

June 23, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286-P
PO Box 8012
Baltimore, MD 21244-8012

Re: CMS-1286-P; Medicare Program, Proposed Hospice Wage Index for Fiscal Year 2006

Dear CMS:

Thank you for the opportunity to comment on the Medicare Program, Proposed Hospice Wage index for fiscal year 2006 which appeared in the federal register on April 29, 2005. VNA Care Hospice, Inc. is one of the largest Hospices in Massachusetts serving most of eastern and central Massachusetts. This letter is to comment on the proposed rule for the Fiscal Year 2006 Medicare Hospice Benefit Regulations.

VNA Care Hospice, Inc. with over 100 staff and annually serving 1,500 Medicare Hospice beneficiaries is unique in that our primary service area covers four counties: Essex, Middlesex, Norfolk, and Worcester. We are very concerned that the proposed changes to the current MSA definitions and related wage index changes will have significant disruptive implications on our reimbursement for care to Medicare hospice beneficiaries.

The Medicare Hospice draft regulations for fiscal year 2006 proposes to change the MSA definitions to CBSA based on counties, which dramatically changes the Massachusetts map and more specifically the wage index calculations in Massachusetts. The current wage index in 2005 for VNA Care Hospice's entire service area is 1.1972. In Essex County alone the new CBSA wage index is proposed to drop to 1.1339, representing a 5.3% drop in the wage index for that county. For VNA Care Hospice, this equates to a \$46,000 decrease in revenue for services we provide in that area and similarly, in Worcester County the 2.3% drop in wage index would be decrease in revenue by approximately \$52,000 between 2005 and 2006. This decrease in revenue comes at a time when there is a nursing shortage and we may need to increase our wages.

We are aware that 29 hospitals in our direct service area (Middlesex, Essex, and Worcester Counties) have successfully applied for and have been reclassified to the neighboring service area of Boston-Quincy. This reclassification significantly increases the wage index and the reimbursement for these twenty-nine hospitals leaving VNA Care Hospice at a serious competitive disadvantage when trying to recruit increasingly scarce nurses. Our local hospitals will be able to offer higher wage and benefit packages than VNA Care Hospice.



If we cannot recruit staff in these areas, access to hospice services to Medicare beneficiaries could be impaired. Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary. CMS recognizes this fact by allowing hospitals to reclassify to a neighboring CBSA. Hospices must also be allowed to reclassify to avoid inequities among providers competing in the same labor market.

VNA Care Hospice will be placed at a serious competitive disadvantage if reclassification is not available to us. Since our service area covers four different counties in Massachusetts, a nurse could be visiting patients in two or three different counties in one day. We do not have different pay scales for the different areas we serve and we are competing with the Boston hospitals and other Boston hospices and home health agencies for employees. We feel that the new CBSA geographic reclassifications will put us at a severe disadvantage.

Not only will our reimbursement be reduced from 2005 to 2006 as mentioned above but our close competitors in the Boston-Quincy CBSA who in some cases are less than twenty miles away will be reimbursed \$276,000 more than VNA Care Hospice for the same services.

Recommendations

We noted that, the proposed CMS changes to the MSA definitions will dramatically change the MSA map for Massachusetts. We believe that any changes to the MSA definitions and wage index should conform to the following principles:

1. The Medicare wage index adjustment should accurately reflect wage level differences among labor market areas throughout the nation.
2. Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary, and that reclassifications that are allowed to hospitals competing in the same labor markets must also be available to hospices.
3. There should be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in a local wage index to give agencies time to adjust.
4. Relief for providers that are impacted negatively by the changes should not come at the direct expense of the providers that benefit from the changes.

Given these principles, we believe that modifications in the proposed rule must be made to accommodate realities in the labor market and to avoid sudden financial dislocations that could financially threaten our agency.

Transitional Hold-Harmless

When significant changes are made in the wage index there should be a transitional "hold-harmless" provision that cushions any significant and sudden reduction in a provider's reimbursement to allow adequate time for adjustment. In the Inpatient Hospital PPS regulation, CMS included a three year hold harmless for former urban hospitals changed to "rural", citing a disproportionate impact on these hospitals as the reason for the hold harmless. We believe that CMS should also offer a hold harmless provision for hospices where there is a sudden reduction in the local wage index. **We recommend that, in the final rule, CMS limit to 2% the amount that a local wage index can drop from one year to the next.**

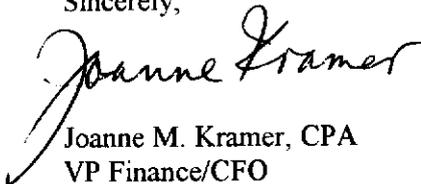
Geographic Reclassification

Wage areas must recognize the realities of labor markets, notably that area borders are somewhat arbitrary. CMS recognizes this fact by allowing hospitals to reclassify to a neighboring MSA. Hospices must also be allowed to reclassify to avoid inequities among providers competing in the same labor market. VNA Care Hospice will be put at a serious competitive disadvantage if reclassification is not available to us. Our service area covers four different CBSAs. In any one day a nurse could be visiting patients in two or three different CBSAs. We do not have different pay scales for the different areas in which we serve and we are competing with the Boston hospitals for employees. We feel that the geographic reclassification would put us at a terrible disadvantage.

We recommend that hospices in a given CBSA automatically be reclassified to a neighboring CBSA if the largest hospital in the CBSA is reclassified. Additionally, we recommend that hospices be allowed to apply for reclassification, subject to the same process and criteria currently available to hospitals. Also we recommend that hospices serving more than one adjacent CBSA have the ability to be reclassified to the CBSA with the highest volume of service.

Thank you for the opportunity to submit these comments. Please give consideration to our interest in minimizing the adverse affect they will have on VNA Care Hospice, Inc. and our capacity to provide care to the terminally ill patients and their families in Massachusetts.

Sincerely,



Joanne M. Kramer, CPA
VP Finance/CFO

9-0
(8)

June 17, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: File Code Number CMS 1286-P, Specific Issue Identifier "Impact Analysis"

Dear Sirs:

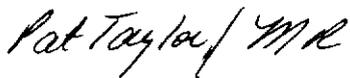
I am deeply concerned at the negative impact that the proposed hospice wage index will have in Lake County, Illinois. As a 78 year old consumer surrounded in my daily life by friends, even now, finding it almost impossible to get dependable and responsible help at the present wage, I fear that many organizations will not be able to continue to provide service in our county or that the service will be limited. I have worked in aging for more than 30 years, and my phone rings constantly asking where to turn for help. I am proud to refer them to good agencies in our area and personally know of the struggle the agencies currently face in staffing effectively. This will only make their job more difficult.

Hospice is a vital part of the continuum of care and to lose the ability to access this service would deprive Medicare beneficiaries of important eligible services. Hospice has served my friends and my family with this continuum of care.

Please reconsider the use of these new definitions for the hospice wage index. Options for your consideration include:

- reclassifying Lake County, or
- attaching it to Cook County, which has always been the sister county, or
- phasing in the new payment over a three year period.

Sincerely,



Pat Taylor
Regional Board Member
Older Women's League



HOLY CROSS

Home Care & Hospice

11800 Tech Road - Suite #240
Silver Spring, Maryland 20904
(301) 754-7740
(301) 754-7743 Fax

June 14, 2005

RE: file code CMS-1286-P
Hospice Wage Index

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286-P
P.O. Box 8012
Baltimore, MD 21244-8012

I am writing to provide you with comments in reference to file code CMS-1286-P
B. Hospice Wage Index.

The proposed rule would set forth the hospice wage index for fiscal year 2006 and
would move Montgomery County Maryland from the CBSA code number 47894 –
Washington D.C. to CBSA code number 13644 Bethesda-Frederick-Gaithersburg,
MD. **I strongly urge you to leave Montgomery County in its current MSA.**

Montgomery County is contiguous to Washington D.C. Montgomery County is a
unified labor market with the District of Columbia and Prince Georges County.
Commuting ties are very strong for Montgomery County with the Washington MSA.
We share a subway system, a bus system and the Capital Beltway. Montgomery
County also has a high degree of social and economic integration with the
Washington MSA. Wages in the County and the overall cost of living have more in
common with Washington D.C. than with Frederick County, which is still a
relatively rural area. **I strongly urge you to leave Montgomery County in its
current MSA.**

Sincerely,

Margaret Hadley
Director



//

June 24, 2005

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1286-P
PO Box 8012
Baltimore, MD 21244-8012

Dear Sir/Madam:

Thank you for the opportunity to comment on 42 CFR Part 418, Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006 Proposed Rule (File Code CMS 1286-P) published in the Federal Register on April 29, 2005.

It is stated in the Federal Register that "...we do not believe that in the aggregate, hospice agencies would be impacted negatively by the new CBSA designations." New York State will experience significant negative impact under the new CBSA designations and this proposed Hospice Wage Index. Forty-seven of New York's 61 counties (77%) will suffer a decrease in the Hospice Wage Index. One small rural hospice will lose \$75,000-\$80,000 in revenue. Large urban hospices will experience losses of \$250,000 - \$1.4 million.

The majority of New York State's geography is rural, and the rural areas are facing a 4.61% decrease. This is made even more devastating by the fact that most of these rural counties actually compete with urban neighbors for staff. Further, even the local hospitals seeking the same nurses can appeal for the higher urban wage index and thus have more dollars to pay nurses, putting Hospices at a disadvantage. While the intent was clearly not to further diminish rural hospice care, the wage index will definitely result in this unfortunate effect.

Combining the New York City urban area with Northern New Jersey will result in a 5.25% decrease in the five New York City boroughs and three Southern Hudson Valley counties, while the New Jersey counties will see a 13.59% increase.

The inequity created by the new CBSA designations and proposed Wage Index could have a devastating effect on hospice care in New York State. Some hospices will be at risk to close because this loss is simply not sustainable. Some will suffer nursing shortages that will negatively affect access to hospice care.

Just two examples of the inequities that will be suffered in New York State include:

1. Tompkins County is a new CBSA and will experience a 12.53% increase. Schuyler County is a rural county adjacent to Tompkins and residents commute from one to another readily, yet Schuyler County will experience a 4.61% decrease, for a wage index difference from Tompkins to Schuyler of -15.3%.

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2. Dutchess County is in a new CBSA with Orange County and will experience a 3.69% increase while adjacent Columbia County will experience a -4.61% decrease, and Orange County will experience a -1.49% decrease.

To be more equitable and facilitate a smoother transition we recommend:

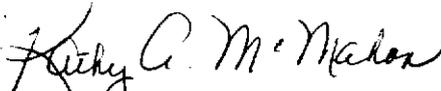
- 1) That the decreases be phased in over a three-year period. As noted in the Federal Register, this was successfully accomplished the last time hospice experienced a major change in the wage index. This would allow hospices the time to make needed adjustments and potentially save several hospices from closing their doors.

- 2) That hospices be allowed to reclassify to the wage index of adjacent counties, which is commonly done with hospitals. This would allow for a more even playing field amongst hospitals and hospices in this tight nursing market. If this is not possible, we offer two alternatives:
 - a) allow hospices to reclassify to the wage index of the local hospital. If there are several hospitals in the County or CBSA and there are different wage indices, then an average could be taken to develop a wage index for the hospice. **OR**
 - b) that an appeal mechanism for hospices be instituted so that the particular issues of each hospice in relation to area hospitals could be reviewed and an equitable decision made.

The wage index is only one piece of the Hospice Medicare reimbursement system. Given the dramatic changes of the wage index, it is vital that CMS establish reasonable base rates for hospice that take into account the increase in cost of service for hospice as it matures as a health care provider and faces the demands of new pharmaceuticals and technology demands.

Thank you for your consideration of our comments on Medicare Program: Wage Index Program FY 06. As we strive to provide open access to hospice care for all patients and families facing a life-limiting illness, it is crucial that additional barriers not be posed by the implementation of an inequitable Hospice Wage Index.

Sincerely,



Kathy A. McMahon
President and CEO

JUN 24 2005



June 22, 2005

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Dr. Mark B. McClellan, M.D., Ph.D.
 Administrator
 Centers for Medicare and Medicaid Services
 Department of Health and Human Services
 Room 445-G, Hubert H. Humphrey Building
 200 Independence Avenue, S.W.,
 Washington, D.C. 20201

ATTN.: CMS-1286-P

Re: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006, Federal Register, Volume 70, No. 82, Friday, April 29th, 2005

Dear Dr. McClellan:

TRUSTEES
John Bennett
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Richard Carlson
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 Chicago
Kathleen Yosko
 Wheaton

On behalf of our approximately 190 member hospitals and health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule incorporating the use of Core-Based, Statistical Areas (CBSAs) to establish the area wage indices for Medicare payments in fiscal year 2006. The CBSAs were the result of analyses by the Office of Management and Budget (OMB) based on Census 2000 information and were first used in the calculation of Medicare payments in FY 2005 as part of the Medicare acute inpatient payment methodology. According to this hospice proposed rule, the revised wage indices would be effective for services rendered between October 1st, 2005 and September 30th, 2006. The labor component accounts for a substantial portion of the Medicare payment rate for hospice services; this component is adjusted by the specific wage index. The wage index value used is based upon the location of the beneficiary's home for routine and continuous home care services and the location of the hospice agency for general inpatient and respite care. Consequently, any significant change in the index value from one year to the next can have serious financial repercussions on the organization. IHA has noted that the FY 2006 wage index is based solely on the values as set by the Census 2000, CBSA data.

The Illinois Hospital Association strongly objects to the FY 2006 wage index values that are based solely on the CBSA data, due to the severe financial impact that some of these hospices will encounter. For example, in FY 2005, Lake County was part of the Chicago Metropolitan Statistical Area; consequently, its Medicare wage index value was 1.1609. If Lake County were still part of the Chicago MSA, its wage index value for FY 2006 would be 1.1550 according to Table C of the proposed rules. However, for FY 2006, Lake County is established as a separate CBSA, and its proposed wage index value is 1.0998, a 5.26% reduction from the previous year. For providing Medicare services to

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 630.276.5400

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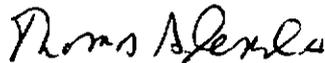
June 22, 2005

Page 2

hospice patients in FY 2006, hospices in that area will be reimbursed at lower rates than in FY 2005. IHA has concerns that any payment reductions in any areas could lead to severe financial hardships, closing of some hospice providers and ultimately, lack of access to this vital service by Medicare beneficiaries. **Therefore, IHA recommends that, at the very least, CMS incorporate the same hold-harmless methodology for the hospice wage index that it applied to acute inpatient services in 2005; i.e., if the FY 2006 CBSA value results in a higher wage index than the MSA value, the CBSA index is fully implemented. However, if the FY 2006 CBSA value is lower than its MSA counterpart, then the FY 2006 wage index is a transitioned value consisting of 50% of the MSA value and 50% of the CBSA value. This approach is not only consistent with the "hold harmless" transition used in FY 2005 for acute inpatient services, but also gives those facilities that are disproportionately affected a one year time period to adjust to the new methodology.**

Dr. McClellan, thank you again for the opportunity to comment. The Illinois Hospital Association welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system.

Sincerely,



Thomas A. Jendro
Senior Director-Finance
Illinois Hospital Association
(630) 276-5516
tjendro@ihastaff.org

13

CMS-1286-P-6 Hospice Wage Index for FY 2006

Submitter : Ms. Patricia Kelleher

Date & Time: 06/24/2005

Organization : Home Health care Association of Massachusetts

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1286-P-6-Attach-1.DOC

**HOME HEALTH
CARE ASSOCIATION
OF MASSACHUSETTS, INC.**

June 24, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
PO Box 8012
Baltimore, MD 21244-8012
Attention CMS-1286-P

Dear Sir/Madam:

On behalf of our nearly 40 member hospices, affiliated with our member home health agencies, the Home & Health Care Association of Massachusetts (HHCAM) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule establishing new policies and payment rates Medicare Program: Proposed Hospice Wage Index for Fiscal Year 2006.

We are restricting our comments to the section:
Annual Update to the Hospice Wage Index

Adequate payments under Medicare prospective payment system (PPS) continue to be essential to ensuring access to high quality end of life care for Medicare beneficiaries, a need that continues to grow in all of our Massachusetts communities. With this in mind, HHCAM has a number of concerns with the hospice wage index as published.

Massachusetts CBSA Experience

HHCAM is concerned in particular with the impact on hospice care – and access to workforce – of the proposed movement from using geographic MSAs to using the new CBSA's. We strongly disagree with the statement in the rule that "...we (CMS) do not believe that in the aggregate, hospice agencies would be impacted negatively by the new CBSA designations." In fact, we see no evidence in Massachusetts to support the statement in the proposed rule that "the variability of CBSAs that can be attributed to different hospice agencies are sufficient to mitigate adverse effects on individual hospice agencies." While our hospices do cover ... (Add here)

As HHCAM understands it, the regulatory intent of the movement to more "refined" geographic areas under CBSAs was to produce a more local wage index so as to reduce reliance on (hospital) geographic reclassification as a means of redressing inappropriate payment levels. In fact, the hospital experience in Massachusetts under CBSAs indicates that just the reverse has been true for our state. With the publication of the

FY2005 pre-floor, prereclassification FY2005 hospital wage index, the former Boston/Suffolk MSA, was broken into a number of new CBSAs, including three in areas directly surrounding and within 30 miles of the center of Boston. **Since the publication of that rule, virtually every hospital – 29 by our count - in the new CBSAs of Worcester (49340), Essex (21604) and Middlesex (15764) has been geographically reclassified by CMS to the Boston/Suffolk (14484) CBSA.**

Another presumption inherent in this hospice rule is that using *hospital* data to calculate *hospice* indices is appropriate as local wage and worker migration patterns are equitable within regions across various sectors of the health system. Yet, CMS has also now recognized in granting such large scale hospital reclassifications that there are patterns of worker migration and salary scales within hospitals in Eastern Massachusetts that warrant continuing to place them in the Suffolk/Boston index area. (If such patterns of migration are presumed to exist for hospitals, they must also be present for hospice whose workers by nature of the site of care (homes) are more mobile.)

These two contrary presumptions - that hospital wages and work patterns apply nationally to hospices, but that they are not applies equally in Eastern Massachusetts - must be addressed with changes to this rule. To not do so would be to create severe disincentives for providing hospice care to patients in several major counties within 25 miles of Boston. As the chart below indicates, the movement to CBSAs has created large parity issues in areas that - through the hospital geographic reclassification process - CMS has already acknowledged are unsustainable:

2006/CBSA	2005 Wage Index	2006 Wage Index	% Difference 2005 – 2006	% difference from Suffolk
21604/Essex	1.1972	1.1339	-5.29	10.4%
15764/Middlesex	1.1972	1.1899	-0.61	5.2%
49340/Worcester	1.1972	1.1694	-2.32	7.0%

Recommended Actions

HHCAM recognizes that no specific statutory directive exists to grant to hospices the right to *request* geographic reclassification. However, HHCAM believes that the Secretary of CMS has broad latitude to address within the final rule wage index inequities that could result in access issues for Medicare beneficiaries.

HHCAM strongly recommends that CMS use the final rule to recalculate hospice wage indices in CBSAs where movement from MSA to CBSA results in a disparity (in a contiguous previous MSA) of more than 5% and where hospitals in these new CBSAs have already been reclassified. Such a recalculation should at a minimum grant to these hospices a transition period. HGCAM would suggest: 67% old MSA 33% new CBSA. (or complete parity?)

HHCAM alternatively recommends that CMS reconsider its decision to not propose any transition for hospices experiencing a decline from MSA to CBSA. In this scenario, we would propose that for hospices with decreases of more than 2% in their

Attachment to #6

wage index, CMS provide an opportunity for a phased-in or blended rate over the next 2-3 years, which establish a wage index for FY2006 which is a blend the 2005 MSA with the 2006 CBSA

In addition to concerns with the calculation and transition to CMS, HHCAM would like to comments on the calculation used to create a rural wage index for Dukes and Nantucket (CBSA 22). The wage indices in these areas are the lowest in the state despite the historically high wage index cost of living. Not surprisingly there are no Medicare hospices on Nantucket. CMS has identified in the rule that "that there were no IPPS hospitals and thus no hospital wage index data on which to base the calculation of the FY 2006 hospice wage index for rural Massachusetts. CMS has further states that "there is no reasonable proxy for more recent rural data within Massachusetts" so the proposal is to establish such a rate using "the prefloor, preclassified hospital wage index data for FY 2005 and apply the FY 2006 proposed budget neutrality factor of 1.063479. " Although CMS is correct that there are no IPPS hospitals in the Massachusetts rural areas, there are hospitals, with whom the hospices do (or would if a hospice were to open as there are now none) compete. HHCAM believes that these areas – which happen to be islands with very unique economic issues – merit a wage index that does use local data. HHCAM would suggest that a more reasonable proxy would be to use the data submitted by the two critical access hospitals in Massachusetts rural area to calculate the area's wage index.

We appreciate the opportunity to offer these comments on Medicare Program: Wage Index Program FY 06 and hope you will give consideration to our interest in minimizing the adverse affect they will have on some Massachusetts hospice programs and their capacity to provide care to terminally ill patient and their families.

Sincerely

Patricia M Kelleher
Executive Director

**HOME HEALTH
CARE ASSOCIATION
OF MASSACHUSETTS, INC.**

*Duplicate
2
E-Comment*

June 24, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
PO Box 8012
Baltimore, MD 21244-8012

Attention CMS-1286-P

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indicates that just the reverse has been true for our state. With the publication of the FY2005 pre-floor, prereclassification FY2005 hospital wage index, the former Boston/Suffolk MSA, was broken into a number of new CBSAs, including three in areas directly surrounding and within 30 miles of the center of Boston. **Since the publication of that rule, virtually every hospital – 29 by our count - in the new CBSAs of Worcester (49340), Essex (21604) and Middlesex (15764) has been geographically reclassified by CMS to the Boston/Suffolk (14484) CBSA.**

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Sincerely



Patricia M Kelleher
Executive Director

14

CMS-1286-P-5 Hospice Wage Index for FY 2006

Submitter : Mr. Brian Schwarberg

Date & Time: 06/23/2005

Organization : Alzheimer's Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

CMS-1286-P-5-Attach-1.DOC

Attachment to#5

www.alzheimers-illinois.org
helpline: 1-800-272-3900



Greater Illinois Chapter

Bloomington/Normal
405 Pine Street, Suite B
Normal, Illinois 61761

309 451 8333 p
309 454 6091 f

Carbondale
620 E. Walnut Street
Carbondale, Illinois 62901

618 529 2107 p
618 457 7830 f

Chicago
4709 Golf Road, Suite 1015
Skokie, Illinois 60076

847 933 2413 p
847 933 2417 f

Joliet
300 Caterpillar Drive
PO Box 3506
Joliet, Illinois 60434

815 744 0804 p
815 773 7340 f

Kankakee
401 N Wall Street, Suite LL08
Kankakee, Illinois 60901

815 936 0464 p
815 936 9363 f

Rockford
4777 E. State Street
Rockford, Illinois 61108

815 484 1300 p
815 484 9286 f

Springfield
6 Drawbridge Road, Suite 4
Springfield, Illinois 62704

CMS
Docket CMS -1286-P
Hospice Wage Index for FY 2006
Comments

To Whom It May Concern:

On behalf of the board Alzheimer's Association Greater Illinois Chapter, I am writing to request that CMS reconsider applying the new MSA definition in defining the Hospice Wage Index. File Code Number CMS 1286-P and specific issue identifier "Impact Analysis." Utilizing this definition will severely limit the ability of hospice service providers to provide care in many counties thus limiting the access for Illinois citizens to hospice care and could also impact the quality of care as providers are forced to work with less funding.

It is especially difficult to lose revenue because of the current nursing and social worker shortages in Illinois, which is already impacting all healthcare and social service providers and contributing to the continuing rise in wages for these professionals. For example, Illinois counties such as Lake have continued to see decreases in the wage index for the last few years, while contiguous counties have received increases but all the providers in this area all from and compete for the same labor pool. This creates major problems in maintaining financial viability for health and social service organizations.

Again, please reconsider the proposed use of the new MSA definitions in defining the Hospice Wage Index. Options to be considered could include:

- reclassifying these counties, or
- attaching the county to an adjacent county with a higher wage rate, or
- phasing in the new payment over a three year period for the counties negatively affected.

Sincerely,
Brian Schwarberg
Public Policy Director



HOSPICE
OF THE NORTH SHORE

expertise in palliative care since 1978

15

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286-P
P.O. Box 8012
Baltimore, MD 21244-8012

RE: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006; Proposed Rule [CMS-1286-P]

Dear Dr. McClellan:

The purpose of this letter is to provide the Centers for Medicare and Medicaid Services (CMS) with Hospice of the North Shore's comments on the **Medicare Proposed Hospice Wage Index** for FY2006 (CMS File Code 1286-P) which appeared in the Federal Register on April 29, 2005. Hospice of the North Shore is the largest not-for-profit hospice provider in New England, annually providing end-of-life care to more than 1,600 Medicare beneficiaries residing in Essex County, Massachusetts.

The division of the Greater Boston MSA into five separate CBSA's, each with its own wage index data, will have a severe negative impact on hospice providers in Essex County, as well as many other counties in New England. Hospice of the North Shore will suffer a loss in Medicare reimbursement of approximately \$650,000 as a result of a 5.29% reduction in its wage index.

Sections 1886(d)(8)(b) and 1886(d)(10) of the Social Security Act and 42 CFR §412.23 allow hospitals to apply to the Medicare Geographic Classification Review Board for reclassification from a lower to a higher, adjacent wage index area, and all of the hospitals in Essex County successfully petitioned CMS last year to have their wage area designation be reclassified with Boston/Quincy. No such reclassification option is available to hospice providers, yet they must compete with their neighboring hospitals for the same limited pool of qualified health care workers. In this era of nursing shortages, recruitment of adequate numbers of skilled registered nurses, which is already a significant challenge for hospice providers, will become even more difficult.

Re: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006;
Proposed Rule [CMS-1286-P]

Hospice care is a cost-effective model for providing care at the end of life, with a focus on keeping the patient at home. If wage index inequities between hospices and hospitals are allowed to continue, and hospices are unable to attract qualified nurses in adequate numbers to care for their patients, they may be unable to care for all the Medicare beneficiaries who need hospice care. Patients who are unable to obtain access to hospice care may then need to seek hospitalization, at far greater cost to the Medicare program. Given that CMS has undertaken initiatives in recent years to educate physicians and eligible beneficiaries about the benefits of hospice services, changes to the wage index that will put hospices at a competitive disadvantage relative to hospitals, seem to run counter to any efforts aimed at increasing hospice utilization.

We would like to see a provision in the rule that would allow hospices in a CBSA to be automatically reclassified when the hospitals in the same CBSA have been reclassified. This would address the parity issue between hospitals and hospices and allow hospices to effectively compete in the health care labor marketplace. The cost of implementing a hospice reclassification provision could be offset by capping the amount the wage index could go up for any area at a certain percentage level.

In the absence of such a reclassification provision, then a transition mechanism should be put in place to mitigate any large annual swings. By establishing a corridor, such as +/- 2 or 3 percentage points, so that no provider's wage index goes up or down by more than that percentage amount in any given year, CMS would provide some protection to hospice providers and give those negatively impacted more time to make the necessary management and staffing changes to cope with wage index reductions that might otherwise have a catastrophic effect on the hospice's ability to meet the care needs of its patients.

To establish such a transition process over a period of multiple years, is entirely consistent with past practice by CMS with respect to updates to the hospice wage index. The final rule published in the Federal Register on August 8, 1997 (62 FR 42860), which implemented a new methodology for calculating the hospice wage index based on the negotiated rulemaking process, provided for a three year transition process. Under the transition plan, a blended index was calculated for the first year by adding two-thirds of the 1983 index value for an area to one-third of the revised wage index value for that area. In the second year, the calculation was similar, except that the blend was one-third of the 1983 index value and two-thirds of the revised index value. In the third year of the transition period, the revised wage index was fully implemented.

The conclusion cited in the current proposed rule, that a transition process is not necessary because "the variability of CBSAs that may be attributed to different hospice agencies are sufficient to mitigate adverse effects on individual hospice agencies," is inconsistent with the facts of the current proposed rule. In the case Hospice of the North Shore, as well as many other hospice agencies in New England, all of the patients served reside in a single county, so there is no mitigating positive effect to offset the 5.29% reduction in our wage index rate, and the negative impact will be applied across our entire patient population.

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services

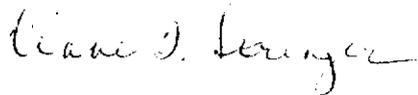
June 24, 2005

Re: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006;
Proposed Rule [CMS-1286-P]

Implementing the **proposed hospice wage index** as published, with no reclassification provision or transition process, will result in a financial crisis for Hospice of the North Shore and many other hospice organizations in New England. We strongly urge you to adjust the proposed hospice wage index in order to ensure that all eligible Medicare beneficiaries have access to hospice care at the end of life.

Thank you for your review of Hospice of the North Shore's comments. We appreciate your attention to the issues we have raised.

Sincerely,



Diane T. Stringer, RN, MS
President



HOSPICE
OF THE NORTH SHORE

expertise in palliative care since 1978

*Duplicate of
#15*

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286-P
P.O. Box 8012
Baltimore, MD 21244-8012

RE: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006; Proposed Rule
[CMS-1286-P]

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Sections 1886(d)(8)(b) and 1886(d)(10) of the Social Security Act and 42 CFR §412.23 allow hospitals to apply to the Medicare Geographic Classification Review Board for reclassification from a lower to a higher, adjacent wage index area, and all of the hospitals in Essex County successfully petitioned CMS last year to have their wage area designation be reclassified with Boston/Quincy. No such reclassification option is available to hospice providers, yet they must compete with their neighboring hospitals for the same limited pool of qualified health care workers. In this era of nursing shortages, recruitment of adequate numbers of skilled registered nurses, which is already a significant challenge for hospice providers, will become even more difficult.

Hospice care is a cost-effective model for providing care at the end of life, with a focus on keeping the patient at home. If wage index inequities between hospices and hospitals are allowed to continue, and hospices are unable to attract qualified nurses in adequate numbers to care for their patients, they may be unable to care for all the Medicare beneficiaries who need hospice care. Patients who are unable to obtain access to hospice care may then need to seek hospitalization, at far greater cost to the Medicare program. Given that CMS has undertaken initiatives in recent years to educate physicians and eligible beneficiaries about the benefits of hospice services, changes to the wage index that will put hospices at a competitive disadvantage relative to hospitals, seem to run counter to any efforts aimed at increasing hospice utilization.

We would like to see a provision in the rule that would allow hospices in a CBSA to be automatically reclassified when the hospitals in the same CBSA have been reclassified. This would address the parity issue between hospitals and hospices and allow hospices to effectively compete in the health care labor marketplace. The cost of implementing a hospice reclassification provision could be offset by capping the amount the wage index could go up for any area at a certain percentage level.

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To establish such a transition process over a period of multiple years, is entirely consistent with past practice by CMS with respect to updates to the hospice wage index. The final rule published in the Federal Register on August 8, 1997 (62 FR 42860), which implemented a new methodology for calculating the hospice wage index based on the negotiated rulemaking process, provided for a three year transition process. Under the transition plan, a blended index was calculated for the first year by adding two-thirds of the 1983 index value for an area to one-third of the revised wage index value for that area. In the second year, the calculation was similar, except that the blend was one-third of the 1983 index value and two-thirds of the revised index value. In the third year of the transition period, the revised wage index was fully implemented.

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Mark McClellan, M.D., Ph.D., Administrator

June 24, 2005

Centers for Medicare and Medicaid Services

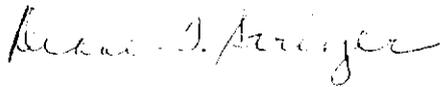
Re: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006;

Proposed Rule [CMS-1286-P]

Implementing the **proposed hospice wage index** as published, with no reclassification provision or transition process, will result in a financial crisis for Hospice of the North Shore and many other hospice organizations in New England. We strongly urge you to adjust the proposed hospice wage index in order to ensure that all eligible Medicare beneficiaries have access to hospice care at the end of life.

Thank you for your review of Hospice of the North Shore's comments. We appreciate your attention to the issues we have raised.

Sincerely,



Diane T. Stringer, RN, MS
President



228 Seventh Street, SE, Washington, DC 20037. 202/547-3540. 202/547/3540 fax

June 28, 2005

Centers for Medicare & Medicaid Services
 Department of Health & Human Services
 Attn: CMS-1286-P
 PO Box 8012
 Baltimore, MD 21244-8012

RE: File Code CMS-1286-P
 Medicare Program; Proposed
 Hospice Wage Index for FY 2006

To Whom It May Concern:

The following are comments from the Hospice Association of America (HAA) and the National Association for Home Care & Hospice (NAHC) regarding the Proposed Rule: "Medicare Program; Proposed Hospice Wage Index for FY 2006," as set out at 70 F.R. 22394 (April 29, 2005). Thank you for the opportunity to present these comments.

IMPLEMENTATION OF REVISED LABOR MARKET DESIGNATIONS

The primary change in the proposed hospice wage index for FY 2006 relates to the revision of labor market area designations, shifting from the existing definitions of Metropolitan Statistical Areas (MSA) to the Core Based Statistical Areas (CBSA) as devised by the Office of Management and Budget utilizing Census 2000 data. The volatility of the hospice wage index has been a significant concern for HAA and NAHC for many years. Annually, a substantial number of hospices face wildly fluctuating wage indices with sizable increases and decreases that are far from predictable. The lack of stability is compounded by weaknesses inherent in the use of the hospital wage index and the disregard of the rural floor and geographic reclassifications applicable to hospitals.

The proposal to institute use of CBSA designations for FY 2006 highlights the ongoing volatility and instability of the wage index. Over 80 percent of all counties are subject to a wage index that is a decrease from the index that would apply if CMS continued use of the current MSA designations. While CMS states that, in the aggregate, the changes are negligible, there are a number of counties where the geographic redesignation brings substantial change. Given that the provision of hospice services is a local endeavor,

viewing the geographic redesignation in the aggregate, in large geographic regions, fails to adequately display the actual impact of the change.

For example, Table 1 displays the impact on the East North Central urban region as a -0.3. However, in Lenawee, Michigan, the county is shifted from a wage index of 1.1513 to a rural wage index of 0.9344. This represents nearly a 19 percent reduction, far in excess of the 0.3 reduction cited for the region that contains Lewanee, Michigan. The redesignation is replete with other examples of dramatic differences between an MSA-based wage index and the CBSA wage index, See, e.g. King George, VA 1.1678/0.8560; Rowan, NC 1.0337/0.9107; Lake, IL 1.1550/1.0998; Henderson, TX 1.0702/0.8472; Monroe, MI 1.0886/1.0109; Garfield, OK 0.9581/0.8174; Madera, CA 1.1078/0.9062. These are only illustrations of dozens of counties where the switch from an MSA to a CBSA designation brings a ten percent or greater adverse effect. There is little comfort to the hospices and their patients in those counties by including them in a large geographic region that measures aggregate impact. HAA and NAHC recommend that CMS evaluate the impact on the financial viability of hospices at the county level, as well as the impact of the redesignations on a patient's access to care in their locale before moving ahead with the proposed rule change.

To be consistent with the spirit and intent of the 1995 Hospice Wage Index Negotiated Rulemaking Committee Agreement and the Final Rule implementing the methodology for calculating the hospice wage index, HAA and NAHC recommend that CMS institute a transition authority for hospices that are subject to geographic area redesignations that allows for appropriate consideration of the great difficulties that are caused by a substantial swing in the wage index rate. The committee agreement and the final rule set up a structure for utilizing the hospital wage index for hospices. As CMS is well aware, certain hospitals were afforded the opportunity to utilize a blended wage index in transitioning from an MSA to a CBSA. Consistent with the stabilization purpose of a blended wage index for hospitals, CMS should institute a comparable transition protection for hospices.

HAA and NAHC recommend that CMS consider a transition opportunity for hospices where the difference in the MSA related wage index and the CBSA wage index exceeds one percent. In those circumstances, the hospice would receive a wage index that represents a blend of 50 percent of the MSA related wage index with 50 percent of the CBSA related wage index. This approach allows those hospices that have CBSA designation related increases and those that are nearly neutral to maintain the proposed wage index. It mitigates any substantial reimbursement rate reduction and recognizes that the wage index is, at best, a weak instrument for accurately distributing payments to hospices.

HAA and NAHC are open to alternatives beyond that presented above. However, the alternatives should address the following principles:

1. Impact on care access and financial stability must be measured at the local level.
2. Significant swings in wage index cause instability and add risk to continued access to care.

3. The use of a hospital wage index that is one year delayed from the index applied to hospitals and fails to consider hospital reclassifications and the application of the rural floor creates an uneven marketplace for health care employers employing comparable staff.

WAGE INDEX REFORM

HAA and NAHC recommend that CMS initiate a comprehensive hospice wage index reform effort. That effort should focus on a goal that puts hospice on a track to establish wage indices comparable to the hospitals and other health care providers with which hospices compete for staff. It should maintain the budget neutrality factor that operates within the current wage index standards. Further, it should include a limitation on changes to the wage index from one year to the next that offers a level of predictability and stability for hospices. We believe that sufficient authority exists in current law for the institution of such an index and are willing to work openly with CMS officials to achieve that change.

SUMMARY

HAA and NAHC appreciate the opportunity to provide these comments. We sincerely hope that CMS will recognize the need for a transition to the new CBSA designations that is intended to maintain access to crucial hospice services. Thank you for your time and consideration of these comments.

Very truly yours,

Janet E. Neigh
Executive Director
Hospice Association of America
Hospice

William A. Dombi
Vice President for Law
National Association for Home Care &

June 27, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Comments Submitted Electronically

**Re: CMS-1286-P
Medicare Program; Proposed Hospice Wage Index for FY 2006**

Dear Sir/Madam:

On behalf of hospices in Connecticut, the Connecticut Association for Home Care (CAHC) and the Connecticut Council for Hospice & Palliative Care submit the following comments on the proposed rules regarding the Proposed Hospice Wage Index for Fiscal Year 2006, published in the *Federal Register* on April 29, 2005.

We are very concerned about the proposed declines in Medicare wage indices that would occur in four of the five wage index regions in Connecticut. These proposed wage index declines hamper our ability to compete for increasingly scarce health care workers. The inability to attract and retain workers has the potential to significantly impact access to care for this important service.

In Connecticut and many other parts of the country, these wage index declines defy logic, common sense and basic economic theory about labor markets.

For instance, the proposed wage index for the Hartford region would decline by 4.5 percent in FY 2006 -- yet CAHC salary surveys indicate that wages have consistently gone up in the 3 to 5 percent range from 2003 to 2005, with similar increases projected for 2006. [Note: Bureau of Labor Statistics (BLS) data from 2000 to 2001, the same time period as the hospital data that makes up the FY '06 hospice wage index, shows that the average wage for Registered Nurses (RNs) went up by 3.9% in the Hartford region. This is typical of healthcare wage increases in that time period in CT.] We believe that accounting changes in hospital cost reports, as well as methodological nuances in the hospital wage index methodology, mask the true change in wages, particularly in urban areas in the northeast.

The impact charts provided in the proposed rule also bear this assertion out: 1) the northeast region would face an aggregate decline of 1.4% and 2) rural regions would increase by 0.8%, while urban areas would decline by -0.2%. If wage index changes were the result of an unbiased methodology, these aggregate impacts should even out for groups of this size. In some specific regions, there are inexplicably large wage index increases and declines in a one-year period. It is hard to believe that the relative wage levels have actually changed that much in such a short period of time in these particular regions.

The Centers for Medicare & Medicaid Services' (CMS') administrative decision to move to Core Based Statistical Areas (CBSAs) exacerbates the wage parity problems for

providers in New Haven County. The wage index for New Haven County would decline by 4.8 percent due primarily to the proposed change in the wage index region (i.e., New Haven County would no longer be grouped with Fairfield County). Again, this is a counter-intuitive result given the steady increases in wage costs experienced by health care providers in New Haven County. [For instance, BLS data for RNs shows a 4.2% increase in New Haven from 2000 to 2001.]

Hospitals – the dominant player in the health care labor market - are generally insulated from these methodologically driven declines by various safeguards such as the rural floor and geographic reclassification – both of which are unavailable to hospices. For instance, since all hospitals in New Haven have been reclassified to other regions with higher wage indices (Long Island and New York), no hospital will experience the above-cited reduction. In the Hartford region, the rural floor insulates all of the hospitals from the proposed decline for hospices. This is unfair and jeopardizes the ability of Medicare-dependent hospices (90%+ of revenues come from Medicare) to attract sufficient staff.

CMS' assertion that the hospital wage index is a valid proxy for regional labor variation in hospices is at odds with its decision to withhold these safeguards (geographic reclassification and rural floor) from hospices. If CMS clings to the assertion that the hospital wage variation is a viable proxy for hospice wage variation, then it must provide similar methodological safety valves to hospices. We believe that there is sufficient statutory flexibility to provide safeguards from these unwarranted and illogical differences between providers competing for many of the same workers. Moreover, we believe that there are reasonable ways to mimic the effect of geographic reclassification and rural floor that would not entail significant additional administrative burden for CMS.

Thank you for consideration of these comments.

Sincerely,

Brian Ellsworth
President & CEO
Connecticut Association for Home Care

Thomas Salemme
Executive Director
Connecticut Council for Hospice & Palliative Care



ILLINOIS
HOSPICE &
PALLIATIVE CARE
ORGANIZATION

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June 28, 2005

Dear CMS:

On behalf of the board and members of the Illinois Hospice and Palliative Care Organization we are writing to request that CMS reconsider applying the new MSA definition in defining the Hospice Wage Index. File Code Number CMS 1286-P and specific issue identifier "Impact Analysis." Utilizing this definition will severely limit the ability of hospice service providers to provide care in 37 of our 102 counties thus limiting the access for Illinois citizens to hospice care and could also impact the quality of care as providers are forced to work with less funding. Therefore IL-HPCO requests that CMS not implement the Proposed Wage Index changes in the following Illinois Counties: Boone, Champaign, Cook, DuPage, Kane, Kendall, Lake, Macon, McHenry, Menard, Ogle, Rock Island, Sangamon, Will, and Winnebago because of the negative impact this will have on consumers in accessing care and the impact on the quality of care. We are asking that CMS:

1. reclassify these counties, or
2. attach the county to an adjacent county with a higher wage rate, or
3. phase in the new payment over a three year period for the counties negatively affect

It is especially difficult to lose revenue because of the current nursing and social worker shortages in Illinois, which is already impacting all healthcare and social service providers and contributing to the continuing rise in wages for these professionals. This creates major problems in maintaining financial viability for health and social service organizations.

Our organization serves as a clearinghouse of information for consumers, professionals and providers as we work to educate the people of Illinois about end of life choices. We work with hospice providers, hospice professionals and consumers to address end of life issues in Illinois. We work directly with Illinois citizens as they seek hospice service. Consumers fear that many organizations will not be able to continue to provide service in their county or that the service will be limited. Hospice is a vital part of the continuum of care and to lose the ability to access this service would deprive Medicare beneficiaries of eligible services. We challenge the logic in utilizing the new definitions. We are very concerned about the impact this will have on healthcare and social service provider in Illinois and to the ability of consumers to access quality care.

Our constituents/consumers are in danger of losing access to hospice care. With the proposed changes in the hospice wage index, hospice providers will be forced to limit their service areas and some may be forced out of business because they will not be able to maintain financial viability. There is also a grave danger of damage to the quality of care as providers are forced to try to make due with fewer resources and try to fill the void caused by other providers limiting their service areas. Examples of the impact this proposed wage index will have on hospice providers are enclosed.

As providers work to deal with the impact of large annual cuts they need would continue to care for undoubtedly more patients in the 2005-2006 budget period and need to figure out how to do this with lower revenues across all of our primary service areas. One of the biggest issues for them would be how to stay competitive with the salaries of their care staff. These cuts would be particularly difficult when they are already running on very slim margins.



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ORGANIZATION

We suggest that CMS phase these changes in over a three-year period rather than to hit hospices all at once. CMS has done this with hospitals, and we find it highly discriminatory to treat hospices this way.

Again, please reconsider the proposed use of the new MSA definitions in defining the Hospice Wage Index. At the very least we request a "phasing in" of the new payment over a three-year period for the counties negatively affected.

Sincerely,

Harriet O'Connor
President/CEO
Illinois Hospice & Palliative Care Organization
1525 E. 53rd Street, Suite 400
Chicago, IL 60615
888-844-7706 fax 888-844-7697
hoconnor@il-hpco.org



Examples: Impacts of Proposed Wage Index

Hospice A

Hospice A states that the reduction of Medicare revenue due to the changes in the wage index is projected to be as follows:

	FY 2006 Impact	
	6 months 10/1/05-3/31/06	Annual impact
Wage index drop, Cook County	12,149	24,298
Wage index drop Lake County	1,969	3,938
Total reduction in Medicare revenue	\$14,118	\$28,236

In addition to the above reduction, the organization actually assumed a modest increase in Medicare rates in their FY 2006 budgeting process. So, in addition to the above cuts, Hospice A will also be impacted by the fact that it will not receive the rate increase its budgeting process assumed. The 6-month impact of this factor is \$148,625 and is big enough to erase Hospice A's projected net income for the entire fiscal year.

Hospice B

Hospice B is located only 15 miles from Rockford and competes with 'urban' wages. Staff must travel further between patients, causing increased hours and mileage for nurses. Hospice B will receive a 13.92% reduction in rates. It must rely on its local community to make up the differences in services versus reimbursement currently. How will Hospice B be able to meet the increasing needs of patients and families, the increased medication cost, rising insurances, and increased salaries while taking a reduction of its already insufficient funds to meet needs?

Hospice C

The reduction to Hospice C's wage index will reduce its funding by \$200,000 a year. This will make it extremely difficult to provide the same quality of care especially as nursing salaries continue to climb as the supply and demand continues to be a problem. In addition: recruitment, liability, and healthcare costs are increasing at over 20% a year. Hospice C is not sure how it can be expected to do the same, let alone more with less.

Hospice D

Hospice D finds that the costs of medications is causing a severe strain as prices have dramatically increased over the years and with these new wage phase endanger the financial viability of being able to serve patients in their service area. Any reduction in wage index will impact their ability to provide service.

Hospice E

The impact to Hospice E of the new wage index for Lake County will be \$64,403.05 loss in revenue next year.

Hospice F

The impact to Hospice F of the new wage index will be a loss of \$20,000 in revenue next year.



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Hospice G

Lake County budget has 26,792 days @ \$5.13 reduction equals	\$137,442
Cook County budget has 110,534 days @ \$.43 reduction equals	\$ 47,530
IPU budget has 4,745 days @\$1.77 reduction equals	\$8,399

Hospice H

(Please Note: This provider actually received an increase but find the small amount a major hardship)

Hospice D used the calculator and census numbers for the first four months of the year and projected for the rest of the year. It tried to look at historical data but does not see how a projected increase of .25% is going to help any hospice, let alone a small (average census 30-35), not for profit hospice is going to continue providing the same level of high quality care. Salaries for skilled nursing positions continue to escalate while competition for talented RNs is fierce. In addition, increases in pharmacy costs have the greatest impact on Hospice D's direct care budget. Equipment decisions are being scrutinized further as a greater focus is being made on "the bottom line" rather than "what is needed" for the patient. Hospice D has a tradition that it is proud of. It has NEVER charged a patient or family for anything and would like to continue that philosophy since the patients and families have enough to deal with already.

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Indiana Hospice & Palliative Care

ORGANIZATION, INC.

*Celebrating 26 years of service to terminally ill Hoosiers,
their loved ones and the professionals working for them.*

June 28, 2005

Dear CMS:

On behalf of the board and members of the Indiana Hospice and Palliative Care Organization we are writing to request that CMS reconsider applying the new MSA definition in defining the Hospice Wage Index. File Code Number CMS 1286-P and specific issue identifier "Impact Analysis." Utilizing this definition will severely limit the ability of hospice service providers to provide care in 64 of our 92 counties thus limiting the access for Indiana citizens to hospice care and could also impact the quality of care as providers are forced to work with less funding.

It is especially difficult to lose revenue because of the current nursing and social worker shortages in Indiana, which is already impacting all healthcare and social service providers and contributing to the continuing rise in wages for these professionals. This creates major problems in maintaining financial viability for health and social service organizations.

Our organization serves as a clearinghouse of information for consumers, professionals and providers as we work to educate Hoosiers about end of life choices. We work with hospice providers, hospice professionals and consumers to address end of life issues in Indiana. We work directly with Indiana citizens as they seek hospice service. Consumers fear that many organizations will not be able to continue to provide service in their county or that the service will be limited. Hospice is a vital part of the continuum of care and to lose the ability to access this service would deprive Medicare beneficiaries of eligible services. We challenge the logic in utilizing the new definitions. We are very concerned about the impact this will have on healthcare and social service provider in Indiana and to the ability of consumers to access quality care.

An example of the impact in Indiana is illustrated by its impact on one of larger hospice providers. In that program, the proposal would amount to a nearly \$500,000 annual cut if they continued to operate at their *current* levels. However, they would continue to care for undoubtedly more patients in the 2005-2006 budget period and need to figure out how to do this with lower revenues across all of our primary service areas. One of the biggest issues for them would be how to stay competitive with the salaries of their care staff. A cut like this would be particularly difficult when they are already running on very slim margins. The highest percentage of the counties this provider covers are considered "rural." All but one of these received a cut. Providers were under the impression that this was supposed to HELP rural areas. Indiana appears to be taking a significant hit, mostly in rural areas. Why?

We suggest that CMS phase these changes in over a three-year period rather than to hit hospices all at once. CMS has done this with hospitals, and we find it highly discriminatory to treat hospices this way.

Indiana Hospice & Palliative Care

ORGANIZATION, INC.

*Celebrating 26 years of service to terminally ill Hoosiers,
their loved ones and the professionals working for them.*

Again, please reconsider the proposed use of the new MSA definitions in defining the Hospice Wage Index. At the very least we request a "phasing in" of the new payment over a three-year period for the counties negatively affected.

Sincerely,



Harriet O'Connor
President/CEO
Indiana Hospice & Palliative Care Organization
10 W. Market Street, Suite 1720
Indianapolis, IN 46204
317-464-5145, fax 317-464-5146
hoconnor@ihpco.org



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www.hospicehavasu.org

June 27, 2005

Centers for Medicare & Medicaid
Services
Department of Health and Human Services
P.O. Box 8012
Baltimore, MD 21244-8012.

Re: Implementation of Revised Labor Market Designations
Annual Update to the Hospice Wage Index

Dear CMS:

I am writing regarding the impact the proposed labor market designations will have on our organization. Hospice of Havasu's primary patient base resides within Lake Havasu City in Mohave County, AZ. This is the county receiving the greatest cut in reimbursement due to labor market readjustments. I have read the impact analysis and certainly recognize the need to balance the negative and positive impacts on all hospices. A 22% decrease in reimbursement in one year, however, will cause profound changes in our program.

When Lake Havasu City became a Micropolitan based on the 2000 Census, we were certainly aware that changes in reimbursement could be possible; however we did not expect the level of reduction we are now facing. The rapid growth of the community, which led to this designation, was even greater than what the official census indicated. The City Council considered requesting a mid-decade census in 2005, to demonstrate a population greater than 50,000 people, but was deterred by the cost.

The decision to designate Mohave County, AZ as a rural Arizona county would appear to make sense given the distance from Las Vegas. The reality is that the significant growth in the Las Vegas area has also been experienced in Mohave County. The labor demands of Las Vegas combined with California nursing shortages and rapid growth along the Colorado River have created a highly competitive healthcare labor market for the entire region.

Much of the growth in the Colorado River corridor between Lake Havasu City and Bullhead City/Laughlin has been the result of California residents relocating for the relative safety and lower housing costs in Arizona and southern Nevada. This influx has driven the local housing

market in to an upward spiral that threatens to leave many service workers without affordable housing. Housing values increased 20% in 2005, causing workers to request higher wages.

Arizona, as a whole, struggles with a significant nursing shortage that began several years before other areas of the country were feeling the problem. It is surprising that even the projected rural Arizona wage index is less than in previous years, as increasing hospital salaries in Mohave and La Paz Counties have driven Hospice of Havasu salaries higher. If other rural counties in Arizona are not experiencing this rise, perhaps Mohave County, in particular, faces different challenges than other areas of the state.

In the last few years, the nursing labor pool in Lake Havasu City, and in most of Mohave and La Paz Counties, has offered few qualified candidates for hospice job openings. The majority of applicants hired have been recruited from out of state through web advertising. In 2005, despite regular newspaper and web advertising, two RN's were hired by Hospice of Havasu, out of a total of only 18 applicants.

In 2004, Hospice of Havasu began a "Grow our Own" program to attempt to meet the staffing needs of our organization. Clinical rotations for nursing students and jobs for externs and LPN's and new RN's were the foundation of the program. Recognizing that hospice case managers need at least an additional 1-2 years of training following completion of their RN degree, the "Grow our Own" program was designed to mentor new nurses through that development process. To date the program has cost nearly \$24,000 for clinical rotations and \$103,000 in wages and benefits. A total of 5 RN candidates received job offers in May, at an additional anticipated cost of \$98,000 for the remainder of 2005. Another 9 students are already scheduled for clinical rotations in the fall, which can be anticipated to cost approximately \$30,000.

To provide care for the a patient census that has grown from an average of 31.2 in calendar year 2000, to an average of 88 in calendar year 2004, we will need to be able to hire, train and retain qualified staff. We can also anticipate the retirement of several key nursing staff within the next 3-5 years. The current geographic distribution and wage index does not appear to reflect the conditions under which we actually live and work. The mission of our organization is to provide care to the terminally ill and their families. **We are already the anticipating the need to raise or find \$200,000-300,000 additional per year beginning October 1, 2005, just to train and mentor the staff needed for the future.** Unfortunately, community donors prefer to give to direct patient care needs such as supplies and equipment, rather than training or salaries.

Service to surrounding rural areas may also face reduction as mileage and staffing continue to be an issue. **Expansion of service to outlying areas in Mohave and La Paz counties has increased mileage expense from \$32,000 to \$105,000 in the last four years. Again, additional fundraising efforts may be needed to meet our mission.** La Paz County is a frontier area with approximately 4.4 people per square mile and very limited home based health care services. Local donations and fund raising are already needed to help support the hospice services provided there.

Our organization understands that the change in our designation from urban to rural is unlikely to be altered from the proposed rule. In light of the potential hardship posed by such a large cut, we would request that the Centers for Medicare and Medicaid Services (CMS) consider phasing the change in over 3 years, as we understand was done for the hospitals. This would allow us more opportunity to evaluate programs, educate our community and develop new fund raising opportunities.

We also respectfully request that CMS reconsider whether the Micropolitan designation received by growing communities like Lake Havasu City in Mohave County, AZ truly equates with other more rural areas such as La Paz County, AZ.

Thank you for your consideration of this matter.

Sincerely,

Nancy Iannone
Hospice of Havasu Administrator

21

CHRIS VAN HOLLEN
8TH DISTRICT, MARYLAND

COMMITTEE ON
EDUCATION AND THE WORKFORCE

COMMITTEE ON GOVERNMENT REFORM

Congress of the United States
House of Representatives
Washington, DC 20515

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www.house.gov/vanhollen

June 28, 2005

Mark McClellan, Commissioner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS - 1286 - P
PO Box 8012
Baltimore, MD 21244

Dear Commissioner McClellan:

I am writing to express my concern regarding CMS -1286 - P, the proposed rule revising the hospice wage index for Fiscal Year 2006. Specifically, I wish to register my objection to Montgomery County being placed in CBSA #13644 (Bethesda-Frederick-Gaithersburg, MD) rather than CBSA #47894 (Washington-Arlington-Alexandria, DC-VA), where it more properly belongs.

According to the Federal Register, Core-Based Statistical Areas (CBSAs) are supposed to "reflect a core population plus an adjacent territory that reflects a high degree of social and economic integration... (as) measured by commuting ties, thus demonstrating that these areas may draw workers from the same general areas."

Based on these criteria, Montgomery County must be included in CBSA #47894. Unlike jurisdictions as far away as Jefferson County, WV which are included in CBSA #47894, Montgomery County shares an eight mile border with the District of Columbia. Moreover, a far greater percentage of Montgomery County residents commute back and forth to Washington, DC than to Frederick County, with whom Montgomery County is currently grouped under CBSA #13644. As a consequence, Montgomery County is clearly more economically and socially integrated with the rest of the Washington Metropolitan region - including Prince George's County, which I also represent -- than with Frederick County.

Unless CMS - 1286 - P is revised to include Montgomery County in CBSA #47894, Montgomery Hospice reports that it will receive at least \$50,000 less in reimbursement than its neighboring providers in Metropolitan Washington over the next year - enough to hire an additional full-time nurse. Moreover, this disparity will only compound over time and could ultimately erode the quality of hospice care in Montgomery County.

I urge you to revise CMS -1286 - P to include Montgomery County in CBSA #47894, where the stated criteria for establishing CBSAs dictate it belongs.

Sincerely,



Chris Van Hollen
Member of Congress

22

Covenant

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Pensacola, FL 32504
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207 West Adams St.
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Enterprise, AL 36330
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Toll-Free FL: 800-541-3072

Toll-Free AL: 877-244-7379

www.covenanthospice.org

VIA FEDERAL EXPRESS

June 27, 2005

Department of Health and Human Services
Attn: CMS – 1286 – P
PO Box 8012
Baltimore, MD 21244-8012

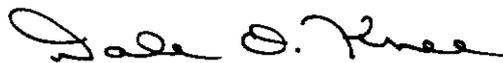
RE: Proposed Rule Comment
FY 2006 Proposed Wage Index for Hospices,
Federal Register dated April 29, 2005

Please accept this as Comment from Covenant Hospice on the FY 2006 Proposed Wage Index as it would be applied to hospices October 1, 2005.

We are deeply concerned over the immediate financial impact this proposed rule would make on multi-county areas we serve in Florida and Alabama. Of the eleven branches we operate, nine are negatively affected by the proposed rule and these nine comprise 94% of our patient base. The projected cut in reimbursement, proposed to be effective less than four months from now, would be \$1,195,000 for Covenant, representing 2.2% of our overall operating budget and effectively our entire operating margin.

Covenant is a relatively large not for profit hospice committed to offering hospice care to all patients in need, without regard to ability to pay. We have made a distinct commitment to the more rural areas of our communities where healthcare access is already difficult. Our ability to make this type of adjustment in so short a period of time is going to prove to be difficult at best. Please consider our Comments, and a request that the Rule be reconsidered in its application.

Sincerely,



Dale O. Knee
President/CEO

cc: Don Schumacher, Psy D., President/CEO, NHPCO
Judi Lund Person, Vice President, Division of Quality End-of-Life Care
NHPCO

June 28, 2005



Merrimack
Valley Hospice

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286-P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Dr. McClellan:

I am writing on behalf of Merrimack Valley Hospice in Lawrence, Massachusetts in response to the Proposed Rule: Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006, CMS-1286P. First let me thank you for the opportunity to comment on the proposal and the issues that will dramatically hurt our ability to care for the dying in our community.

360 Merrimack St.
Building 9
Lawrence, MA 01843
Fax: 978.552.4599
Phone: 978.552.4543
1.800.475.8335

Merrimack Valley Hospice is a community based, non-profit agency serving Northeastern Massachusetts and Southeastern New Hampshire. We have an average daily census of over 175 consisting mainly of Medicare and Medicaid recipients.

I am very concerned regarding the impact on our ability to deliver hospice care – and on our ability to hire competent staff that will result from the proposed movement from using geographic MSAs to using the new CBSAs. I strongly disagree with the statement in the rule that “.....we (CMS) do not believe that in the aggregate, hospice agencies would be impacted negatively by the new CBSA designations.” Nor can I agree with the statement in the proposed rule; “the variability of CBSAs that can be attributed to different hospice agencies are sufficient to mitigate adverse effects on individual hospice agencies.” These changes will in fact be devastating to Merrimack Valley Hospice. They will result in a loss of revenue of over \$400,000 on a \$10M budget. In addition, because all the hospitals in our service areas have been reclassified into the higher Boston CBSA we will see a differential of more than 10% between our wage index and that of our neighboring hospital one mile away. Our ability to compete in the labor market will be seriously impacted as the wage index of the CBSAs may have very little relationship to the actual cost of labor in our area. In an era of nursing shortages and mandated staffing ratios in hospitals, hospice programs will be competing with hospitals for staff which will put our hospice program at a severe disadvantage. The goal of hospice care is to keep the patient at home, thus providing a cost savings to the Medicare system. If the inequity of the pay continues, our hospice will be unable to recruit nurses and may have to deny admissions to some beneficiaries for lack of staffing. It is likely that these beneficiaries may then be placed in a hospital or other facility, a far more expensive alternative with far less quality at the end of life. In addition the changes have Merrimack Valley Hospice going from one MSA to four CBSAs all with different wage indices. We only have one pay scale. We do not pay nurses differently if they care for a dying patient in Lawrence or Lowell Mass down the road.

As I understand it, the regulatory intent of the movement to more “refined” geographic areas under CBSAs was to produce a more local wage index so as to reduce reliance on (hospital) geographic reclassification as a means of redressing inappropriate payment levels. In fact, the hospital experience in Massachusetts under CBSAs indicates that just the reverse has been true for our state. With the publication of the FY2005 pre-floor, prereclassification FY2005 hospital wage index, the former Boston/Suffolk MSA, was broken into a number of new CBSAs, including three in areas directly surrounding and within 30 miles of the center of Boston. **Since the publication of that rule, virtually every hospital – 29 by our count - in the new CBSAs of Worcester (49340), Essex (21604) and Middlesex (15764) has been geographically reclassified by CMS to the Boston/Suffolk (14484) CBSA.**

Another presumption inherent in this hospice rule is that using *hospital* data to calculate *hospice* indices is appropriate as local wage and worker migration patterns are equitable within regions across various sectors of the health system. Yet, CMS has also now recognized in granting such large scale hospital reclassifications that there are patterns of worker migration and salary scales within hospitals in Eastern Massachusetts that warrant continuing to place them in the Suffolk/Boston index area. (If such patterns of migration are presumed to exist for hospitals, they must also be present for hospices whose workers by nature of the site of care (homes) are more mobile.)

These two contrary presumptions - that hospital wages and work patterns apply nationally to hospices, but that they are not applies equally in Eastern Massachusetts - must be addressed with changes to this rule. To not do so would be to create severe disincentives for providing hospice care to patients in several major counties within 25 miles of Boston, particularly Essex County where most of our patients reside. As the chart below indicates, the movement to CBSAs has created large parity issues in areas that - through the hospital geographic reclassification process – CMS has already acknowledged are unsustainable:

2006/CBSA	2005 Wage Index	2006 Wage Index	% Difference 2005 – 2006	% difference from Suffolk
21604/Essex	1.1972	1.1339	-5.29	10.4%
15764/Middlesex	1.1972	1.1899	-0.61	5.2%
49340/Worcester	1.1972	1.1694	-2.32	7.0%

In addition to how these changes affect Medicare reimbursement, they also directly affect our Medicaid payment rates that in Massachusetts are directly tied to Medicare rates.

Recommended Actions

I recognize that no specific statutory directive exists to grant to hospices the right to *request* geographic reclassification. However, I believe that the Secretary of CMS has broad latitude to address within the final rule wage index inequities that could result in access issues for Medicare beneficiaries.

I strongly request that CMS use the final rule to recalculate hospice wage indices in CBSAs where movement from MSA to CBSA results in a disparity (in a contiguous previous MSA) of more than 5% *and where hospitals in these new CBSAs have already been reclassified*. Such a recalculation should at a minimum grant to these hospices a transition period. HGCAM would suggest: 67% old MSA 33% new CBSA (or complete parity?)

Alternatively CMS could also reconsider its decision to not propose any transition for hospices experiencing a decline from MSA to CBSA. In this scenario, we would propose that for hospices with decreases of more than 2% in their wage index, CMS provide an opportunity for a phased-in or blended rate over the next 2-3 years, which establish a wage index for FY 2006 which is a blend the 2005 MSA with the 2006 CBSA.

I appreciate the opportunity to offer these comments on Medicare Program: Wage Index Program FY'06 and hope you will give consideration to our interest in minimizing the adverse affect they will have on our hospice program and our ability to care for the terminally ill patients and their families of our communities.

Thank you again for the opportunity to discuss my concerns. I know you will consider the harm you will cause if no accommodations are made and trust you will find a reasonable solution that will not put those in need of hospice care in jeopardy.

Sincerely,

A handwritten signature in black ink that reads "Joan Stygles Hull RN". The signature is written in a cursive style with a large initial "J" and "S".

Joan Stygles Hull RN
President/CEO
Merrimack Valley Hospice

Please accept these comments on CMS 1286-P.

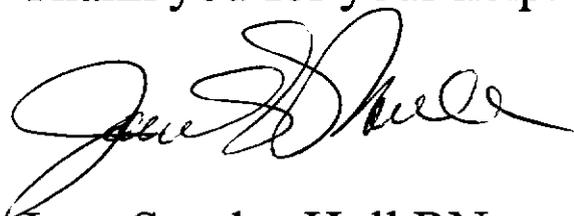
The comment closing time was to be 6/28/2005 at 5PM.

I attempted to send these comments electronically on the morning of 6/28/2005 and again in the afternoon but the "Dockets Open for Comment" did not include CMS 1286-P. See web page below;

<http://www.accessdata.fda.gov/scripts/oc/dockets/comments/commentdocket.cfm?AGENCY=CMS>

I called CMS at 877-267-2323 to see what the problem was but received no call back in response to my message.

Thank you for your help.

A handwritten signature in black ink, appearing to read "Joan Stygles Hull". The signature is fluid and cursive, with the first name "Joan" being the most prominent.

Joan Stygles Hull RN
President/CEO
Merrimack Valley Hospice
360 Merrimack Street, Building 9
Lawrence MA 01843
(978)-552-4001

MELISSA L. BEAN
8TH DISTRICT, ILLINOIS

COMMITTEE ON FINANCIAL SERVICES
COMMITTEE ON SMALL BUSINESS

24

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Washington, DC 20515-1308

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www.house.gov/bean

June 28, 2005

JUN 28 2005

Dr. Mark McClellan
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: CMS-1286-P, "Implementation of Revised Labor Market Designations"

Dear Dr. McClellan,

I am writing to provide comment on the proposed rule updating the Medicare hospice wage index for Fiscal Year (FY) 2006 published in the Federal Register on April 29, 2005 ("proposed rule"). Specifically, I write to request your careful review and reconsideration of CMS' proposed implementation of revised labor market designations for purposes of hospice wage indexing for FY 2006 (CMS-1286-P, "Implementation of Revised Labor Market Designations").

Given the challenges inherent in administering a program of Medicare's size and complexity, I commend CMS' attempts to ensure fairness and efficiency in delivering services to the 40 million Americans who rely on Medicare. Regardless of your agency's hard work and diligence, however, efforts at updating or proposing changes to Medicare policy no doubt almost always result in "winners" and "losers" who feel the effects of your decisions in different ways.

As you may know, in its decision on new Census Bureau standards for defining Metropolitan and Micropolitan Statistical Areas (MSA) issued on December 27, 2000, the Office of Management and Budget (OMB) urged federal agencies to exercise careful consideration in utilizing these units constructed purely for statistical uses for purposes of administering programs and devising policy used to determine eligibility for and the allocation of Federal funds. Specifically, OMB advised that "[p]rograms that base funding levels or eligibility on whether a county is included in a Metropolitan or Micropolitan Statistical Area may not accurately address issues or problems faced by local populations, organizations, institutions, or governmental units (65 FR 82228-82229)."

One result of the new Census standards was the identification of a new Core Based Statistical Area (CBSA) "metropolitan division" of the Chicago MSA called "Lake County-Kenosha County, IL-WI" (CBSA code number 29404). Prior to this designation, Lake County, IL was classified only as being a part of the greater Chicago MSA. Of all the Illinois counties that comprised the greater Chicago MSA, Lake County is the only one to become its own new CBSA.

I understand the rulemaking process is time consuming and complicated. However, while discussion of the appropriateness of the creation of the new Lake County-Kenosha County CBSA is outside the scope of this correspondence, I am concerned that your proposal to immediately and unconditionally transition to the new labor market area definitions and wage index values may be unnecessarily rigid.

As outlined by the proposed rule, hospice providers in Lake County will now see a wage index value of 1.0998, compared to other Illinois hospice providers in the rest of the Chicago MSA which will see a wage index value of 1.1558 (CBSA code number 16974). I am concerned that this proposed value may not accurately reflect the costs of labor in Lake County and that the wage index value assigned to the eight other Illinois counties in the Chicago MSA may more accurately reflect wages in Lake County. In fact, some of the other Illinois counties in the Chicago MSA are further away from the Chicago city boundary and considerably more rural than Lake County. Not only does the disparity in wage indices within the Chicago MSA confound hospice providers in Lake County, but the new value of 1.0998 will represent a considerable and unexpected decrease in Medicare payments for hospice services in Lake County. The results of this decrease could manifest through higher costs for Lake County hospice providers and increased barriers to hospice care for some of my constituents.

There is precedence for CMS allowing for more general forms of transitional assistance to providers who are negatively impacted by a new labor market definition. As noted by the authors of the proposed rule, CMS' final rule for FY 2005 Medicare Hospital IPPS changes instituted several transitional mechanisms to assist hospitals in adjusting to new labor market areas and wage index values (69 FR 49032-49034). One such mechanism that might be applied to hospices under a final FY 2006 hospice wage index rule was the blending of old and new wage indices for hospitals negatively impacted by the final FY 2005 Medicare Hospital IPPS rule. Unfortunately, the proposed rule categorically dismisses the prospect of transitional assistance for hospice providers negatively impacted by a new labor market area definition.

The authors of the proposed rule fail in explaining why their interpretation of federal law precludes similar transitional assistance for hospice providers. I understand that hospice providers are not required to submit uniform data on their costs the way hospitals are, but I am uncertain that this presents a statutory barrier to considering temporary transitional assistance for hospices similar to the forms of transitional assistance employed by the final FY 2005 Medicare Hospital IPPS rule changes. Further, the authors of the proposed rule fail to explain their assumption that "adjustments to CBSAs because of negative impact would necessitate adjustments to CBSAs that are positively impacted (70 FR 22398)." This clearly was not the same logic employed by CMS when hospitals were offered multiple forms of transitional assistance through the final FY 2005 Medicare Hospital IPPS rule changes.

I urge CMS to consider instituting a transition process to assist hospice providers and Medicare beneficiaries during the implementation of a new hospice wage index rule. I

would also urge CMS to reexamine the wage index value assigned to the Lake County-Kenosha County CBSA to determine whether it is the most accurate representation of labor costs for this area.

Please do not hesitate to contact Nathan Fenstermacher in my office at 202-225-3711 if you require further information or seek additional comment on the proposed rule. I look forward to receiving your response and reading the next published rule discussing the FY 2006 hospice wage index changes.

Sincerely,

A handwritten signature in black ink that reads "Melissa L. Bean". The signature is written in a cursive style with a large initial "M".

Melissa L. Bean
Member of Congress

MLB/NF

MELISSA L. BEAN
8TH DISTRICT, ILLINOIS

COMMITTEE ON FINANCIAL SERVICES
COMMITTEE ON SMALL BUSINESS

Congress of the United States
House of Representatives
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www.house.gov/bean

June 28, 2005

To Whom It May Concern,

Due to a printing and formatting error, the comments from U.S. Representative Melissa Bean dated and submitted June 27, 2005 regarding the CMS proposed rule on hospice wage index changes (CMS-1286-P) contained several typos on the second and third pages. These comments were delivered by courier and deposited in the appropriate drop slot at HHS.

Please accept these comments dated and submitted June 28, 2005 for comment consideration on the proposed rule, and disregard the comments of June 27, 2005.

If you have any questions regarding this comment submission, please contact me at he congresswoman's office, 202-225-3711.

Thank you,



Nathan Fenstermacher,
Legislative Assistant

CMS-1286-P-7

25
(no attachment)

Submitter : Jill Lampley
Organization : Hope of Southwest Florida, Inc.
Category : Hospice

Date: 06/27/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Note: CMS did not receive an attachment to this document. This may have been due to improper submission by the commenter or it may have been a result of technical problems such as file format or system problems.

26

CMS-1286-P-8

Submitter : Jill Lampley
Organization : Hope of Southwest Florida, Inc.
Category : Hospice

Date: 06/27/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1286-P-8-Attach-1.DOC

Attachment to #8

Annual Update to the Hospice Wage Index

Hope of Southwest Florida, Inc. is making comments to the Medicare Program; Proposed Hospice Wage Indexes for Fiscal Year 2006; Proposed Rule.

We are the sole hospice provider in CBSA 15980, Cape Coral – Fort Myers, FL. The proposed rule will decrease the wage index from 1.0462 to .9966, a reduction of 4.96%. The proposed rule will cause immediate and lasting undue hardship and has the potential to comprise clinical care standards for Hope of Southwest Florida, Inc. We are urgently requesting a consideration of exemption to the proposed rule due to its impact that will severely impair our ability to remain competitive in hiring qualified healthcare professionals

The hospice wage index is used to adjust payment rates for hospice agencies to reflect local differences in area wage levels. Realizing that the wage index is based on the most current available hospital wage data, in this case 2002, this creates an anomaly that needs to be reviewed to assist CMS in fully considering all the issues in this proposed rule.

The table below shows an 11.3% increase in wages from 2001 to 2004 the most current available year. Certainly not a decrease in wages as is contained in the proposed rule. Wages in this CBSA have grown 20.1% growth over the last five years.

DEMOGRAPHICS	2000	2001	2002	2003	2004*
Employment	186,535	195,306	201,266	208,376	217,391
Population	440,888	454,918	475,073	495,088	521,253
Unemployment	2.6%	3.2%	4.0%	4.0%	3.6%
Average Wage	\$25,409	\$27,427	\$28,466	\$29,264	\$30,524

* Employment and Unemployment are estimates for the 12 month period 11/03 - 11/04

2004 Annual Review Lee County Economic Development Office

In such a dynamic environment, it is critical to the mission of hospice to be able to attract and hire qualified staff. The constraint imposed by the current and continuing healthcare worker shortage has been and remains exacerbated in our CBSA. Adding to this is the continued growing concentration of Medicare eligible recipients which currently represents over 25 percent of the CBSA's total population. By reducing the wage index component of our reimbursement it implies a decrease in average wages in our CBSA, the data disputes this fact. If this wage adjustment is allowed to go forward our agency will not be able to remain competitive in salary offerings to healthcare professionals and will cause us to lose current staff to other healthcare providers. The economics of our CBSA are unique from the greater economic trends of our country. This is due in large part to the concentration of elderly in our service area and should be given considerable attention prior to implementing the proposed rule.

The hospital wage index used to calculate our rate is based on FY 2001 data. This wage rate represents an anomaly in wage information provided from the largest hospital in the CBSA. The hospital system experienced uncharacteristic financial conditions that required a cutting of staff and freezing of wages, thereby lowering the average wage. This information was obtained from the CFO of the hospital. Wage index data that is four years old is not representative of the current marketplace in Cape Coral – Fort Myers, FL.

The following Table shows statistics from numerous sources regarding the tremendous growth of this CBSA.

WHAT OTHERS HAVE TO SAY ABOUT LEE COUNTY

Inc. Magazine ranked Fort Myers - Cape Coral 9th among it's top 25 medium metropolitan cities for entrepreneurs (2005).

Forbes magazine ranked Fort Myers - Cape Coral 2nd among the Top 150 Cities for Job Growth in 2005.

U.S. Housing Markets ranked Fort Myers - Cape Coral as the number one housing market in a metropolitan area in the nation for the second year in a row. (2004)

The Milkin Institute named Fort Myers - Cape Coral best performing city in the nation for job growth in the 2004 survey of Best Performing Cities: "Where America's Jobs are Created."

The **U.S. Census Bureau** has named Cape Coral the 5th fastest growing city in the nation. (2004)

The Boyd Study, Inc. found Fort Myers - Cape Coral 5th among the top 50 locations in the nation to locate a corporate headquarters. (2004)

Time magazine featured Lee County in their November 24, 2003 cover story as one of the "Hot Towns" for jobs.

POPULATION CHARACTERISTICS

Fort Myers-Cape Coral is one of the fastest-growing metro areas in the United States.

Already half a million strong, Lee County's population is expected to grow nearly 20% between 2004 and 2010. Lee County is now dominated by working-age people. In fact, Lee County's 18-24 year old population (those available to enter the workforce) is growing about twice as fast as that of Florida and many times faster than that of the United States. *Forbes, Inc.* and *Money* magazines have recognized Fort Myers-Cape Coral as one of the top places to live and do business in the country.

Submitter : Mr. Brian Gragnolati

Date: 06/27/2005

Organization : Suburban Hospital

Category : Hospice

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1286-P-9-Attach-1.DOC



SUBURBAN HOSPITAL

Healthcare System

June 27, 2005

Comments by Suburban Hospital on CMS-1286-P; Issue Identifier "Implementation of the Revised Labor Market Designations"

In accord with the Montgomery Hospice and in support of their position, Suburban Hospital respectfully disagrees with the placement of Montgomery County in CBSA 13644 Bethesda-Frederick-Gaithersburg, MD. Montgomery County should not be removed from Metropolitan Washington's current CBSA (47894) Washington-Arlington-Alexandria DC-VA.

In support of Montgomery Hospice's position, Suburban Hospital references data from the Maryland Health Services Cost Review Commission (HSCRC). The HSCRC, whose mandate is to regulate the charges of hospitals, has recognized a disparity in the wage rates of the individual hospitals for many years.

The HSCRC, through an annual survey process which has been refined over the more than 25 years of its existence, isolates hospital wage rate differentials, for all positions by zip code, for its use in setting hospital charges.

According to the most recent HSCRC data published (based upon February 2004 survey data), the five Montgomery County Hospitals have labor costs averaging 7.2 percent above the state average. In comparison, Frederick Memorial Hospital, located in Frederick County, has labor costs only 3.1 percent above the state average. Similarly, Washington County Hospital, located in

Hagerstown, has a wage rate differential that is 3.4 percent below the state average. Though this observation is made on hospitals, it clearly demonstrates that Montgomery County's healthcare providers face much higher labor differentials than the state average and the providers of Frederick and Washington counties.

In conclusion, if one recognizes the wage rate disparity for the Montgomery County hospitals to be a proxy of that experienced by the Hospice, then the re-alignment of the Montgomery Hospice into a comparison group operating in a very different market will impose an unwarranted hardship upon the program.

Sincerely,

A handwritten signature in black ink that reads "Brian A. Gagnolati". The signature is written in a cursive style with a large initial 'B' and a distinct 'A'.

Brian A. Gagnolati
President and CEO
Suburban Hospital Healthcare System

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(No attachment
Received)

Submitter : Mr. Fred Kagarise
Organization : MidMichigan Health
Category : Hospice

Date: 06/27/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Note: CMS did not receive an attachment to this document. This may have been due to improper submission by the commenter or it may have been a result of technical problems such as file format or system problems.

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CMS-1286-P-11

Submitter : Ms. Susan Young
Organization : Granite State Home Health Association
Category : Hospice

Date: 06/27/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1286-P-11-Attach-1.DOC



(603) 225-5597
(800) 639-1949
Fax (603) 225-5817
Eight Green Street, #2
Concord
New Hampshire
03301-4012

June 27, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1286
P.O. Box 8012
Baltimore, MD 21244-8012

**Re: CMS-1286-P
Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2006**

Dear Sir/Madam:

Granite State Home Health Association submits the following comments on the proposed rules relative to the Proposed Hospice Wage Index for Fiscal Year 2006, published in the *Federal Register* on April 29, 2005.

Our major concern rests with the use of the Core-Based Statistical Areas (CBSAs) first published in the hospital in-patient payment rules in 2004. While CMS does not anticipate significant impact on hospices *in the aggregate*, we anticipate a major impact resulting from the removal of the four southern New Hampshire counties from the Boston MSA. In fact, we recently assessed the impact on New Hampshire home health and hospice providers of application of the proposed rules related to hospital reimbursement, including the new CBSAs, and we concluded that applying these indices will result in significant losses for New Hampshire providers serving the non-rural counties in our state.

The New Hampshire Environment. All but two of the state's Medicare-certified hospices are housed within home health agencies, and most of these are non-profit visiting nurse organizations. Of the two free-standing hospices, one is a local non-profit, while the other is part of a national proprietary chain. The hospice programs in New Hampshire also tend to be small, with modest daily census and modest revenues. Any changes in Medicare payments have a dramatic financial impact on these small programs and on programs that do not have a national base to counterbalance variations in revenues in particular geographic regions.

Six of New Hampshire's counties are designated as "rural," and the four southern counties in the more densely populated region of the state are non-rural. Until now, those four non-rural counties have been considered part of the Boston MSA. Under the new rules, providers in these

counties will experience a dramatic drop in their wage index as most of their patients reside in one of the two New Hampshire CBSAs. However, personnel costs at these programs will not decrease at all.

The healthcare labor pool here is highly mobile, and healthcare employers in southern New Hampshire find themselves competing with Boston and suburban Boston healthcare organizations. Likewise, home health and hospice programs compete most intensely with the hospitals and other health facilities in their local communities. Thus, hospice providers are keenly concerned with the competitive forces not only in their own area, but in neighboring regions as well.

Recommendations on the Hospice Wage Index

Our comments are guided by two principles that we believe should govern the application of the wage index. First, we believe any rules affecting payment systems should strive to assure some reasonable level of parity with the hospitals in a given region. Second, significant shifts in payment levels from year to year should be minimized to allow providers to manage their operations and avoid negative consequences to patient care. Payment changes driven by somewhat arbitrary statistical methodologies do not necessarily reflect actual cost experiences and should not drive reimbursement levels.

We have been exploring several alternatives that could address our concerns with the application of the pre-floor, pre-reclassification hospital wage index to both hospice and home health payments. The following options have some merit, and should be considered by CMS.

1. *Ensure Hospital Parity* – Apply to hospice services the same wage index that is applied to the hospitals in an area.
2. *Apply the Rural Floor* – Similar to the option above, hospitals in a CBSA or MSA where the wage index is lower than that applied to hospitals in the rural sections of the state will be subject to the higher rural index. The same rural index should be applied to hospice services delivered in that hospital's county. Application of the rural floor to hospice and home health services will result in hospital parity.
3. *Establish a Two-Three Year Transition for Significant Index Changes* – In order to provide some predictability for providers, CMS should establish some range for year-to-year changes. For example, if the wage index for an area decreases by more than 3% in one year, the change would be phased in over 2-3 years.

We hope that CMS will consider these and other options to make the hospital wage index a fairer, more equitable tool for adjusting rates for hospice services.

Thank you for the opportunity to comment on the proposed hospice wage index rule.

Very truly yours,

Susan M. Young
Executive Director