

CENTERS FOR MEDICARE AND MEDICAID SERVICES

**SPECIAL OPEN DOOR FORUM:
WAGE INDEX REFORM**

**Leader: Marc Hartstein
Moderator: Natalie Highsmith
May 20, 2008
2:00 pm ET**

Operator: Good afternoon. My name is (Hillary) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Wage Index Reform Conference Call.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during that time, simply press star, then the number one on your telephone keypad and if you would like to withdraw your question, press the pound key.

Thank you Ms. Highsmith. You may begin your conference.

Natalie Highsmith: Thank you (Hillary) and good afternoon to everyone or good morning, if you have joined us from the west coast and thank you for joining us for this special open door forum on wage index reform.

This special open door is to provide an opportunity for the public to discuss and share suggestions and comments on wage index alternative methods for computing the wage index. Participants will be able to comment on the nine matters related to the wage index at section 106C2 of the MIEA (Trisha) required CMS to consider, the MedPAC recommendation and CMS' proposal in the fiscal year 2009 IPPF proposed rule.

CMS awarded a tax audit to Acumen LLC to assist in evaluating the impact of the MedPAC recommended revisions to the hospital wage index and in developing proposals to revise the wage index.

The comment period for the FY2009 IPPF proposed rule ends on June 13, 2008. After short presentations by CMS and Acumen staff, there will be time for comments if you are listed on the agenda that is posted on discussion open door forum Web site.

Participants who are unable to present their comments during the open door today or unavailable or unable to elaborate within a two minute time frame allotted, can submit their comments to CMS on the email address which is cms_wage_index_ods@cms.hhs.gov. Please keep in mind that submitting your comments to this email address will not replace the form comment submission process listed in the federal register.

I will now turn the call to Mr. (Mark Hartstein) who is the Deputy Director of the CMS Hospital and Ambulatory Policy Group. (Mark).

(Mark Harstein): Thank you Natalie. As Natalie this is (Mark Hartstein). I'm the acting Deputy Director of the Hospital and Ambulatory Policy Group and it's really a

pleasure to be here today to listen to the presentation by Acumen and hear the comments from the public on the performance to the IPFS wage index.

Now that I'm at the group level and the acting Deputy Director of the Hospital Ambulatory Policy Group, which includes four divisions, one of them includes the Division of Acute Care which does the in-patient hospital wage index.

But we also have another division, the Division of Practitioner Services that does something called the geographic practice cost index and I've worked in a variety of different payment areas across my career and I've noted that it is always very, very difficult when you work in our payment systems to work with geographic adjustments in payment.

One the one hand it's certainly – they're certainly policy merit and adjusting for geographic differences in payment because there are different costs in different areas, that are higher or lower, and our payment really should reflect those area cost differences, in the case of the hospital wage index, area wage differences and the amount of wages that a hospital pays, in the physician fee schedule area, cost differences and the cost of operating a physician practice.

But the other thing that we've – I've noted over the course of my career, that once you start doing this, it becomes very, very difficult to make precise boundaries for where you should make those adjustments and the magnitude of those adjustments and finding data to be able to do those adjustments.

So over time, there has been some, I think, concern potentially controversy associated with Medicare's area geographic adjustments in differentials in payment.

So I think what we're very much interested in here today, is to get your ideas to present some ideas that are out there, some ideas from the Medicare Payment Advisory Commission that came out in a report to congress from them a couple years ago, or year before last. They were very kind in studying the specific areas that the statute requires the Secretary of Health and Human Services to study and then, of course, we're supposed to consider the MedPAC Report as well of applying ourselves on those specific areas of inquiry.

So we will certainly – we are certainly very interested in the MedPAC ideas and we're interested in your reactions to those ideas.

And I think the one thing I would like to encourage people to do is, please give us constructive ideas for how you think we can make improvement in the area of wage index and geographic reclassification. If you have criticism of the MedPAC idea or any ideas that we present, please let us know what your alternatives are to make it better.

I mean, our goal here is really to build a better system of area adjustments for wage differences. It's very, very important because the in-patient hospital wage index is used not just for in-patient hospital services, but it's also used for out-patient hospital services, skilled nursing facilities, and across a variety of other payment settings.

So it is a very, very important area adjustment in Medicare's payment. It's very important that we consider all of the ideas that are out there and try and make improvements in it.

I think my feeling is that over time, what has happened is, that the law and the regulations have created what we thought were certainly very good systems,

but then there may have been one or another inequity in one area of the country or another, and as a result, additional regulations were –tried to address those particular inequities until we had really a patchwork system of many, many special rules.

And I think what the interest here is, to try to establish – get rid of all the special rules and the special provisions that are intended to address particular areas of the country where there might be an inequity and really establish a better overall payment system, a good system that can fairly and equitably adjust for area – cost differences area, wage differences, and establish a good payment system that’s easier to understand, easy for hospitals to comply with and results in fair and equitable payments.

And even though I’m no longer in the Division of Acute Care, I do know the Division of Acute Care and our Office of Research Demonstrations and Information have devoted some excellent resources to doing this inquiry and this study and I’m very much interested in hearing your ideas as I said, and I just wanted to point that the Division of Acute Care is very well led by Mr. (C. Heffer).

Just yesterday, he was joined by (Gay Burnetts) who is the acting Deputy Director, Wage Index Team Leader, (Valerie Miller) really put a lot of thought into the inquiry that we’re doing now and they’ve been assisted from our Office of Research Demonstrations Information by (Phil Cotteral) and (Craig Cathland), so I think we’ve got some great resources here at CMS to help us through this project and we really very much look forward to your ideas.

So thank you for letting me speak to you today and I’ll turn it back over to Natalie.

Natalie Highsmith: Thank you (Mark).

Okay, now we will move into the summary of Acumen's Analysis Plan and (Tom DeLeer) from Acumen is on the phone lines and he will give that summary.

(Tom DeLeer): Thank you very much. First let me say that Acumen's very pleased to be able to assist CMS in evaluating the MedPAC proposal and in considering modifications to the hospital wage index.

I'm only going to speak for a few minutes, but in that time, I'd like to first provide very little background and second, describe the analysis we plan to do in response to Section 106 of the (TRHCA).

So first, as some background, any hospital compensation index that one can consider or use, including the existing one, is going to have four important components you have to make decisions over.

The first one, is how to define the market areas, the labor market areas we're going to use. The second is what source of data we're going to use as – to get wage compensation information. The third is how to deal with occupancy mix adjustments and the fourth is what time period the data are going to come – are going to cover.

Now, the existing hospital wage index and proposed MedPAC index differ in these four components. The CMS hospital wage index for market areas uses metropolitan physical areas and rural area residuals at the state level. There's no smoothing done between these –any contiguous areas or nearby areas, but there are a whole host of reclassifications and other exceptions that are put into place to try to deal with that.

The data that the CMS hospital wage index use come from the (ITPS)' hospital own report on compensation and hours, which have a distinct advantage of acting very accurately reflecting hospital costs, but have a number of disadvantages, which I'll discuss in a moment.

The occupational mix adjustment is done using another survey in the existing wage index and the time period that's covered is that these cost reports are used – the index is updated annually using cost reports from four years prior.

Now, there's three problems with the existing hospital wage index. The first is – has to do with the geographic boundaries. As I mentioned, MSA is the primary wage area for the index, and these are – they are designed to represent labor market areas and including reflections of existing community patterns.

But some boundary problems might – or proceed to exist in that. Near by hospitals can be in different MSA's and receive very different index values, and therefore, very different payments as a result.

To deal with this, about a third of hospitals have been reclassified and provide an exception to one sort or another. The second perceived problem is the year to year volatility index. The current index is perceived as being volatile and it could be the result of – in some areas have relatively few observations or hospitals in them, index uses hospital cost reports from – cost reports from hospitals themselves.

And second, entry of exit of hospitals can lead to volatility in this index. But importantly, this volatility may not be related to any underlying changes in the labor market conditions in those areas that should be, you know, reflected in the underlying costs.

The third perceived problem is what we call, refer to as indogeneity, and by that I mean, changes in the index values that are associated simply with the index itself. For example, there's some potential circularity in the index. Hospitals that choose to pay relatively high wages will therefore, tend to get higher index values, which in turn, may allow them to pay higher wages.

And second, issues like the occupational mix. Hospitals with relatively higher proportions of skilled staff are going to tend to receive higher index values.

So those are at least three perceived problems of the index. Now, the MedPAC index is designed to attempt to deal with those three issues and the four components of their wage index, as I mentioned earlier, they define wage market areas in a similar way using metropolitan physical areas, but they do county adjustments within the metropolitan physical areas as well and they smooth across – they propose to smooth across contiguous wage areas in a – as a way of replacing the existing reclassification and adjustments in the current index.

The way to compensation data they propose to use come from the BLS Occupational Employment statistics survey, which is a survey of establishments which is completed every three years. And there's some advantages and disadvantages to these data.

The advantages are if occupational detail are available, but the disadvantages are that the industry are only known in these data at the national level. So the data might be relatively imprecise for a particular hospital.

The nice thing about these data, is occupational – mix adjustment is not needed because the occupational data are available and the time period, the

data are essentially available on a three year rolling average, which should minimize volatility in the index.

Now the analysis – the second thing I wanted to talk about, the analysis that Acumen is going to do in conjunction with CMS response to Section 106 consists of eight components.

First, we're going to explore differences in the data sources used between the MedPAC proposal and the existing wage index. In particular, we're going to explore what the differences are between the BLS and CMS wage data.

For example, we're going to see whether area differences and industry mix, the number of hospitals, the number of part-time workers or self employed workers matter in terms of the index value that different hospitals might get – different area might get.

We're going to look at the impact of using fixed national occupational weights, as suggested in the MedPAC methodology, as compared to using the current occupational mix adjustment. And we also propose to explore differences between these methods by using the American Community Survey, along with other approaches to address these issues.

Second, we're going to provide a detailed impact analysis of alternative methods of incorporating benefit costs into the wage index. So the MedPAC is proposing two different wage indexes. One that doesn't adjust for benefits and one that adjusts for benefits using wage related costs from Worksheet A in the Medicare Cost Report.

So we're going to propose, exploring some alternative methods of incorporating benefits into this wage index, including using other CMS data and other BLS data.

Third, we're going to explore the extent of year to year volatility with this CMS wage data and whether change, just simple changes in the CMS wage data, just as using multiyear averages might in of itself reduce the volatility of having to change the index.

Fourth, we're going to explore potential methods for reducing differences in wage index values between and within continuous wage areas. In particular, we want to explore how the MedPAC's smoothing method that they propose, compares with alternative methods.

Fifth, we're going to provide an impact analysis and explore reasons for differential impacts across hospitals and across different wage areas. We're going to identify the impact on hospitals, move through the MedPAC index from the existing index.

In particular, we're going to identify the impact in hospitals which would no longer qualify for exceptions or other types of reclassifications. And we're also going to determine if they're identifiable reasons for these differential impacts across hospitals or wage areas.

Sixth, we're going to determine whether the MedPAC's compensation index or other potential alternatives could be applied to other fee for service respective payment systems. For example, whether they could – their method could be effectively applied to skilled nursing facilities that are home health agencies.

Seventh, we're going to explore alternative wage area definitions by – we're going to review past research and ongoing discussions and also what definitions of wage areas are currently in use by other agencies, such HUD, the Department of Labor and Census.

So eighth and finally, we're going to examine changes to and explore alternative methods to the MedPAC proposed method. We're going to explore whether one can control for inter-industry differentials in the wage seen by workers or in the occupations represented in the hospital industry.

We're going to explore whether one can allow for the occupational mix to be reflected in the wage index in a much flexible way than in the MedPAC method and finally, we're going to explore alternatives to the smoothing – to the alternative approaches to the smoothing method proposed by MedPAC to smooth differences in the wage values- wage index values across contiguous wage areas.

So those are the eight components of the analysis that Acumen is going to do in conjunction with CMS in response to Section 106, with the (TRACA).

Thank you.

Natalie Highsmith: Okay. Thank you (Tom). Okay. Now you can see on the agenda that we have come to the comment session. And first I'm going to move into topic group one and if you have comments on the use of BLS data or other data or methodology to calculate relative weights, issues relating to occupational mix, such as staffing practices, minimizing – I can't pronounce that – volatility of wage index adjustments while maintaining budget neutrality.

So (Hillary) if we could just open the lines up now for comments for people to comment on the – only right now for topic group one.

Operator: Again, if you have a comment, please press star one on your telephone keypad.

Our first comment is from (Steven Frame). Your line is open.

(Steven Frame): Yes, this is (Steve Frame) from the Connecticut Hospital Association. And I wanted to just briefly talk about volatility of the wage index and figuring out ways to minimize that volatility over time.

We took a look at our data for the last 12 years and in those – across those 12 years out of about eight of those years, we actually had wage indices that were going down and four of those years wage indices that went up.

Some of those years, the degree to what the wage index went down, wiped out more than half of the market basket and in four of the 12 years wiped out the whole market basket.

So one of our very large concerns is figuring out ways to minimize kind of the downward pressure on the wage index. Clearly we did not roll back wages in any of those years. It's just simply that we're a state where the wage index started very high and because we're not raising our wages at rate faster than the national average, we have kind of no place but to go, and that is down.

I think one of things that we've looked at over time, was trying to put in a floor to the degree to which a wage index could down limiting that to say one and a half percent. And I think one of the values of doing something like that, would be that it would minimize the downward pressure on wage indices and I think, when we've done the analysis effective cost to do that, is fairly low on the overall payments. I think nationally, it's about \$200 million.

Thank you.

Natalie Highsmith: Okay. Next comment please.

Operator: Our next comment is from (Don May). Your line is open.

(Don May): Thank you. I'm with the American Hospital Association. I'm Vice President for Policy and I want to thank CMS for hosting this call today. The wage index is a very important part of our payment system and we believe there are some fundamental problems with it. So we appreciate CMS taking the time to thoroughly evaluate it with Acumen.

Specifically on the use of BLS data and some other non-hospital data sets. We are very concerned about the use of BLS data in use in calculating a hospital wage index and there are several key reasons. I think first and foremost, this data wasn't collected for this purpose and there are lots of reasons why – the purpose is – what it was collected for, is –it's working fine for, but it's not going to be good for a hospital index.

It's not only – it's not just hospital data and we think that the hospital wage index should be a measure of hospital wages. We have no ability to verify or audit the data to make sure it's correct. There is – it excludes hospital benefits.

And so, that is a very key component of wage costs is related to benefits. The time period is different, rather than a full year, it's only a pay period and it – we also have a problem with full time versus part time employees, because they are equally weighted in the BLS data.

So there is a lot of issues with using that data and we believe that continuing to use hospital reported data is going to be the best approach moving forward.

We're also concerned about minimizing volatility of wage index adjustments from year to year. And I think one of the key problems we have, is the basic under funding in the Medicare payment system for in-patient services. And because of that, what you have is a scenario that (Steve Frame) eloquently talked about where even hospitals that can raise their wages above the national average for all employers, because hospital wages are going up faster, they could still have a drop in their area wage index.

And that kind of scenario means that we will continue to have an under funded system. And we believe that alternatives to finding ways of putting additional funding into accommodate for these wage increases need to be addressed.

Thank you.

Natalie Highsmith: Okay. Next comment please.

Operator: Our next comment is from (Dale) –sorry, (Dale Baker). Your line is open sir.

(Dale Baker): Thank you and thank you CMS for offering us this alternative. Following up with what (Steve) and (Don) just said. I think one of the major problems with today's system, is the cataclysmic negative adjustments that occur with individual hospitals. And this creates a lot of the pressure to change the system. And as (Steve) said, putting in a stop loss floor would be a good first step to reducing that.

There's another easy way of – that I think would be extremely uncontroversial to reduce volatility very quickly and very easily and it would be just to use two years hospital data, use a rolling average of two years hospital data in computing the annual wage index.

We currently use one year's data. And obviously, by definition, if you use two year's data, you'll cut the volatility in half. And I think there's a great possible argument for the combination of a stop loss floor, such as (Steve) suggested with reducing the volatility which could be done very quickly.

It would not change total payments over a two year period to hospitals, it would just soften the increase or decrease in one year and I think it would be something that would quickly address these cataclysmic adjustments that create so much havoc within the system.

Thank you.

Operator: Our next comment is from (Steve Steele). Your line is open sir.

(Steve Steele): Thank you very much and thanks CMS for having this open door call and for its efforts over the years to try and work out some of the problems with the system.

Everyone is agreed that there are problems with the system, but I think we need to guard against a situation which we have a cure that's worse then the disease. Along those lines, you know, we would echo the comments of (Don May), with respect to the problems in using BLS data.

Our chief concern would be the lack of transparency in that data. We really don't know who submitted the data, nor is there an opportunity to review it and make corrections which is one of the hallmarks of the current system. Using cost report data it's a trusted source. Hospitals have a lot of experience with it, as do the contractors.

There's an opportunity to correct mistakes and make sure that the data that's out there is representative and the best available data that there is.

So we would urge great caution in moving to a system that is not using hospital derived data.

With respect to volatility, the stop loss idea has a lot of merit to deal with the situation in Connecticut and other states. At the same time, it would not limit the ability of the wage index value to properly reflect an increase in the wages. There are situations in which that happens. The New Orleans situation is one. And there are high growth areas, high population growth areas that may result in a wage index value rising at a fast rate and we wouldn't want to punish the hospitals net area that have to provide wages that reflect the market realities.

So along those lines, we would urge caution against a two or three year rolling average to the extent it would have negative consequences for certain other areas.

So, I'll just stop there. And again, thank you for having this session.

Operator: Our next comment is from (Jeff Reed). Your line is open sir.

(Jeff Reed): I wanted to find out if Acumen would be considering state requirements for staffing at – for example, California hospitals had a staffing ratio that's required for hospitals. And so I think that should be considered either as part of the occupational mix requirements.

We have a specific RN ratio to patient ratio that we must maintain and it may impact quality of care, so there may need to be a comparison of quality of care versus staffing to before an adjustment should be made.

Just a consideration among the eight other items.

Operator: Our next comment is from (Thomas Hindro). Your line is open sir.

(Tom Hindro): Yes, good afternoon and I too would like to thank CMS for conducting this call today.

My comment, I just wanted to dovetail on some of the previous comments on the volatility of the wage index. And my comment is simply it's not to me just only volatility between years, but it can also happen between the proposed and final rule. Lots of times when the proposed rules come out and they indicate the wage indices for various services, we know that hospitals are using that data to forecast their Medicare payments, put their budgets together.

And when there are big differences between the proposed rule and the final rule, it causes all of the financial managers and hospitals to go back, retrench, and redo their data. And what I'm suggesting is that maybe to look at ways to eliminate some of the gaps that sometimes occur between the proposed and the final rule figures.

Thank you.

Operator: At this time, that was our last comment in queue.

Natalie Highsmith: Okay. Well now we can go ahead and move to topic group number two, which is problems with the definition of labor markets for purposes of wage

index adjustment, minimizing variations in wage index adjustments between and within MSA's and state wide rural areas, the modification or elimination of geographic reclassifications and adjustments.

So we are taking comments only for topic group number two please.

Operator: At this time, we have no comments in queue. Oh, I'm sorry. I spoke too soon. We do have one from (John Rig). Your line is open sir.

(John Rig): Hi, just wanted to make a quick comment about this. In the state of California and we're not unique. There are other western states that have this sort of similar arrangement whereby counties that tend to be very geographically large then incorporate extremely urban and extremely rural areas.

For example, using (Ruca) scores we have one county in northern California that has a (Ruca) score of one, which is very low, a very urban area and in the same part of –in the same county which is over 80 miles distant, a (Ruca) score of ten. And by the way, it's over a major mountain pass, so it's very difficult and inaccessible through much of the year, and yet the hospital therein is contained – is considered a metropolitan hospital.

They're a lot of variety of distortions both to wage index and to other programs, VERSA funding for example, that rely upon the presence or absence of a metropolitan designation.

So I would strongly encourage CMS to consider other measures of wage areas, rather than just the county, if because of the distortions that it creates in places like Californian's very large counties and then in other states where they tend to be very small counties.

Thank you.

Operator: I did have a couple more comments pop into the queue. Our first one is from (Steven Steel). Your line open again sir.

(Steven Steel): Thank you very much. Following up on the last comment, I think that illustrates the theme I wanted to address here, which is that there is no perfect labor market definition. Regardless of where you are, there's going to be some local situation that is likely not to be addressed in the new definition.

So I don't think we should lose sight of that and let the perfect be the enemy of the good here. To the extent that in our view, there is no perfect labor market definition, it really points the need for reclassification authority. You should never eliminate that need. There's always going to be a situation in which a hospital has a legitimate claim to a wage index value that better reflects its wages and would do a better job of insuring that the hospital is in a position to compete fairly against other neighboring institutions.

So I guess the bottom line here is, to preserve reclassification authority and see it as a good, rather than an evil.

Thanks very much.

Operator: Our next comment is from (Jerome Rivet). Your line is open sir.

(Jerome Rivet): The opportunity to comment on this and kind of reiterate what the previous caller was touching on. You know, under the current situation, when there are a small number of hospitals in the same CVSA one hospital is allowed to reclass out. The rules do not always allow equality when even these hospitals may be located right next door.

So I think, you know, going forward, you know, I think we should also keep track of the small competitive environment that exists between facilities and their locations.

Operator: Our next comment is from (Greg Ping). Your line is open sir.

(Greg Ping): Hi, can you hear me?

My comment. I'm a home health and hospice provider in Southwest Washington in a somewhat rural area. Our issue is that, now many people might not know this, but we take the same wage index that hospitals have to take. They don't have a separate wage index for home health. Whatever your area hospital takes, you have to take.

And the issue that we have in Southwest Washington is that some of these geographical areas that we serve are rural and we are right next to a metropolitan area, which is Vancouver and Portland.

And the issue is that in Vancouver and Portland the wage index there has been anywhere between six to 12 points higher than in our area and the hospital in town, we have one hospital in town, can reclassify itself into Vancouver and Portland, but other providers like home health hospice physicians or any other providers are not allowed to reclassify.

So it creates an uneven playing field for us. If you compound the difference over the course of many years, you know, the hospital can afford to pay much higher wages and benefits to staff which creates access problems for home based and community based care.

Now the hospital does rely on us, of course, for being able to discharge patients, but you know, since we have trouble retaining staff in favor of the hospital being able to reclassify into higher wages, it creates a real problem.

And so, two issues. One is, the cliffs that occur between geographies that are right next to each other because when we need to attract staff, we've got to go into Vancouver and Portland to go get them, so there's no reason why our wage index should be lower and so substantially lower.

The second thing, is the ability for all agencies to reclassify in a geographical area, not just hospitals.

Thank you.

Operator: Our next comment is from (James Cooper). Your line is open sir.

(James Cooper): Thank you. I'd like to just thank CMS for holding this forum. I just wanted to comment briefly on the reclassification and I think that in a rural state like ours, we're in North Dakota, 200 mile difference is not that great around here, despite the gas prices, people here think nothing of driving that far, because there's not much in between.

And I just think that reclassification to the – would hate to see that go away, because I think it does provide an opportunity to look at this situation especially in sparsely populated rural areas. I think that's a special case and I would urge that we not do away with that.

Thank you.

Operator: Our next comment is from (Don May). Your line is open sir.

(Don May): Thank you. I guess first I'd like to agree with (Steve Steel)'s comments and some of the other callers around reclassification. Regardless of what type of reforms or new wage index system we have, there are always going to be exceptions to the rule. Wage areas are not going to be defined exactly the way the market plays out. And we're going to need some type of exception process.

I think that said, there are concerns with how you draw the lines and how you define labor markets. And if you look at MedPAC recommendation around smoothing, that's something that could offer some opportunity to help minimize those cliffs, but would like to urge some caution there, because depending on how you do it, you can smooth out all the variations, which in essence means you don't have a wage index measuring local markets. And we'd want to be careful that that does not happen in the process of doing a smoothing adjustment.

I think the other part around reclassification and in particular related to the proposed rule, CMS has two provisions in the rule in particular that we have real concerns with. First, the provision that would adjust how reclassifications are determined and whether a hospital qualifies to reclassify. In essence, I think CMS suggested around 15% of hospitals could possibly lose their ability to reclass based on the new data that they're using to calculate the thresholds for reclassification.

And the second big provision was related to how CMS applies budget neutrality for those hospitals that are put at the rural floor of the state wide rural average. And we have major concerns with that provision as well.

Budget neutrality is something makes sense and those types of adjustments make sense when they are coming out of all hospitals, out of the entire

country, but when you do that at such a small level, for example in Vermont, where I believe there are only a handful, seven, eight PPS hospitals, that type of an adjustment makes no sense in a small state with small numbers.

Budget neutrality doesn't – should not be done with those types of small numbers and we are really opposed to both of these provisions. Short of major change and really addressing the fundamental problems, we don't see a need to tweak the system right now making it harder for hospitals to reclassify when the fundamental problem of their wage index hasn't been addressed.

Thank you.

Operator: Our next comment is from (Michael Loftis). Your line is open sir.

(Michael Loftis): Yes, this is (Mike Loftis) with (Yilda Haven Health). And I want to echo some of what the speaker from AHA was pointing out, but there's a couple good points that have been brought forward on classification as well as issues that are going on with neutrality.

And you know, Connecticut similar to Vermont, similar to some of the other states that we're looking at. We're right next to New York City. We compete with New York City for employees regularly. I think that ability to reclass is really going to alter the job market and how services are provided potentially.

In the state of Connecticut and some of the hospitals specifically, they're literally a few miles from the border of New York State and greater New York metropolitan area. And to be able to rather than put in a state neutrality adjustment on that, is going to have, and I'm sure, CHA would agree, a catastrophic effect on what's going on with funding to the state of Connecticut

and it's going to really alter almost all elements of the calculation that's coming in from net revenue.

So I think similarly we should stay with what we have, understand it without looking to do these wide range tweaks and I think these are two examples of what would really impact the volatility of the wage index. And if we're concerned with that, we should be looking at it and at least smoothing it out, phasing it in, or finding alternatives that don't have these sorts of very dynamic swings.

But also, ultimately don't save anything to the Medicare system.

Thank you.

Natalie Highsmith: Next please.

Operator: I'm sorry. Your next comment is from (Michael Gerard). Your line is open sir.

(Michael Gerard): Again thank you. I do want to echo the comment made earlier regarding the reliability of the hospital cost report. I do think that is what is most important and most accurately and currently reflects wage data, you know, going on in whatever particular area.

I know this may be a separate issue, but I also want to comment on – earlier staffing was discussed and I run a hospice, Circle of Life Hospice in Reno, Nevada. With the proposal to eliminate the wage index for hospice, that's going to be something that really hurts those people who have really invested in putting, you know, the optimum hours at the bed side.

I think the reaction of CMS to the growth in Hospice and to the potential excessive profit margins have basically been achieved by, you know, decreasing staff per patient or asking staff to take twice as many patients.

And so the elimination of the wage index is really going to greatly hurt those who have held true the philosophy and put hours at the bed side. You know, again, I know this may be tangential to this discussion, but I wanted the opportunity to make that statement as well.

Thank you.

Operator: Our next comment is from (Mike Hack). Your line is open sir.

(Mike Hack): Hello yes. Thank you for this opportunity to speak today. I just wanted to remind everyone on the conference call in CMS to be sure and pay some attention to the current calculations of wage index in terms of contracted services and how that is used in the industry of health care, compared to other industries.

I'm not sure how the Bureau of Labor Statistics includes such labor as these expensive medical services, but certainly they have a great impact on the health care industry and I'd also like to also put in a plug for the benefits portion being considered and looked at and scrutinized in comparison to other industries.

Thank you.

Operator: Your next comment is from (Dale Baker). Your line is open sir.

Natalie Highsmith: Hi Mr. (Baker).

Okay, let's go to the next comment please.

Operator: The next one is from (Mike Shindock). Your line is open sir.

(Mike Shindock): Yes and thank you for this opportunity to comment on the proposed changes. I represent an organization from northeastern Pennsylvania that has all post acute care providers. We have two rehab hospitals, two skilled nursing centers, and home health, and all of them while they're based on the acute care cost report information for a wage index for our area, we do not have three major issues that help low wage index areas. We don't have that available to us.

And this was mentioned by a previous caller. The geographic reclassifications for acute hospitals, the rural floor, and I just found this out recently, there's a 62% labor share cap for areas that are under a 1.0 wage index area. And I think any proposed changes need to be consistent across all type of providers, because using CMS' own words in previous reasons for using the acute hospital information, is that there's not really much of a difference in correlation and we all compete in the same labor market.

But, these three major issues that help the acute hospitals in low wage index areas aren't available to the other providers. And I think that's a really required change in any proposed changes or recommendations.

Thank you.

Operator: Our next comment is from (Steven Frame). Your line is open sir.

(Steven Frame): Hi, this is (Steve Frame) from the Connecticut Hospital Association. And I wanted to just lend from Connecticut our support to the comments made

earlier on the topic of (Don May) of AHA. I think we too would see that any new system should maintain the ability to reclass and have re-designations, simply because it's hard to imagine that we could craft a formula that would, in fact, take into account all of the unique circumstances that hospitals and other providers experience in their local communities.

Also, we'd like to lend support for the notion that budget neutrality adjustments need to be done on the national level and not turned inward to the states. In particular, we're very opposed to what's in the current proposed rule regarding the rule of floor and making that a budget neutral for the state.

For Connecticut, if that goes through, all of our hospitals in the state will experience a year over year loss which would be the fourth time that would have happened in the last ten years. I don't know how we're expected to operate and continue to deliver quality services to the Medicare population with less than zero as a rate of increase.

Thank you.

Operator: Our next comment is from (Dale Baker). Your line is open again sir.

(Dale Baker): This time I got it right. I'd like to just mention one subset of rural hospitals and that's rural referral centers. These are sophisticated hospitals, urban like hospitals, that are in the middle of rural America and most of them provide a very high level of sophisticated services compared to other rural hospitals. And virtually all of them are presently reclassified in using a nearby urban area as wage index.

And some of the wage index proposals that are out there could devastate the ability of these hospitals to provide the sophisticated level of services needed in rural America.

Also, for other rural hospitals, a total of 39% of all rural hospitals are reclassified. So this is a very big, big issue in terms of geographic reclassification for rural America. And I'll stop with that.

Operator: Our next comment is from (James Moyland). Your line is open sir.

(James Moyland): Yes, thank you. I want to support (Steve Frame)'s position on the not having the budget neutrality be a state by state basis. I have a significant impact on the hospitals in Connecticut. I'm the CFO of a hospital in New Haven County and an impact to us would be somewhere in excess of a half of million dollars.

And we just also did a bond issue and many of you know, other hospitals needing access to capital in negotiating covenants, these kinds of changes on our reimbursement are rather dramatic and very difficult to offset.

Thank you.

Operator: Our next comment is from (Robert Bowman). Your line is open sir.

(Brad Bowman): This is (Brad Bowman) with Price Waterhouse Cooper. I'm calling to comment on the proposed statewide neutrality factor you use for the rural floor. My concern, and I'm not quite sure how it's being reconciled back, that the implementation of the floor on area wage index specifically calls for the adjustment that takes place to apply for all hospitals not described in the subsection above, which is those hospitals that are receiving the rural floor payment.

By going to a statewide methodology, those states that do not have hospitals paid at the rural floor are not included in this. And secondly, the methodology that's currently being proposed, appears to be applying this against the hospitals that are described in the previous subsection, those are receiving the rural floor payment.

Again, this is one of those complex issues that the Secretary's going to have to address on behalf of the industry for us.

Operator: Our next comment is from (Mike Hack). Your line is open sir.

(Mike Hack): I figured I'd come in one more time. But I wanted to be sure and mention that whether we go with CMS current version or with the BLS proposed version, it would behoove CMS to come up with very detailed explanations or definitions to what adjustments are made or what goes into the data to avoid a lot of confusion and a lot of spotted issues and adjustments and concerns down the road.

With current data, as I talked before, with contracted services and benefits as such, it has become over the years very convoluted and there's still a lot of you know, potential abuse or concern about how we are reporting you know, the same consistently in our cost reports and I don't want this to occur – use the Bureau of Labor statistics either.

Thank you.

Operator: Our next comment is from (Steve Godfrey). Your line is open sir.

(Steve Godfrey): Hello. I'm calling from the Hospital of Central Connecticut. We're a midsize teaching hospital up in New Britain, Connecticut. I wanted to join in with the

comments that (Steve Frame) and the other folks from Connecticut made, particularly about the wage index, the statewide budget neutrality piece of it.

We're in the early stage of our budget for '09, but I'm sure our costs will rise this year, as they have every year. We're estimating that the aggregate impact of the proposed rule will result in a net year over year decrease for us of \$1.4 million, which is about 1.8% decrease for us, and the biggest part of that is the statewide budget neutrality adjustment.

So, we're not sure we can sustain that kind of decrease for us. We're in a state that isn't growing very much at all. Our ability to make up that increase by cost shifting is pretty much over at this point and so in the interest of our communities that we'd like to see a net increase for next year.

Thank you very much.

Operator: Our next comment is from (Robert Trifry). Your line is open sir.

(Robert Trifry): Hi, my name is (Bob Trifry) with the Bridgeport Hospital in Bridgeport, Connecticut.

And I appreciate the opportunity to be able to comment on the proposed rule today. It has a tremendous effect on the hospitals in the state of Connecticut and our hospital in particular. Bridgeport Hospital is in Fairfield County and we have met all the requirements for reclassification to the New York Metro Wage Index.

As a result of the requirement for budget neutrality by each state on the rural floor, we would end up with a wage index that it would in fact, be lower than

the New York metro area and also lower than the permanent wage index for the county that we are residing in.

That translates into about a decrease for us of about \$2.3 million per year or said another way, about 38 registered nurse's salaries. The bottom line, is we're experiencing as the Hospital of Central Connecticut had just said before me, as opposed to our Medicare payments going up by the 2.9% of index that was proposed, we would actually see an absolute decrease in reimbursement between fiscal year '08 and '09 of \$2.1 million.

Our bottom line last year was only \$2.5 million and we know that our expense are going up next year. Your hospitals in states with rural floor adjustments we feel should not be forced to bear the entire burden. It should be adjusted nationally, as the other types of adjustments that are done with the wage indexes are done and not put the burden on each state to cover that, and therefore, really devastate hospitals that are in other parts of the state.

Operator: Our next comment is from (Tom Que). Your line is open sir.

(Tom Que): This is (Tom Que) from Allied Services. And if reclassification is going to be allowed under the new system, we would ask that Medicare consider reclassifying all entities that use a wage index in their computation of payment be reclassified with the acute cares.

We are in MSA, where all non-acute hospitals have been transferred to other MSA's and we're left with a variety of facilities that with the wage index and that MSA and no relief. And so we've ask that be corrected in the new system.

Thank you.

Operator: At this time, we have no further comments in queue.

Natalie Highsmith: Okay, now we will move into topic group number three, which is effect an implementation of proposal would have on health care providers and on each region of the country, methods for implementing proposal including methods to phase in such implementation, evidence of the effect on quality and patient safety and any recommendations for alternative calculations and feasibility for applying all components of proposal to other settings, meaning home health agencies, skilled nursing facilities.

We're taking comments on topic group three.

Operator: Our first comment is from (Steve Steel). Your line is open sir.

Natalie Highsmith: Hi (Steve).

(Steve Steel): Oh, I'm sorry. I was speaking to myself on mute. This is (Steve Steel) from the Federation of American Hospitals. Thanks again for the opportunity to speak.

If this change were to go forward or any proposed change were to be finalized, the MedPAC proposal being one example, there would likely be a massive redistribution of dollars, probably on the scale of the MS DRG's which transferred some 2% or at least it's estimated to have transferred some 2% out of rural hospitals into other areas.

So we obviously would need to have an extended transition to help mitigate the immediate consequences of that loss of funds for any hospital, because the redistributions would be not just on a by category or class of hospital or by

region, but there would be wide variation on individual hospitals within those classes or regions.

So, we would obviously want to give hospitals an extended opportunity to adjust to that change and financial circumstance.

And one way to conduct that transition would be to blend the wage index values using the existing method with whatever new method would be finalized going forward. So we'd want to preserve as much as possible existing financial flows and that would obviously have an affect on a hospital's continuing ability to invest in patient safety and quality improvements to insure the highest quality of care possible for patients.

Thanks very much.

Operator: At this time we have not further comments in queue.

Natalie Highsmith: Okay. (Hill) if you could just remind everyone on how to get into the queue, so we can make sure that we have covered most of who wanted to comment on topic group three please.

Operator: Again, that is star one on your telephone keypad if you would like to ask a question and we did have one pop in from (Bill Donby). Your line is open sir.

(Bill Donby): Thank you. Thank you CMS for this opportunity. I'm with the National Association for Home Care and Hospice. We've set two principals that we want in wage index reform. One of them is parity and the other is stability. Currently as other speakers have mentioned, there is no parity for post acute providers using the pre-floor pre-reclassified hospital wage index. And all speakers on behalf of hospitals seem to be in common voice saying that the

refinements and adjustments that are necessary through such things as rural floors and reclassifications are essential for making a wage index work.

But home care, as an example, does not have those kinds of benefits and so in a labor driven sector of health care, home health services, is competing with hospitals for the same labor pool, but competing on an un-level playing field in terms of the revenue coming from the Medicare program so we would urge CMS in any consideration of non-hospital health care provider wage index action that parity be a hallmark for their operation as well.

And in terms of stability, you know, home health would echo the remarks made by others previously, which is that the year to year changes sometimes are just not manageable. It's one of the few business sectors where you have to manage based on someone else's pricing, but it's very hard to do so when you don't know from one year to the next whether you're going to have a 5% increase or a 7% decrease, just based on the wage index alone.

So, when looking at switching to any new type of wage index, we would urge support for some transition protection but also even in the non-transition setting to urge some protection from the kinds of hills and valleys or mountains and gorges that we seem to face with wage index changes from one year to the next.

And we would encourage CMS certainly to give serious consideration to a new wage index approach for home health services, because the problems are making the business of home health care not sustainable with the wage index as it is now. So thank you for this opportunity.

Operator: Our next comment is from (Heather Holsher). You line is open ma'am.

(Heather Holsher): Yeah, thanks for this opportunity to comment. The only caution I might have is should congress adopt a value based purchasing plan going forward and then any other revisions to the wage index, that's a lot of moving targets and a lot of moving dollars all at one time.

So it just asks for some just of an acknowledgement of those potential big moving vehicles.

Operator: And that this time, that was our last comment in queue.

Natalie Highsmith: Okay, well I guess since we have a few more minutes left, we can get ahead and take comments on any of the topic groups, one, two or three from our participants. You can just remind everyone on how to get into the queue to ask a comment please?

Operator: Again, that is star one on your telephone keypad.

We do have a comment from (Ken Webdale). Your line is open sir.

(Ken Webdale): Yeah, that's (Ken Webdale) and what I wanted to comment on is the integrity and the consistency and the volatility of the data and that's really in the topic one, but in the September 1, 1994 Federal Register had an extensive write up by (Hickler) at the time regarding solving the problem of inconsistency of the data and what they proposed is the utilization of GAAP for that.

So for a number of years GAAP was used and there was somewhat less volatility. Lately, CMS had modified the GAAP to be GAAP adjusted by Medicare cost principals and there ought to be just one standard that's being used.

This date when the hospitals submit their data, they're submitting their data. There ought to be consistency in the way that's submitted and if a hospital can't afford to fund its pension plan that year, it's pulled out so that particular CBSA suffers because of it.

So that's not a consistent standard. So whatever is being accumulated here we would you know, seek to have something that's more consistent and I would think the GAAP is that and there's an extensive write up of the September 1, 1994 Federal Register that describes that process.

Thank you.

Operator: Our next comment is from (Jennifer Jeffco). Your line is open ma'am.

(Jennifer Jeffco): Yes, hi I'd like to also reinforce the consideration of the rule for and the change in the wage index and the reclassification process currently. Right now, based on the proposed rules, it would end up impacting (Chamberhouse Billing Connecticut) about \$2.5 million as a negative impact to us, which is very substantial to us.

Again, I would also reiterate the ability to absorb that kind of dollar impact into cost savings would be a serious concern for the organization.

Also, I'd like to stress concerns regarding the use of the BLS data and the ability to audit and monitor that information to make sure that it is accurate. The availability of just reviewing that is really critical for all hospitals I would think to make sure that it's filed as best as possible.

Thank you.

Operator: Our next comment is from (Jerome Rivet). Your line is open sir.

(Jerome Rivet): One last comment I had regarding the wage – the reclass process. If that's something that's going to be continued, you know, the review, I'd suggest that something be put in place for if an error is made and then accepted in the wage reclass data and then how that effects other hospitals within that CVSA, that some sort of vehicle is put in place to address that type of situation.

Because, you know, under the current situation, you know, current rules, it does not facilitate that. So, just another comment. Thank you.

Operator: Your next comment is from (Mike Hack). Your line is open sir.

(Mike Hack): Thank again for your tolerance in my questions and comments. I would just like to say I agree with the previous commenters, that if there are large variances or swings in this, then the hospital industry will have, you know, the significant impact on their financial viability, I would like to go on record saying that a phase in will probably be necessary, based on the Acumen studies and so it could kind of smooth out the impact in any one year.

I'd also like to mention that having the right amount of data for the Bureau of Labor Statistics, you know, for over the right period of time, is essential too, rather than maybe just one pay period, so we want to make sure that that's comparable.

And also in regards to the phase in, if there was also a way as we have in the current system, a way to make adjustments over – after the fact, such as we do in the current system, with audits and the like or maybe an appeal approach that we could use when things are drastically incorrect, so that we could fix

some of those things to not put anybody in a dire financial situation, that should be something considered too.

Thank you.

Operator: Our next comment is from (Don May). Your line is open sir.

(Don May): Great. Thank you. And once again I just wanted to say thanks to CMS for hosting this call. This is a critically important issue for hospitals and we appreciate the attention and the effort that CMS is putting into looking at real wage index change.

I would like to reiterate some of the last comments we've heard about a transition, because any type of re-distribution is going to have a significant impact on those- on hospitals that start to see a reduction.

And I guess I would just offer that you've heard a lot today about some Connecticut hospitals about the impact – being about a 1% impact, but and that that's a significant number. I think there are those out there who would suggest that an impact from one to one – negative one to one percent really isn't an impact at all. But what you've heard today is that a one percent reduction is a big impact to them.

And so as you're doing your analyses and looking at impact studies, realize that even those small changes can mean the entire margins of the hospital at the end of the year. And what that does is it makes it difficult for hospitals to pursue new quality efforts and it jeopardizes our ability to be there when our community needs us and access is there.

So we'd just like to leave with those comments. And again, thank you for hosting the call today.

(Mark Harstein): This is (Mark Hartstein). I'm – as we're listening to a lot of the comments. I've heard a lot of comments about how we apply rural score budget neutrality from some of the national hospital associations from some of the state hospital associations and state hospitals themselves.

But I haven't heard any comments about the rural score provision itself. So if anybody has any comments on that rural score provision itself, that would certainly be something we'd be interested in hearing from you on, whether through the comment process or on this call.

Natalie Highsmith: Okay, we'll take our next comment from the phone.

Operator: Our next one is from (Dale Baker). Your line is open sir.

Natalie Highsmith: Mr. (Baker)?

(Dale Baker): Whoops. All right. Now, I was talking to myself as (Steve Steel) mentioned earlier.

As Acumen and the CMS continue to study this, I have a question, is what are your real objectives of this study and are there incremental changes within the existing system that could be used to achieve most of, all of, or a very substantial number of the objectives that would not involve scrapping the system and replacing it with a new system? We're not starting from ground zero, we're starting from existing system and I hope that Acumen and CMS will consider those alternatives, rather than what MedPAC just looked at replacement of the system, not any incremental change.

Thank you.

Operator: Our next comment is from (Michael Matovich). Your line is open sir.

(Michael Matovich): Very good. It is (Mike Matovich). We'd like to add to the comments of a number of the other commenters with regard to the ceilings and floors. We think that would be a much better change than switching to the BLS. I mean right now, we've –we're investing the situation with 4,000 hospitals that it's all audited data and it's been data that's been prepared for a number of years now and reviewed by consultants and auditors.

We wouldn't have that kind of situation with BLS and if we move that way, we'd probably have more cases before the (PRRB) than we have now. I do agree with earlier commenters that some (Health and Smiths) probably ought to get the same rates as reclassified hospitals, since they're part of the continuum of care now with the (Prescue) Transfer Policy and other issues like that.

So, I agree with a number of the other commenters, that we ought to fine tune the system that we have that's working and adjust the issues rather than switch to a whole new data source like the BLS.

Thank you.

Operator: At this time, that was our last comment in queue.

Natalie Highsmith: Okay (Hill) if you could just remind everyone how to get into the queue again before we end the call please?

Operator: Again, that is star one on your telephone keypad.

And we did have a couple more pop in. (Steven Frame) your line is open again sir.

(Steven Frame): Thank you. This is (Steve Frame) from Connecticut. And I just wanted to follow-up on a question I think that was being posed by (Mark) moments ago to hear from us about what do we think about the rural floor itself as an adjustment and whether it's – I'm assuming the part of the nature of the question is – is it an adjustment that should be maintained into the future?

I think our view would it should be into the future, principally because in Connecticut, although I can't speak for how it operates in other states, it is one of the important adjustments that helps maintain some assemblance of consistency throughout the state with the various wage indices.

Without the rural floor, we would have some extraordinarily large cliffs within the state and that would create some fairly significant problems. So from our prospective, having that adjustment becomes vitally important in order to be able to maintain our current ability to pay staff what's currently being paid.

Thank you.

Operator: Our next comment is from (Don May). Your line is open again sir.

(Don May): Thank you. And (Mark) to answer your question around the rural floor, I believe we're in the same place as (Steve Frame) in Connecticut. We would be very supportive and would urge you to continue to look at the rural floor as a policy that makes sure that urban hospitals that are below that will not drop below that rural statewide average.

One of the things that we do know, is that there are oftentimes inconsistencies or idiosyncrasies in the data and setting a rural floor helps to minimize the impact of those types of idiosyncrasies that may or may not be explainable and it insures that those hospitals – those urban areas who are in the – who are at the rural floor oftentimes are more isolated urban areas and we think it would be important to make sure that those hospitals continue to have the floor- the rural area be the floor on the wage index.

Thanks.

Operator: Your next comment is from (John Rig). Your line is open sir.

(John Rig): Thank you and I just wanted to reemphasize what (Don) and my colleague from Connecticut just said about the rural floor. In California we're one of the states where there's fairly substantial use of the floor and it's largely sort of an artifact of one of the data anomalies that (Don May) mentioned a moment ago.

As I mentioned in my comments earlier, we have several metropolitan areas that wind up in very large counties in which we have extremely urban areas and extremely rural areas. We have areas with ten for example exist and Los Angeles County.

Rural areas of ten exist in San Bernardino County and yet those are considered metropolitan areas. And so, the rural floor exists to support those hospitals in the – within the cities in those counties to make sure that they are adequately reimbursed for the cost of labor that is more reflective of their metropolitan area then it would be if you just simply took the county wide average.

The other thing that I wanted to add was with respect to the cuts themselves, or what we review as the cuts themselves. I think it's important to keep in mind that while – as again my colleague from Connecticut mentioned a moment ago, or perhaps it was (Don) mentioned a moment ago a one percent cut may not seem like a lot, it really can amount to a lot and it can also be extreme- it can affect hospitals very differentially.

Don't forget that the one percent essentially attaches to the number of discharges you have through Medicare. And so the more Medicare dependent the hospital, which incidentally tend to the more economically vulnerable, the greater the odds of a larger impact.

And we've noticed that small our most vulnerable institutions in the state of California are those that tend to treat a lot of Medicare patients and those which are hit the hardest by the proposed in state budget neutrality adjustments.

So thank you again for taking the time to listen to us today.

Operator: Our next comment is from (Steve Steel). Your line is open again sir.

(Steve Steel): Thanks and responding to (Mark)'s question on the rural floor. Conceptually Federation is not troubled by a rural floor. Having said that, we do support CMS' effort to make sure that it is applied fairly and appropriately and to make sure that there is not – there are not efforts to exploit the floor in a way would disadvantage hospitals nationally, while advantaging just a select few.

But the floor itself is a good device. It works well. That said, in California, but we urge a more targeted approach to making sure that it is used in the way that it was originally intended.

Thank you.

Operator: Our next comment is from (Brad Bowman). Your line is open sir.

(Brad Bowman): Hello. Again this is (Brad Bowman) with Price Waterhouse Cooper. One concern I have is with regards to the BLS data. The BLS survey instrument is a voluntary instrument and while the missing data is imputed by BLS and placed within the systems so they can maintain a cross representation, that is a significant concern that the data is voluntary.

You will have providers and other organizations for various reasons choose not to submit that data. And in that black box of BLS calculation they're imputing some data, which in turn, will flow down through the providers in a BLS driven wage index is concerning.

The second component is that the BLS survey instruments are not done on an annualized basis in every community. So you'll have some communities whose BLS survey data will be several years old, and while they do provide for updates of those figures on a community by community basis, those updates there can be questions or concerns raised with regards to the way those updates are calculated and carried forward.

Again, thank you for your time and listening to our concerns related to the BLS survey instrument.

Operator: And at this time, that was our last comment in queue.

Natalie Highsmith: Okay, (Mark Hartstein) has some comments.

(Mark Hartstein): So, I want to thank everybody who decided to participate today and contribute comments and concerns and questions to us. I'm sure that we will be able to go through all of these comments and I know I heard some very interesting ideas for potential changes that we can make to improve the wage index in labor market areas and so forth.

So really very much appreciate all of the input that we got from people. I not only said at the beginning of this call, if you want us to consider your comments as part of the public comment process on the IPPS proposed rule, you need to submit those comments as formal comments on the IPPS proposed rule through the formal comment process.

The instructions are in the IPPS proposed rule. Very precise instructions, so make sure that they get into the rule making record, so I urge you to do that.

I just some reaction that I had to some of the comments and concerns that I heard. I think some of these ideas are things that we've heard before and we've considered. Some of the ideas that you suggested are things that we may have already incorporated. Some of them would require changes in law and are not things that we could without further acts of congress.

And some of those are just simply ideas that have not come to us before of potentially of things that we could consider under our current rule making authority and very much appreciate those suggestions.

And so we will certainly reflect on all of them that we've heard today and look forward to considering them carefully and making further changes that improve the wage index. We certainly don't want to make any changes that will not improve the wage index, so we will certainly do our best to pursue

IPPS reform of the wage index and labor market areas very carefully considering everything that was said today.

And proceed to consider those ideas that we think have merit and we can adopt under our current authority and those that we can't, it will be up the congress to decide, whether or not, they want us to make those kinds of changes.

So again, appreciate all of the input and ideas we got from all of you today.

Natalie Highsmith: Okay. Please remember to submit your – any other comments that you might have to the email address cms_wage_index_odf@cms.hhs.gov and (Hillary) can you tell us how many people joined us on the phone lines today?

Operator: We did a total, let's see here one second, of – see here, 423.

Natalie Highsmith: 423, great. Wonderful. Thank you everyone.

Operator: This concludes today's Center for Medicare and Medicaid Special Open Door Forum on Wage Index Reform. You may now disconnect.

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