May 15, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1677–P
P.O. Box 8011
Baltimore, MD 21244–1850

RE: CMS–1677–P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices (Vol. 82, No. 81), April 28, 2017

Dear Ms. Verma:

On behalf of its 71 acute care hospital members, the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on Medicare's proposal not to extend the imputed floor wage index policy. At a later date and under separate cover, NJHA will submit additional comments on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2018.

We are extremely disappointed that CMS has signaled its intention to discontinue its policy on the imputed floor. In the rulemaking process for the FY 2005 inpatient PPS, CMS proposed, then finalized, an "imputed" floor wage index policy for all-urban states. Part of the agency's rationale was the fact that hospitals in all-urban states with predominant labor market areas did not have any protection, or "floor," from declines in their wage index:

> In this final rule, we are adopting a variation of the policy that we discussed in the May 18, 2004 proposed rule. We note first that there are similarities among the three States that are not impacted by the rural floor. Obviously, they are urban States. In addition, each of the three States has one predominant labor market area. That, in turn, forces hospitals that are not located in the predominant labor market area to compete for labor with hospitals that are located in that area. However, because there is no ''floor'' to protect those hospitals not located in the predominant labor market area from facing continued declines in their wage index, it becomes increasingly difficult for those hospitals to continue to compete for labor. In the BBA, Congress spoke of an "anomaly" in States where hospitals located in urban areas had a wage index that was below the wage index applicable for hospitals located in rural areas. (See H.R. Rep. No. 149, 105th Cong., 1st Sess. At 1305.) **We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or "floor," from declines in their wage index. Therefore, we are adopting the logic similar to that articulated**

> **by Congress in the BBA and are adopting an imputed rural policy for a 3-year period** (emphasis added). (69 FR 49110)

NJHA has strongly supported the policy ever since, as it creates wage index consistency and equity between states with rural areas and entirely urban states.

We would like to bring to your attention the following policy views in favor of maintaining the imputed wage index floor policy.

"Status Quo"
In both the FY 2014 and FY 2015 inpatient PPS final rules, CMS extended the imputed floor for an additional year, during which time the agency would continue to explore potential wage index reform. As of the publication of the FY 2018 inpatient PPS proposed rule, comprehensive reform of the Medicare wage index system has not yet occurred nor have plans to do so been announced. **CMS should maintain the status quo – including the imputed floor policy – throughout the entirety of the Medicare wage index system until such reform is achieved.**

Transfer of Payments
In the FY 2018 inpatient PPS proposed rule, CMS states that:

> …the application of the rural and imputed floors requires transfer of payments from hospitals in States with rural hospitals but where the rural floor is not applied to hospitals in States where the rural or imputed floor is applied. For this reason, in this proposed rule, we are proposing not to apply an imputed floor to wage index calculations and payments for hospitals in all-urban States for FY 2018 and subsequent years. (82 FR 19905)

By eliminating the imputed floor wage index, CMS is alleviating only a fraction of the combined payment transfer from the application of the rural and imputed floors. According to data in the FY 2017 inpatient PPS final rule, 18 New Jersey hospitals received the imputed floor. Combined, hospitals in the three all-urban states (New Jersey, Rhode Island and Delaware) accounted for less than 10 percent of the 397 hospitals nationally that received either the rural or imputed floor last year.

Loss of Future Protection / Uneven Playing Field
CMS also states that the imputed floor creates "a disadvantage in the application of the wage index to hospitals in States with rural hospitals but no urban hospitals receiving the rural floor" (82 FR 19905). However, those urban hospitals retain all the future wage index protections associated with the rural floor. Eliminating the imputed floor would create the same uneven playing field that existed prior to 2005, in response to which CMS initially established the policy. The anomaly originally cited by CMS (i.e., that hospitals in all-urban states with predominant labor market areas do not have any type of protection, or "floor," from declines in their wage index) would exist again should the imputed floor policy be discontinued.

Other Medicare Programs Are Redistributive
There are many Medicare payment programs that redirect scarce Medicare funding to a class of unique hospitals. Not all states have hospitals that benefit from these programs. For example, CMS makes

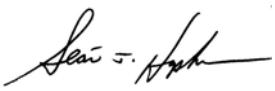
payments to Critical Access Hospitals (CAH) at a rate of 101 percent of their cost. New Jersey does not have any Critical Access Hospitals and therefore does not benefit from this program. While CAHs are paid outside the inpatient PPS program, the dollars continue to come from a finite Medicare trust fund. This represents a transfer of payments from hospitals in states without any CAHs into states with CAHs similar to the transfer of payments CMS cites as its rational to discontinue the imputed floor.

There is precedent for CMS to restore, in the final rule, policies or provisions that were scheduled for elimination or discontinuation in the proposed rule. In the FY 2012 inpatient PPS proposed rule, CMS stated that the imputed floor would expire on Sept. 30, 2011. However, in the final rule CMS announced that the imputed floor provision was extended for two additional years, through FY 2013 (Sept. 30, 2013).

NJHA and our member hospitals throughout the state have long maintained that the imputed floor wage index creates a climate of symmetry, equity and consistency in the Medicare reimbursement process.

The New Jersey Hospital Association appreciates the opportunity to comment on Medicare's proposal not to extend the imputed floor policy. Should you have any questions, please feel free to contact me directly at shopkins@njha.com or Roger Sarao, vice president, Economic & Financial Information at rsarao@njha.com.

Sincerely,



Sean J. Hopkins
Senior Vice President, Federal Relations & Health Economics
New Jersey Hospital Association