report data that will be used in calculating the final MS-DRG relative weights for fiscal year 2009. The line reassignments correct errors in the assignments of charges and costs reported by many hospitals for non-standard revenue center lines on their annual costs reports. CMS should apply these corrections to the cost report data before calculating national cost-to-charge ratios (CCRs) for the revenue center groupings it uses to estimate costs per case for each MS-DRG (see the third item below).
- Adopt the RTI-recommended reclassification of MedPAR intermediate care charges from the critical care revenue center group to the routine care revenue center group. This action would correct a mismatch in the assignment of intermediate care charges between the cost report (where they are grouped with routine care charges) and the MedPAR file (where they are grouped with critical care charges).
- As a short-term step to ameliorate the effects on the weights from aggregation bias, adopt the revised regression-based CCR estimates developed by RTI to calculate national CCRs for seven additional revenue centers in the drugs, supplies, and radiology revenue center groups. As a necessary related step, CMS would have to re-generate the MedPAR file with an expanded breakdown of revenue codes to get charge groups that match the expanded list of revenue center groups. These actions would increase the number of revenue center groups from the current 15 to 22. The increase in the number of revenue groups would reduce biases in estimated costs caused by grouping services with different markups together, thereby improving the accuracy of the cost estimates that are the foundation of the MS-DRG relative weights.
- As a longer-term step to improve the accuracy of the cost and charge information that hospitals provide on their annual cost reports, add several other new revenue center lines in addition to the new line proposed for devices and implants. We commend CMS for undertaking a comprehensive review of the current cost reporting form and accompanying instructions, and for proposing to add a new line to break out costly devices and implants from other supplies charged to patients. However, the regression-based CCR estimates in the RTI report demonstrate convincingly that additional lines are also needed for drugs that require additional detailed coding (mostly chemotherapy agents), CT scans, MRI scans, and cardiac

catheterization. These additional lines are needed to distinguish services that hospitals tend to mark up differently within existing revenue centers. For example, RTI shows that CT scans have a significantly higher markup than most other radiology services. Consequently, using the overall radiology CCR causes CMS to overestimate the cost of these services. Adding a separate line for CT scans would permit hospitals to separate charges and costs for these services, thereby correcting this problem. In aggregate, these additions would enable CMS to permanently reduce aggregation biases and estimate relative weights more accurately in the future.

- As a related longer-term step, CMS should make the categories of charges in the MedPAR file at least consistent with the 23 revenue center groups RTI has identified (including cardiac catheterization). This is feasible because the MedPAR file is derived from a claims data set that has charges broken down by detailed revenue codes that RTI aggregated to match the 23 revenue center groups used in its study.
- Based on the findings of the RAND report, revise the method of standardizing claim charges to remove the effects of factors that affect hospitals' costs. Among other findings, the RAND report concludes that the current method of standardizing charges based on the hospital payment factors—the wage index and COLA, the indirect medical education adjustment (IME), and the disproportionate share adjustment (DSH)—over adjusts for the effects of these factors on hospitals' costs. The over-adjustment occurs because the current policy adjustments for the payment factors (especially the IME and DSH adjustments) substantially overstate the empirically estimated effects that they have on hospitals' average costs per case. CMS could avoid the resulting distortions in the relative weights by using empirically based estimates of the effects these factors have on hospitals' costs instead of the current policy adjustments.[a] MedPAC periodically makes such estimates and CMS also has done so in the past.

In last year's final rule with comment period, CMS declined to adopt RTI-recommended regression-based CCRs for subgroups of drugs, supplies, and radiology services for several reasons. One reason was that the scope of RTI's initial analysis was limited to inpatient charge and cost data (excluding outpatient charges and costs) and the effects of adopting regression-based national CCRs were evaluated using CMS DRGs rather than MS-DRGs. CMS was concerned that the CCR estimates based only on inpatient data might create inconsistencies between the financial incentives under the IPPS and incentives under the outpatient prospective payment system. CMS was also concerned that the CCR estimates might change substantially if they were re-estimated using both inpatient and outpatient charges and costs. Further, the initial analyses gave no indication of how regression-based CCRs might interact with MS-DRGs or with other policy changes that might be considered, such as alternative methods of standardizing costs in the process of calculating relative weights. Finally, RTI found substantial mismatches for many hospitals between the total charges they reported for specific services on their claims and the charges they reported for the same groups of services on their annual cost reports. CMS was concerned about the impact that little understood reporting mismatches might have on the accuracy of regression-based CCRs.

To address these concerns, CMS contracted with RTI to expand its study of aggregation bias using charges and costs for both inpatient and outpatient services and MS-DRGs. When RTI examined hospitals' reporting of charges and costs for non-standard lines on their cost reports it found that many hospitals were assigning erroneous cost codes to indicate the types of services included on these lines.

[a] Alternatively, CMS could adopt the hospital-specific relative value (HSRV) method of standardizing charges. (This method is discussed more fully in our comment letter, dated June 11, 2007, in response to last year's proposed rule.) Using the HSRV method, however, would require a substantial revision in the methods CMS now uses to calculate cost-based weights for MS-DRGs.

(Many hospitals use non-standard lines to break out costs and charges for specific services, for example, cardiac catheterization or CT scanning.) RTI developed a method for reliably correcting the erroneous cost codes and reassigning the costs and charges on these lines. The reassignment of the costs and charges on these lines accounted for most of the observed mismatches between hospitals' charges reported on their claims and the charges they report for the same groups of services on their cost reports. Further, when RTI estimated regression-based CCRs based on combined inpatient and outpatient data (after reassignment of the non-standard lines), the results were strongly consistent with their earlier estimates based on inpatient data alone. In addition, the effects of adopting RTI's regression-based CCRs on the relative weights for MS-DRGs are similar to what RTI had estimated the effects would have been for CMS DRGs.

As a result, most of the previous legitimate concerns about the accuracy and appropriateness of regression-based national CCRs appear to have been resolved. Therefore, CMS should adopt the regression-based CCRs most recently developed by RTI (except for those in cardiology, where RTI expressed some misgivings):doing so will achieve a substantial gain in payment accuracy for many MS-DRGs.

One objection to adopting the regression-based CCRs might be that CMS has insufficient time to repeat all of the analysis carried out by RTI on the more recent claims and cost report data that CMS will use to develop the final MS-DRG weights for fiscal year 2009. We believe, however, that CMS could achieve essentially the same result without replicating RTI's methods. Instead, CMS would use relatively simple ratio techniques to adapt RTI's estimates to the newer CMS data. One way of doing that is as follows:

- First, CMS should adopt the non-standard line reassignments using the methods (and software program) that RTI developed.
- Then, CMS would generate a separate version of the MedPAR file that will be used to calculate the cost-based relative weights for MS-DRGs for the final rule. This version of the MedPAR file would have the target revenue codes (identified in the RTI interim report) broken out for specific items and services within the drugs, supplies, and radiology revenue centers.
- CMS would use the revised MedPAR file to group claim charges into 22 revenue center groups using 12 of the current 15 revenue center groups plus 10 groups that break out the drugs, supplies, and radiology revenue centers (3 groups for all other drugs, IV solutions, and detail coded drugs; 2 groups for all other supplies, and devices and implants; and 5 groups for all other radiology services, CT, MRI, therapeutic radiation, and nuclear medicine).
- Next, CMS would calculate national CCRs for each of the current 15 revenue groups using its current methods (but applied to cost report data that reflect the line reassignments).
- Then, CMS would calculate national CCRs for the 10 revenue center subgroups within drugs, supplies, and radiology using the RTI regression-based estimates. For example, to break out the national CCRs for the 5 subgroups within the radiology revenue center group CMS would:
    - Calculate 5 ratios based on the RTI regression-based CCRs for the radiology revenue center subgroups (all other radiology services, CT scanning, MRI, radiation therapy, and nuclear medicine) relative to the original RTI-estimated national CCR for the broader radiology category.
    - CMS would then multiply these 5 ratios by its own national overall CCR for the broad radiology revenue center group (from the previous step above) to get national CCRs for the 5 radiology revenue center subgroups that are consistent with the newer cost and charge data that CMS is using for the final rule.
    - CMS would follow the same procedure to calculate regression-based CCRs for the 3 subgroups of the drugs revenue center group and the 2 subgroups of the supplies revenue

center group.
    - CMS would use the 10 estimated national CCRs that result for the drugs, supplies, and radiology subgroups with the national CCRs for the other 12 (of the original 15) revenue center groups from the earlier step above. This would create a total of 22 national revenue center CCRs.
- Finally, CMS would multiply the 22 national revenue center CCRs by the national charges for the 22 revenue center groups for each MS-DRG and sum the resulting cost estimates to get the total cost for each MS-DRG.
- The rest of the calculation and recalibration of cost-based relative weights would proceed as it does now.

We believe that this approach is feasible and would produce a substantial improvement in payment accuracy with little loss of precision compared with repeating all of RTI's analysis on CMS's updated data set. If CMS can not adopt these changes in time for the fiscal year 2009 final rule, it should make the necessary preparations to adopt them in next year's proposed rule. To be equitable, CMS needs to implement the short term (regression-based) fix for all three revenue centers (radiology, supplies, and drugs). Equity also requires that the long-term fix (more detailed reporting on the cost report and MedPAR file) applies to all three revenue centers: radiology (disaggregating costs into five categories), drugs (three categories) and supplies (two categories).

Physician-owned implant and medical device companies

CMS reports an increase in physician investment in device manufacturing and distribution companies, as well as group purchasing organizations. Physicians have influence over which devices hospitals purchase, and they recommend specific devices to their patients. Allowing physicians to profit from recommending devices made or distributed by their companies may undermine fair competition and lead to overuse of these products. CMS asks for comments on whether the physician self-referral rules (also known as the Stark rules) should be modified to specifically address these physician-owned companies, or if concerns about these companies are better addressed by existing fraud and abuse laws. In its June 2008 report to the Congress, the Commission discusses the advantages of public reporting of information on physicians' financial relationships with device companies (MedPAC, *Report to the Congress: Reforming the Delivery System*, June 2008). Public reporting could encourage physicians to reflect on the propriety of these arrangements and would allow the media and payers (including Medicare) to explore potential conflicts of interest.

In addition, physicians could be given an incentive to constrain device costs while maintaining quality through gainsharing, or shared accountability arrangements, which would exert downward pressure on device prices. Under shared accountability agreements with quality safeguards (described further below), hospitals could share savings with physicians when physicians agree to use a standardized set of supplies or devices, which would enable the hospital to negotiate steeper discounts with manufacturers.

Gainsharing

CMS asks for comments on whether it should issue an exception to the Stark rules that would allow gainsharing (or shared accountability) arrangements between physicians and hospitals. Under shared accountability, hospitals and physicians agree to share savings from reengineering clinical care in the hospital. These arrangements have the potential to encourage cooperation among providers in

reducing costs and improving quality. We have recommended that the Congress grant the Secretary the authority to allow shared accountability arrangements between physicians and hospitals with safeguards to ensure that cost-saving measures do not reduce quality or influence physician referrals (MedPAC, *Report to the Congress: Physician-owned specialty hospitals*, March 2005).

CMS should take all necessary administrative actions to allow shared accountability with safeguards. We describe potential safeguards in our report on physician-owned specialty hospitals. For example, CMS could require that shared accountability agreements identify specific actions that would produce savings, are transparent and disclosed to patients, include periodic quality reviews by an independent entity, and do not increase physicians' share of savings if physicians increase admissions to the hospital. Ultimately, however, the Congress should modify the civil monetary penalty provision in the Social Security Act, which inhibits broader development of shared accountability arrangements.

Disclosure of Financial Relationships Report (DFRR)

The commission has expressed some concerns about the growth of various physician-hospital relationships that may be designed to increase the volume of services provided without improving the quality and coordination of care. It is reasonable for CMS to first obtain detailed information on physician-hospital relationships from a sample of hospitals. After the initial data is reviewed, CMS could evaluate whether annual disclosures on a smaller set of variables is warranted. If data gathered from the DFRR suggest that annual disclosures are warranted, future disclosure requirements should be designed to apply to all hospitals, impose a low administrative burden on reporting hospitals, and result in information that is available to the public.

Preventable Hospital Acquired Conditions

Beginning October 1, 2008, Medicare will no longer assign an inpatient hospital discharge to a higher paying MS-DRG if the only secondary diagnoses on the claim are one or more of eight selected hospital-acquired conditions (HACs) and these conditions were not present on admission. In those cases, Medicare will pay the hospital as though the secondary diagnosis was not present. However, the non-payment provision will apply only when the selected HACs are the only diagnoses on the claim that would otherwise lead to a higher payment. That is, if the claim has at least one non-HAC secondary diagnosis that qualifies as a comorbidity or complication (CC) or a major CC (MCC) that would lead to the same higher payment, the case will continue to be assigned to a higher-paying MS-DRG. In these cases, the hospital will receive the higher payment. As a result, CMS estimates that the policy will reduce Medicare spending by $50 million to $60 million per year from fiscal year 2009 through fiscal year 2013, or by less than 0.01 percent of total annual spending on inpatient hospital services.

Under the law, the policy described above is scheduled to go into effect for the current list of eight HACs on October 1, 2008. For fiscal year 2009, CMS proposes to add up to nine more HACs.

We recommend two different payment policies for HACs depending on whether or not an HAC is a "never event," that is, identified on the National Quality Forum's list of "Serious Reportable Adverse Events." The never events that CMS has included in the Medicare payment policy on HACs are: foreign object retained after surgery, air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, and falls or other injury trauma. For HACs that are never events, the Commission suggests that the presence of the HAC upon discharge should bar assignment to a higher paying MS-DRG regardless of

any other CCs or MCCs that are on the claim. Although this policy could result in a significant reduction in payment resulting from unrelated complications in these cases, never events reflect such an unacceptable and preventable breach of patient safety and quality that the penalty should be large enough to stimulate hospitals to eliminate them.

However, even the highest quality hospitals may experience some prevalence of potentially preventable HACs that are not "never events". Consequently, the policy outlined above might have the undesirable effect of disproportionately penalizing hospitals that treat patients with higher than average complexity and severity of illness. For these HACs, MedPAC believes that it may be more appropriate to calculate occurrence rates at the hospital level. To the greatest extent possible, hospital-level HAC occurrence rates should be risk-adjusted for patient-specific risk factors, such as the severity of illness, presence of comorbidities, and other clinically relevant factors (which may differ depending on the HAC). Then the risk-adjusted rates should be used as part of the calculation of a hospital's overall performance score in the planned Hospital Value-Based Purchasing (VBP) program. HAC rates should be a separate quality domain within the VBP program, giving CMS the flexibility to vary the weight assigned to these measures relative to the other quality domains such as process of care, patient experience of care, and outcomes. Public reporting of hospitals' HAC rates as part of the larger VBP program would also provide an incentive for hospitals to engage in performance improvement.

Reporting and use of Hospital Quality Data

The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) requires CMS to penalize hospitals that do not successfully report designated quality measures with a 2 percentage point reduction in the market basket update to their payments. The hospital quality information gathered through the initiative is available to the public on the Hospital Compare website.

CMS is proposing to add 43 new measures for the fiscal year 2009 reporting period, and to retire one existing measure. However, for some of the new measures, hospitals will not have to affirmatively report data to CMS. Instead, CMS will calculate them from administrative data. If the proposals are adopted, the total number of measures for reporting for fiscal year 2010 would be 72. The proposed list of new measures includes readmissions of Medicare patients within 30 days post-discharge for three selected conditions.

The Commission strongly supports CMS's efforts to move Medicare toward value-based purchasing and in that spirit we support additional quality data collection. Given the importance of collecting quality of care data from providers, we recommend that quality data reporting should be required as a condition of participation for all acute care hospitals. Also, we noted in our previous work on criteria for Medicare pay-for-performance programs that collecting and analyzing provider performance measurement data should not be unduly burdensome for either the provider or the Medicare program. We therefore encourage CMS to minimize the proposed additional reporting burden on hospitals whenever possible, for example by leveraging data reports that hospitals already submit voluntarily to state health agencies or hospital associations.

While we support all of the proposed additional quality data reporting, the Commission suggests that CMS might consider developing composite measures for public reporting and presentation purposes, for example on the Hospital Compare website. If all 72 proposed measures were presented individually, the sheer number of them may be overwhelming for beneficiaries and others who are interested in using the information to differentiate quality of care among several hospitals in a given

community. If technically feasible, reliable and valid, appropriate composite measures could convey the essence of quality differences in a more easily-understood format. CMS could continue to make the individual quality measures publicly available for those interested in more detail.

Changes to the capital IME adjustment

In the fiscal year 2008 final rule for IPPS hospitals, CMS proposed to reduce the capital IME adjustment by half for fiscal year 2009 and then eliminate the adjustment in fiscal year 2010. CMS bases its assessment on an analysis of Medicare capital margins, which show that teaching hospitals have substantially higher capital margins than other hospitals.

MedPAC analysis over the past decade has consistently shown that capital and operating IME adjustments have been set substantially above what can be empirically justified, leading to large disparities in financial performance under Medicare between teaching and nonteaching hospitals. The Commission in its March 2007 and 2008 reports to the Congress recommended that the operating IME adjustment be reduced from 5.5 percent to 4.5 percent per 10 percent increment in teaching intensity and that the funds obtained from reducing the IME adjustment be used to fund a quality incentive payment program. The reduction in IME payments from eliminating the capital IME adjustment would be smaller than the effect of the Commission's recommendation.

Proposed changes to the post acute transfer policy

The Secretary proposes to extend the time frame for application of the post-acute transfer policy for discharges to home health care from three days to seven days. We have questions about the need for this policy change.

We do not believe that the analytic findings that CMS presents in the proposed rule indicate a problem with the current three-day window. If hospitals have frequently delayed the start of home care to circumvent the transfer policy, we would expect to see a spike in the number of home health admissions that start four days after discharge. Our analysis of hospital and post-acute care claims in 2005 and 2006 finds no evidence of such a spike in home health use four days after discharge. In addition, the distribution of claims by the number of days between hospital discharge and the beginning of home health care is similar between DRGs subject to the transfer policy and those that are not subject to the transfer policy. This suggests that there has not been significant gaming of the system under the current three-day window. CMS needs to provide stronger support for why this change is needed.

Hospital wage index

MedPAC looks forward to seeing CMS's analysis of our proposals to create a new wage index. As an interim step, we support the proposed statewide budget neutrality calculation for rural floors and the imputed rural floor.

In our June 2007 Report to the Congress, MedPAC recommended that "The Congress should repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems." One of the troubling exceptions under current law is the rural floor, which requires that all wage indexes in a state be above the state's rural wage index. This policy is designed to benefit urban hospitals, not rural hospitals. It is built on the

false assumption that hospital wage rates in all urban labor markets in a state are always higher than the average hospital wage rate in rural areas of the state.

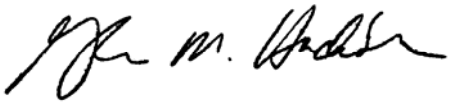
Under current regulations, when a hospital's wage index is raised by the rural floor, all other hospital in the nation, rural and urban, face a budget-neutrality offset that reduces their Medicare payments. Under the proposal, budget neutrality would be calculated at the state level and thus only wage indexes in the same state would be lowered. This would preclude the case CMS has raised of a single critical access hospital in a rural area of a state becoming an IPPS hospital and thus, because of the rural floor exception, increasing hospital payments in the state by $220 million. It would also reduce the incentive for all rural hospitals other than the highest cost hospitals to reclassify out of a state to raise a state's rural floor wage index. In sum, the state-wide budget neutrality proposal would improve fairness and reduce opportunities to game the wage index system.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/js/wc