Submitter : **Date: 07/12/2005**

Organization :

Category : **Drug Association**

Issue Areas/Comments

Background

Background

I was admitted to the hospital for infection in my hip. I returned home to find out I was disqualied from Medicade for being in the hospital for 30 days or longer.

Submitter : **Mr. Warren Harris** **Date: 07/18/2005**

Organization : **Humility Of Mary Health Partners**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow “Attach File” button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Robin Warren** **Date: 07/29/2005**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to respond to file code CMS-1301-P. I feel that this is a good change. There need to be improves that are made to Medicare and Medicaid. There were only slight adjustments that were made to the 2005 amount and the 2006 amount. Changes need to be made so that the people who really need Medicare and Medicaid becasue if they didn't have those they may go without medical treatment.

Submitter : **Brian Ellsworth** **Date: 08/25/2005**

Organization : **Joint State Associations Comment Letter**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

See attachment.

GENERAL

GENERAL

See attachment.

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

See attachment.

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment.

CMS-1301-P-4-Attach-1.PDF

Connecticut Association for Home Care
Home & Health Care Association of Massachusetts
Home Care Association of New Hampshire
Vermont Assembly of Home Health Agencies
Associated Home Health Industries of Florida
Ohio Council for Home Care

August 24, 2005

Dr. Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
Sent via Electronic Transmission

Re: **CMS-1301-P**, Medicare Program: Home Health Prospective Payment System Rate Update for CY 2006

Dear Dr. McClellan,

On behalf of the undersigned associations, representing home health agencies serving over 525,000 Medicare beneficiaries annually, we are submitting the following comments on the proposed update notice for the home health agency (HHA) prospective payment system (PPS) for CY 2006. These comments focus exclusively on the inaccurate and inequitable **wage index** used in the HHA PPS.

Our comments and the enclosed proposal are based on the presumption that the Centers for Medicare & Medicaid Services (CMS) will, absent significant input to the contrary, finalize the home health rate update with a one-year transition identical to what has recently been finalized in payment rules for hospices, skilled nursing and inpatient rehabilitation facilities: a 50-50 blend of wage indices based on the labor market definitions for 2006 Metropolitan and Core-based Statistical Areas.

For reasons outlined below, we strongly believe that the presumed CMS transition approach, while helpful in some circumstances, is inadequate because the solution only addresses the issues created by the proposed change in labor market definitions. **The real problem is that the wage indices are becoming increasingly divorced from the actual economic reality faced by home health agencies for reasons that can, and must be addressed.**

Given the unparalleled discretion accorded to CMS by Congress on the home health wage index,[1] we see no statutory impediments to addressing the wage index problems through the modest changes proposed herein. We also propose a methodology for regions with no hospital data for the wage index calculation and a framework for a longer–term solution after the transition expires.

Background

In theory, the wage index is supposed to measure the relative variation in the cost of labor faced by home health care providers. Since the advent of PPS in 2000, CMS has repeatedly asserted that the "pre-reclassification, pre-floor" wage index based on hospital data is a viable measure of such variation for home health agencies.

Unfortunately, relatively recent policy decisions have had the effect of destabilizing the wage index and increasing the disparity between the wage index and the economic reality of home health agencies. Prior to FY 2004, the typical year-to-year changes in the HHA wage index for most of the regions were in the +/- 1 to 2 percent range. Subsequent to that time, the year-to-year variability has gone up significantly (see Table at the beginning of **Attachment A).**

The problems boil down to two main areas: **inaccuracies** in the wage index methodology and **lack of parity** with hospitals.

Inaccuracies in the Wage Index Methodology

Causes of Wage Index Distortion. **Attachment A** highlights two case studies that illustrate the kinds of distortions that have been introduced into the wage index calculation: 1) the exclusion of Critical Access Hospitals (CAHs) and, 2) variability in pension & post-retirement benefits. The CAH exclusion issue helps to explain the increased year-to-year variation in the wage index, while the pension and post-retirement issue illustrates how a wage index can become misrepresentative for a specific region.

These are only some of the reasons why the pre-reclassification, pre-floor wage index can become misrepresentative of economic reality for home health agencies. Other examples include deletion of certain hospital labor costs from the wage index calculation, hospital occupational mix adjustments and allocation of hospital home office overhead costs. A casual reading of the wage index portion of the Final Rules for inpatient hospital PPS from the last few years reveals a long list of concerns. Although these issues can create biases that either help or hurt individual wage index regions, the one thing that they have

[1] Section 1895(b)(4)(C) of the Social Security Act merely states: "The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E)."

in common is that they tend to have very little to do with the labor market realities faced by home health agencies.

Analysis of the Collective Effect of Inaccuracies. To evaluate the collective effect of these issues on the accuracy of the wage index, we turned to an independent database developed by the Bureau of Labor Statistics (BLS) – the Occupational Employment and Wage Statistics found online at: http://www.bls.gov/oes/oes_dl.htm. These data are familiar to CMS as they are used in the occupational mix adjustment to the hospital wage index. For a full description of the methodology employed, please see **Attachment B**.

Conclusion. During the time period in question (1999 - 2002), the BLS data shows clear patterns of differences between the 2002 average hourly wage as estimated by incorporating the BLS data versus the 2002 hospital average hourly wage calculated according to the current wage index methodology.[2] Those differences are material in some cases and they are entirely consistent with the issues we have identified. Accordingly, the enclosed proposal employs the BLS data as an independent benchmark to assess the need for relief. The "BLS-Adjusted Benchmark Wage Index" does not contain distortions introduced from the exclusion of CAHs or fringe benefit accounting disparities, among other things.

Disparity Between Hospitals and Home Health Agencies

Large and Growing Problem. By our count, hospitals now have up to eight different ways to receive relief from an inaccurate or inappropriate wage index, while home health agencies have none. Since 1996, there have been four major changes to Medicare laws[3] that have accorded additional avenues of wage index relief to hospitals, so this is a large and growing problem.

Parity Ratio Concept. To analyze the extent of the differences between what hospitals receive as a wage index and what home health agencies receive, we developed the concept of a "**hospital parity ratio**." Briefly, it is the ratio of the average[4] wage index received by hospitals in a region (after reclassifications, rural floor, etc) to the pre-reclassification, pre-floor wage index received by home health agencies. It is a measure of the degree to which hospitals are being paid at a different rate for their labor costs than home health agencies. The methodology is described more fully in **Attachment C**.

Using the hospital parity ratios, we estimate that in only about one-third of the counties does a hospital actually receive a similar wage index to that which is applied to the home health patient.[5] Parity ratios in the other two thirds range from 1.01 to 1.27, with a raw

[2] 2002 is the cost report base year for the CY 2006 wage index.
[3] BBA of 1997, BBRA of 1999, BIPA of 2000 & MMA of 2003.
[4] Weighted by each hospital's total wages from the same time period - see Attachment C for full explanation.
[5] Similar being defined as less than 1% different, on average.

average of 1.06 across all 3238 counties. While the average hospital parity ratio is high enough in its own right, it masks some even more significant disparities. See **Attachment C** for specific examples and a discussion of their consequences.

Inaccuracy and Parity problems are Inter-related. A lack of safety valves, such as geographic reclassification and the rural floor, mean that many home health agencies end up being stuck with inaccurate and unfair wage indices. Hospitals, on the other hand, generally do not have to live with the consequences of unfair or inaccurate wage indices if they are eligible for reclassification or the rural floor, or if they successfully apply for CAH status. Consequently, in many regions (especially those subject to the rural floor) there may be little incentive for hospitals or CMS to rectify either unintended consequences on other providers or bad data, because they have little practical effect for hospitals. The independent wage data from the Bureau of Labor Statistics verifies these concerns.

Proposal for CY 2006: Modifications to the Presumed One-Year CMS Transition

Criteria

In developing a proposal to begin to address the problems of inaccuracy and parity, we first examined the considerations for wage index reform developed by the National Association for Home & Hospice Care (NAHC). The considerations were:

"*NAHC would support alternatives beyond that presented above [addressing the change in labor market definitions] if they address the following considerations:*

1. *Impact on care access and financial stability of agencies must be measured at the local level;*
2. *Significant swings in wage index cause instability and jeopardize access to care; and*
3. *The use of a hospital wage index -- modified in that it does not include hospital wage index reclassifications nor the application of the rural floor for hospitals -- creates an uneven marketplace for health care employers seeking to hire and retain comparable staff."*[6]

To those considerations, we added two more. Any proposals for wage index reform must:

1. Be simple to administer; and
2. Target relief to areas most in need as demonstrated by objective measures.

We believe that relief is necessary because we do not concur with CMS' assertion that since the wage index is determined by the region in which the beneficiary resides, home health agencies are able to spread the impact of the transition to new labor market definitions over several different regions. First, for most of New England, the wage indices in many contiguous regions are going down. Second, home health agencies tend to serve local markets, something that the most recent CMS Home Health Market Analysis has also observed.[7]

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[6] *NAHC Report* July 11, 2005.
[7] CMS Health Care Industry Market Update – Home Health, September 22, 2003, page 4.

Proposed Modifications to the Presumed CMS Transition

After extensive analysis, we propose the following methodology to modify the presumed CY 2006 wage index transition of a 50-50 blend of the 2006 MSA and CBSA wage indices:

1. **Eligibility for any relief**. Array all counties based on the ratio of the "2006 BLS-Adjusted Benchmark Wage Index"[8] to the actual 2006 pre-reclassification, pre-floor MSA wage index based on hospital cost reports (hereafter the "BLS Ratio"). Only those counties with a BLS ratio > 1.02 would qualify for any relief.[9] 858 out of the 3238 counties examined meet this criterion.

2. **Addressing inaccuracy**. Apply a second threshold to the 858 counties that meet the criterion above: select those counties with a BLS ratio > 1.03. This leaves 591 of the 858 counties eligible for this component of relief. For those 591 counties, the MSA portion of the blend will be the raw average of the applicable 2004, 2005 & 2006 MSA wage indices for home health.[10] This is intended to smooth out the effects of any unjustified reductions during that time period.

   For the remaining counties, the MSA portion of the blend would be the 2006 MSA.

3. **Addressing parity with hospitals**. Apply a second threshold to the 858 counties that meet the test in #1 above: select only counties with a hospital parity ratio > 1.02. This leaves 629 of the 858 counties eligible for parity relief. For those 629 counties, multiply the 2006 CBSA wage index by the parity ratio and blend that with the unadjusted 2006 CBSA on a 50-50 basis – this becomes the CBSA component of the blend for the 629 counties that qualify. This results in essentially a one-quarter parity adjustment for qualifying counties -- envisioned to be the <u>first step</u> in a multi-step process leading to increasing parity with hospitals.

   For the remaining counties, the CBSA portion of the blend would be the 2006 CBSA.

4. **Blend**. Blend the 2006 MSA & CBSA wage indices as defined above on a 50-50 basis.

Attachment D shows the effect of this proposal on the states represented by the undersigned associations.

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[8] See Attachment A for a complete description of the method for using the BLS data as a benchmark.
[9] The threshold is applied in order to ensure that relief is directed to those areas whose relative labor costs are most likely to be currently under-recognized.
[10] The three-year average should be a familiar concept to CMS because it is the statistic that is used by Medicare Geographic Reclassification Appeals Board to determine eligibility for certain reclassifications.

Discussion

This proposal has several features. First, it works from the base of what CMS has finalized for other post-acute providers – i.e., it is not a radical overhaul from what has been implemented elsewhere. It addresses the transition to new labor market definitions, as well as the inaccuracy and equity issues. It meets the criteria specified by NAHC, as well as our two additional criteria – administrative simplicity and objective basis for targeted relief.

In short, it helps to mitigate unwarranted damage to home health agencies during the transition to new labor market definitions, while setting a stage for further reform.

Fiscal Impact

The projected fiscal impact of this proposal for CY 2006 is $45 million when compared to the FY 2005 MSA wage index (using projected 2006 claims utilization in both the numerator and denominator). This is approximately 0.4% of the total labor component of projected 2006 home health expenditures.[11]

It is important to note that, unlike virtually all other providers under Medicare prospective payment, the home health PPS does not have a year-to-year budget neutrality requirement for the wage index update. In fact, our analysis indicates that the update of the wage index from FY 2004 to 2005 removed over $20 million from home health agencies -- a fact unmentioned in the regulatory impact statement last year. Moreover, we believe that the CY 2006 presumed blended transition policy removes another $5-7 million in comparison to FY 2005 wage index.

Given these year-to-year swings, we feel that it is appropriate to propose some modest modifications to the one-year transition in order to begin to ensure that already existing parity and inaccuracy problems are not made worse, and to take **an initial step in the direction of more complete parity**.

Proposal for Regions with No Hospitals

In the notice of proposed rulemaking, CMS solicited input on how to address wage index regions with no hospitals. We do not concur with CMS' proposal to use the FY 2005 wage index. This problem has largely arisen from CMS' policy decision to exclude CAHs from the wage index calculation (please see **Attachment A** for a full discussion).

We strongly recommend that in cases where CMS was able to establish a FY 2003 wage for hospitals (using FYE 1999 cost report data), that it employ the methodology described in **Attachment B** to establish the "2006 BLS-adjusted Benchmark Wage Index" for those regions that no longer have any hospitals. This is the only instance

[11] The CMS Actuary's 2006 Medicare home health projections is $13.6 billion. The labor component is 76.8% of the total projection, or $10.4 billion.

where we propose to use the Bureau of Labor Statistics (BLS) data to directly establish a wage index.

In the case of the Massachusetts rural wage index region, the "2006 BLS-adjusted Benchmark Wage Index" is 1.1431. We believe that this is substantially more accurate than the CMS-proposed value of 1.0216 from FY 2005.[12] **Accordingly, we strongly recommend that CMS use a value of at least 1.1431 for the Massachusetts rural region.**

Framework for a Longer-Term Solution

We believe that the basic concepts employed for the CY 2006 proposal have applicability on a longer-term basis. We are concerned about regions such as New Haven (CT), Essex County (MA), the four southern NH counties formerly in the Boston MSA and De Soto County (FL), all of which will see a further drop in their wage index once the transition is complete. This will exacerbate an already significant hospital parity problem in these and other similarly situated areas. Therefore, once the transition (including our recommended modifications) to new labor market definitions is complete, there should be:

1. **Benchmarking** of the wage indices with an independent data set to determine whether there are unwarranted year-to-year reductions occurring. If so, positive adjustments need to be made to mitigate the unwarranted declines. Regions with a hospital parity problem should have a lower threshold to obtain relief.

2. **Hospital parity ratios** should be recalculated each year and a transition plan developed to move toward fuller parity as fast as independent data indicates is necessary.

3. **Capping** of unwarranted large year-to-year increases in the wage index should be considered; provided there is an independent and objective method to ascertain the extent to which the increase is unwarranted and there is opportunity for notice and public comment by agencies in affected regions.

These longer-run steps could be integrated into a larger refinement of the PPS if the timing works out, but they should not be delayed if the refinement is delayed. We will be happy to provide more detailed recommendations on the specifics of a longer-run proposal at a later date.

Our immediate priority, however, is the implementation our proposals for CY 2006.

[12] We note that our proposed value of 1.1431 is in between the imputed rural floor of 1.07 and the Barnstable County 2006 wage index of 1.26. See Attachment A for a full discussion of the dynamics of the Massachusetts rural region.

We appreciate your consideration of our comments. If you have any questions, please do not hesitate to call Brian Ellsworth at (203) 265-9931.

Sincerely,

Brian D. Ellsworth, President & CEO
Connecticut Association for Home Care

Patricia Kelleher, Executive Director
Home & Health Care Association of Massachusetts

Susan Young, Executive Director
Home Care Association of New Hampshire

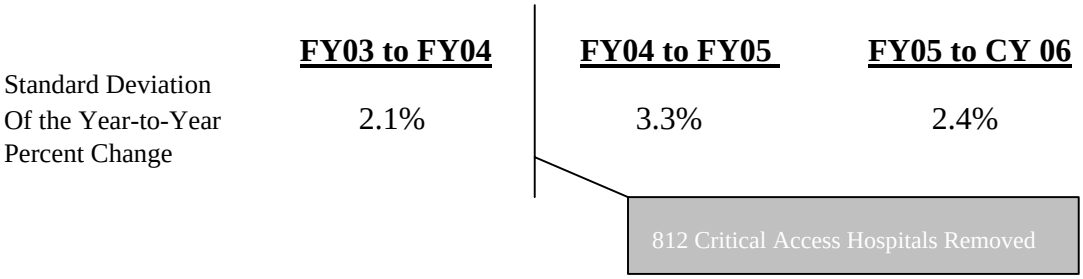
Peter Cobb, Executive Director
Vermont Assembly of Home Health Agencies

Gene Tischer, Executive Director
Associated Home Health Industries of Florida

Kathleen Anderson, Executive Director
Ohio Council for Home Care

Cc: Representative Nancy L. Johnson, Chair, Health Subcommittee of Ways & Means
Representative Ralph Regula, Chair, Labor & HHS Subcommittee of Appropriations
Congressional Delegations of Connecticut, Massachusetts, New Hampshire, Vermont, Florida & Ohio

Increase in the Variability of Year-to Year Changes in the HHA Wage Index
FY 2004 through CY 2006



The degree of year-to-year variation increased by 60 percent from 2003-04 to 2004-05.

Examples of Wage Index Inaccuracies

Exclusion of Critical Access Hospitals. In the hospital inpatient PPS final rule issued on August 1, 2003, CMS announced its decision to eliminate CAHs from the wage index calculation for FY 2004 and thereafter. At the time, the home health wage index was a year behind the hospital wage index, so home health felt the effects of this policy decision in FY 2005. This exclusion of 812 hospitals (over 1,050 today and ultimately could be over 1200[13]) has had the effect of significantly increasing the year-to-year swings in the pre-reclassification, pre-floor wage index.

The exclusion of CAHs acts to systematically reduce wage indices in regions that are not populated by low-cost CAHs -- generally urban counties. Although CMS did analysis on the effect of this policy change on hospitals at the time it was made, it has not undertaken any analyses of the effects in subsequent time periods, nor has the impact on other provider groups been undertaken to our knowledge. The Medicare Payment Advisory Commission (MedPAC) has correctly pointed out that the CAH exclusion issue goes beyond inpatient hospitals, and affects other providers including home health agencies.[14]

An extreme version of the consequences of the CMS policy decision to exclude CAHs occurred in the rural wage index region for Massachusetts. Under the current labor market regions, three counties in Massachusetts are designated as rural: Franklin, Dukes (Martha's Vineyard) and Nantucket. The hospitals on Martha's Vineyard and Nantucket islands were designated as CAHs in 2004, leaving the single hospital in Franklin County as the only rural hospital in MA.

[13] According to the American Hospital Association and the General Accountability Office, respectively.
[14] See wage index section of the 2006 Final Rule for IPPS for a discussion of the MedPAC recommendations in this regard.

For 2006, Franklin County is incorporated into the Springfield wage index region, leaving the state with a rural region but no hospital data to create a wage index. CMS has proposed to use the FY 2005 wage index value of 1.0216 (calculated from the hospital in Franklin County) for the Massachusetts rural region (Dukes and Nantucket Counties) for CY 2006.

However, data reported by CMS in the August 11, 2004, *Federal Register* final rule for IPPS show clearly that the two CAHs in Dukes and Nantucket Counties had average hourly wages in 2003 (the last year before they became CAHs) that are nearly identical to the average hourly wages of hospitals in Barnstable County (Cape Cod), and far higher than the average hourly wage for the hospital in Franklin County:

	Average Hourly Wage FY 2003
Nantucket Cottage Hospital (Nantucket County)	31.1325
Martha's Vineyard Hospital (Dukes County)	29.6084
Cape Cod Hospital (Barnstable County)	31.1041
Falmouth Hospital (Barnstable County)	29.6837
Franklin Medical Center (Franklin County)	24.6149

We see no possible rationale for CMS' proposal to use a wage index based on old data from Franklin Medical Center to set the wage index for Dukes and Nantucket Counties.

We strongly recommend that in cases where CMS was able to establish a FY 2003 wage for hospitals (using FYE 1999 cost report data), that it employ the methodology described in **Attachment B** to establish the "2006 BLS-adjusted Benchmark Wage Index" for those regions that no longer have any hospitals.

In the case of the Massachusetts rural wage index region, the "2006 BLS-adjusted Benchmark Wage Index" is 1.1431. We believe that this is substantially more accurate than the CMS-proposed value of 1.0216 from FY 2005.[15] **Accordingly, we strongly recommend that CMS use a value of at least 1.1431 for the Massachusetts rural region.**

[15] We note that our proposed value of 1.1431 is in between the imputed rural floor of 1.07 and the Barnstable County 2006 wage index of 1.26.

Pension, Post-retirement Health Benefits and Deferred Compensation Costs. Uniform accounting of the accrued liabilities of pension funds has been a long-standing area of controversy in the hospital wage index.[16] Depending on which accounting method is chosen by a hospital, there can be a large effect on the wage index. CMS has acknowledged this problem in the FY 2006 IPPS final rule by formalizing uniform accounting rules for 2007 cost reports going forward.[17] Unfortunately, this policy change won't have an impact on the wage index until at least 2011, due to the time lags involved.

Apart from the "misrepresentative" wage index variation created by inconsistent accounting policies, there is a substantive question about whether hospital post-retirement and deferred compensation costs should be driving variation in wage indices applied to other providers. Some hospitals are restructuring post retirement and deferred compensation retiree benefit packages in ways that have little immediate effect on their cash outlays for wages, but can significantly change their region's pre-reclassification, pre-floor wage index applied to home health care. Is this fair or appropriate, especially given the accounting controversies?

For example, in the Hartford (CT) wage index region, we understand that the two largest hospitals (Hartford Hospital and St. Francis) restructured their retiree benefit packages sometime around 2000-2001. We believe that this change drove the 4.5 percent *reduction* in the HHA wage index from FY 2004 to 2005 (Note: the cost report base year for FY 2004 was 1999, while the base year for FY 2005 was 2001.) The BLS data that indicates that actual cash outlays by hospitals for wages were actually going *up* in that region at approximately the same rate as the national average. The ultimate irony is that the hospitals in question experienced no change in their Medicare reimbursement from this change because their region's wage index is below the rural floor. This is patently unfair and exacerbates workforce recruitment & retention problems for home health agencies in that region.

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[16] The controversy centers around the use of Medicare cost principles or Generally Accepted Accounting Principles (GAAP) to account for pension fund liabilities. In the FY 2006 Final Rule for IPPS, CMS concedes, "Including unfunded deferred compensation costs in the wage index can significantly misrepresent an area's average hourly wage, especially if the plan is never funded." See also "*Review of Windham Hospital's Controls to Ensure Accuracy of Wage Data Used for Calculating Wage Data Used for Calculating Inpatient Prospective Payment System Wage Indexes,*" Office of Inspector General, April, 2005.

[17] See FY 2006 Final Rule for Inpatient PPS, discussion starts on page 370 of the display copy.

Explanation of the Method for Benchmarking the Wage Indices Using BLS Data

In order to evaluate the collective effect on the wage index of the type of issues described in Attachment A, we turned to an independent database developed by the Bureau of Labor Statistics (BLS) – the Occupational Employment and Wage Statistics found online at: http://www.bls.gov/oes/oes_dl.htm. These data are familiar to CMS as they are used in the occupational mix adjustment to the hospital wage index.

Steps to Create the BLS Benchmark Data

1. Determine the typical mix of employees by BLS occupational code for a hospital. See next page for a listing of the occupational codes employed in this analysis. Weights for each category were developed from hospital occupational mix data from the FY 2005 hospital Final Rule and a report by BLS entitled, "Hospital Staffing Patterns in Urban and Non-urban Areas," Wootton & Ross, *Monthly Labor Review*, March, 1995.

2. Calculate a simulated average hourly wage using the BLS data for 1999 (the base year for the FY 2004 HHA wage index) and for 2002 (the base year for the CY 2006 wage index).

3. Calculate the percent change in the average hourly wage for each state between 1999 and 2002 and determine the ratio of each state's change to the national average percent change during that time period (also from the BLS data). A spreadsheet with each state's data follows in one page.

4. Calibrate the results from #3 to the increase in the national average hourly wage as calculated according to the CMS wage index methodology.

5. The product of these steps is called the "**2006 BLS-Adjusted Benchmark Wage Index**." This is an independent estimate of what each region's wage index would be in 2006 substituting the statewide BLS wage cost growth estimate for the region-specific wage & fringe cost growth as calculated from hospital cost reports. The BLS-Adjusted Benchmark Wage Index does not contain distortions introduced from the exclusion of CAHs or fringe benefit accounting disparities (during the relevant time period), among other attributes.

6. The ratio of the 2006 BLS-Adjusted Benchmark Wage Index to the actual 2006 MSA wage index forms the basis for assessing the degree of accuracy of the wage index methodology. This is called the "**BLS ratio**."

Conclusion. During the time period in question (1999 - 2002), the BLS data shows clear patterns of differences between the 2002 average hourly wage as estimated by using the BLS data versus the 2002 hospital average hourly wage calculated according to the current wage index methodology. **Those differences are material in some cases and they are entirely consistent with the issues described in Attachment A**. Accordingly, the enclosed proposal employs the BLS data as an independent benchmark to assess the need for relief.

Occupational Codes & Weights Used to Create BLS Wage Growth Estimates

Occ Code	Title	Weights
11-9111	Managerial & Administration	5.00
13-0000	Business & Financial Operations	1.43
21-1022	Social Workers	1.14
29-0000	Residual Other Health Professional & Technical	9.59
29-1031	Dietitians and Nutritionists	0.33
29-1051	Pharmacists	0.96
29-1111	Registered Nurses	25.88
29-1122	Occupational Therapists	0.48
29-1123	Physical Therapists	0.92
29-1126	Respiratory Therapists	1.36
29-2011	Medical and Clinical Laboratory Technologists	1.73
29-2012	Medical and Clinical Laboratory Technicians	1.26
29-2051	Dietetic Technicians	0.26
29-2052	Pharmacy Technicians	0.88
29-2054	Respiratory Therapy Technicians	0.51
29-2061	Licensed Practical and Licensed Vocational Nurses	3.86
31-0000	Other - Healthcare Support Occupations	7.25
31-1012	Nursing Aides, Orderlies, and Attendants	6.96
31-2011	Occupational Therapist Assistants	0.11
31-2012	Occupational Therapist Aides	0.04
31-2021	Physical Therapist Assistants	0.35
31-2022	Physical Therapist Aides	0.24
31-9092	Medical Assistants	0.93
31-9095	Pharmacy Aides	0.13
35-0000	Food & Beverage Preparation	4.17
37-0000	Cleaning & Building	3.73
43-0000	Office & Admin Support Occupations	17.50
47-0000	Construction & Extraction	1.50
51-0000	Production Occupations	1.50
		100.00

Sources: Hospital occupational mix data from the FY 2005 IPPS final rule and a Bureau pf Labor Statistics (BLS) study entitled, "Hospital Staffing Patterns in Urban and Nonurban Areas," *Monthly Labor Review*, March 1995.

Comments: Calculating wage indices in this manner neutralizes the effects of: hospital occupational mix differences, exclusion of Critical Access Hospitals and accounting differences for fringe benefits. Reliability of the BLS data is increased by reliance on "major" occupational codes and statewide averages. Since the weights are used in both the numerator and denominator of the calculations, any minor inaccuracies in the weights will tend to cancel out.

State-by-State Estimated Growth in Hospital Wages – 1999 to 2002

State	1999 AHW	2002 AHW	2002 Over 1999	State	1999 AHW	2002 AHW	2002 Over 1999
Alabama	$ 14.78	$ 16.89	1.1430	Montana	$ 13.84	$15.75	1.1384
Alaska	$ 19.33	$ 21.89	1.1321	Nebraska	$ 14.64	$17.04	1.1633
Arizona	$ 16.23	$ 19.18	1.1818	Nevada	$ 18.31	$21.77	1.1887
Arkansas	$ 14.27	$ 15.99	1.1204	New Hampshire	$ 16.22	$19.13	1.1792
California	$ 19.49	$ 22.44	1.1515	New Jersey	$ 19.95	$22.12	1.1086
Colorado	$ 17.04	$ 19.97	1.1719	New Mexico	$ 15.21	$17.91	1.1778
Connecticut	$ 19.86	$ 22.51	1.1335	New York	$ 19.29	$22.32	1.1568
Delaware	$ 16.97	$ 20.57	1.2122	North Carolina	$ 15.84	$18.36	1.1593
District of Columbia	$ 18.99	$ 22.58	1.1894	North Dakota	$ 14.30	$16.32	1.1412
Florida	$ 16.20	$ 18.54	1.1442	Ohio	$ 16.27	$18.97	1.1656
Georgia	$ 15.69	$ 18.54	1.1818	Oklahoma	$ 14.56	$16.64	1.1433
Hawaii	$ 19.11	$ 21.32	1.1153	Oregon	$ 17.96	$20.19	1.1239
Idaho	$ 15.16	$ 17.47	1.1520	Pennsylvania	$ 16.87	$18.79	1.1138
Illinois	$ 16.22	$ 18.68	1.1519	Rhode Island	$ 18.14	$20.83	1.1480
Indiana	$ 15.65	$ 17.91	1.1449	South Carolina	$ 15.79	$17.87	1.1316
Iowa	$ 14.42	$ 16.60	1.1517	South Dakota	$ 14.63	$16.22	1.1081
Kansas	$ 15.39	$ 17.01	1.1055	Tennessee	$ 15.40	$17.58	1.1420
Kentucky	$ 15.50	$ 17.27	1.1143	Texas	$ 16.02	$18.39	1.1479
Louisiana	$ 15.03	$ 16.72	1.1127	Utah	$ 15.60	$18.32	1.1745
Maine	$ 15.63	$ 18.27	1.1686	Vermont	$ 16.31	$19.01	1.1653
Maryland	$ 18.69	$ 21.95	1.1745	Virginia	$ 16.35	$19.04	1.1644
Massachusetts	$ 18.79	$ 21.81	1.1610	Washington	$ 19.02	$21.39	1.1251
Michigan	$ 18.00	$ 20.35	1.1304	West Virginia	$ 14.25	$16.18	1.1356
Minnesota	$ 17.90	$ 20.17	1.1269	Wisconsin	$ 16.08	$18.85	1.1721
Mississippi	$ 14.62	$ 15.93	1.0897	Wyoming	$ 14.34	$16.79	1.1708
Missouri	$ 15.41	$ 17.68	1.1473	National	**$ 17.01**	**$19.51**	1.1464

	Year	National AHW	Percent Change
	1999	$17.01	
National BLS Data	2000	$17.85	4.9%
	2001	$18.55	3.9%
	2002	$19.51	5.2%

Note: 1999 is the base year for the FY 2004 home health wage index, while 2002 is the base year for the CY 2006 wage index.

Hospital Parity Ratio Methodology

To analyze the extent of the differences between what hospitals receive as a final wage index and what home health agencies receive, we developed the concept of a "**hospital parity ratio**." It is calculated as follows:

1. Obtain each hospital's final wage index from Table 2 of the inpatient hospital prospective payment system (IPPS) final rule.

2. Obtain each hospital's unadjusted (by occupational mix) total wages from the Public Use Files posted on www.cms.hhs.gov for the hospital inpatient prospective payment system final rule.

3. Calculate the average wage index for each wage index region, using hospital wages as the weighting factor.

4. The "**hospital parity ratio"** is the result of #3 compared to the unadjusted, pre-reclassification, pre-floor wage index for each region. It is a measure of the degree to which hospitals are being paid at a different rate for their labor costs, on average, than home health agencies by the Medicare program.

Examples of Hospital Parity Problems and their Consequences

- In Litchfield County, Connecticut, New Milford Hospital receives a wage index that is 22 percent higher than nearby New Milford VNA. The Administrator of the VNA reports that the hospital's wage scale is significantly higher than the VNA's, imperiling the home health agency's ability to recruit nurses and other workers. The reason for the difference is that the hospital has been reclassified to New York City.

  Had that hospital not been eligible for reclassification, the differential still would have been 7 percent because of the "rural floor."[18] The rural floor creates a minimum of a 7 percent difference between every hospital in that region and every home health agency, ensuring a region-wide wage parity problem.

- In Burlington, Vermont, the hospital parity ratio is 1.185 (i.e., an 18.5 percent wage index differential between hospitals and home health agencies, on average), creating a similar effect on recruitment and retention for the VNA of Chittenden and Grand Isle and Franklin County VNA. This differential results in hospitals routinely "out-bidding" home health agency nurse recruitment efforts. A home

[18] Policy enacted in BBA 1997 which provides that no urban wage index can be lower than the rural wage index for that state.

health agency director in this region whose staff transfer to the hospital reports that outgoing staff has said, "I'm giving up the work I love because I can't afford to not take advantage of what the hospital is offering."

In addition to the hospital parity problem, the Burlington wage index has been *highly unstable*, resulting in significant challenges to home health agency budget planning and operations management:

Period	Burlington Index	Yearly Change	Cumulative Change
October 2000	1.056		
October 2001	1.074	1.7%	1.7%
October 2002	0.988	-7.9%	-6.4%
April 2004	1.005	1.7%	-4.8%
January 2005	0.933	-7.2%	-11.6%
January 2006	0.945	1.2%	-10.5%

This up and down pattern bears no relationship whatsoever to the trends in actual labor costs in this region. The 2006 MSA "BLS ratio" (see Attachment B for a description of the methodology) for this region is 1.086, validating the notion that the proposed 2006 wage index has substantially under-represented the relative labor cost growth in this region from 1999 to 2002 (the base years for the 2004 and 2006 wage indices, respectively).

- New Haven County (CT), Essex County (MA), the four southern counties of New Hampshire and De Soto County (FL) are examples of fairly large regions where the wage index is declining (because of the transition to new labor market definitions), while the hospital parity problem is increasing. When the transition to the new labor market definitions is over, the wage indices for these regions will go down again, exacerbating the already existing parity problems with the hospitals.

Anecdotally, home health agencies from all of the above regions are reporting increased difficulty in attracting and retaining nurses and other healthcare workers due to increased competition with hospitals, the dominant health care employer in all of these regions.

Salary survey data from New Hampshire and Vermont reveals a $3 an hour differential between hospitals and home health agencies for Registered Nurses (RNs) with comparable levels of work experience and credentials. For RNs with specialty backgrounds, the differential is more like $5 an hour. For other disciplines, such as therapy, the differentials are less dramatic, but still significant ($1-2 an hour range).

Impact of the Joint State Proposal on Those States

County and State Name	County Estimated 2006 Home Health Expenditures	Presumed CMS 50-50 Blend Transition Wage Index (from SNF Final Rule)	2006 BLS Adjusted Wage Index Over Actual: "BLS Ratio"	2006 Hospital Parity Ratio	50/50 Blend of 2006 MSA & CBSA as defined in State Coalition Proposal	% Chng Over Prior YR Index	Dollar Impact Over Prior Year Index
Fairfield County, Connecticut	$ 60,456,211	1.2394	0.97	1.05	1.2394	1.1%	$ 530,460
Hartford County, Connecticut	$ 68,006,518	1.1073	1.03	1.07	1.1349	2.7%	$ 1,394,138
Litchfield County, Connecticut	$ 14,283,161	1.1073	1.03	1.07	1.1349	2.7%	$ 292,806
Middlesex County, Connecticut	$ 11,592,537	1.1073	1.03	1.07	1.1349	2.7%	$ 237,648
New Haven County, Connecticut	$ 63,827,238	1.2042	1.03	1.07	1.2298	0.4%	$ 177,131
New London County, Connecticut	$ 19,075,530	1.1345	1.03	1.03	1.1440	-1.3%	$ (196,823)
Tolland County, Connecticut	$ 7,881,550	1.1073	1.03	1.07	1.1349	2.7%	$ 161,572
Windham County, Connecticut	$ 7,121,901	1.1730	1.04	1.00	1.1872	-0.4%	$ (20,730)
Barnstable County, Massachusetts	$ 28,954,433	1.2600	1.06	1.00	1.2656	2.6%	$ 578,985
Berkshire County, Massachusetts	$ 13,438,319	1.0181	1.02	1.10	1.0181	-2.5%	$ (255,074)
Bristol County, Massachusetts	$ 44,624,849	1.1072	1.04	1.03	1.1178	-1.0%	$ (340,377)
Dukes County, Massachusetts	$ 1,168,343	1.0216	1.12	1.00	1.1205	9.7%	$ 86,836
Essex County, Massachusetts	$ 55,963,761	1.0858	1.08	1.06	1.1053	-2.1%	$ (903,166)
Franklin County, Massachusetts	$ 5,315,800	1.0232	1.12	1.06	1.0573	3.5%	$ 142,820
Hampden County, MA	$ 38,384,427	1.0256	1.08	1.06	1.0514	3.4%	$ 987,822
Hampshire County, MA	$ 10,491,006	1.0256	1.08	1.06	1.0514	3.4%	$ 269,986
Middlesex County, MA	$ 103,471,086	1.1175	1.02	1.02	1.1175	-1.0%	$ (809,439)
Nantucket County, MA	$ 532,311	1.0216	1.12	1.00	1.1205	9.7%	$ 39,564
Norfolk County, Massachusetts	$ 49,219,722	1.1368	0.98	1.00	1.1368	0.7%	$ 261,157
Plymouth County, Massachusetts	$ 33,356,303	1.1368	0.98	1.00	1.1368	0.7%	$ 176,986
Suffolk County, Massachusetts	$ 43,399,986	1.1368	0.98	1.00	1.1368	0.7%	$ 230,277
Worcester County, MA	$ 56,386,960	1.1103	1.03	1.02	1.1193	-0.9%	$ (373,395)
Belknap County, New Hampshire	$ 4,107,988	1.0817	0.93	1.05	1.0817	8.8%	$ 278,358
Carroll County, New Hampshire	$ 3,307,236	1.0817	0.93	1.05	1.0817	8.8%	$ 224,099
Cheshire County, New Hampshire	$ 4,244,921	1.0817	0.93	1.05	1.0817	8.8%	$ 287,637
Coos County, New Hampshire	$ 2,666,778	1.0817	0.93	1.05	1.0817	8.8%	$ 180,701
Grafton County, New Hampshire	$ 4,718,975	1.0817	0.93	1.05	1.0817	8.8%	$ 319,758
Hillsboro County, New Hampshire	$ 19,022,788	1.0766	1.12	1.12	1.1096	-1.7%	$ (251,290)
Merrimack County, NH	$ 7,856,284	1.0766	1.12	1.12	1.1096	-1.7%	$ (103,781)
Rockingham County, NH	$ 13,909,403	1.0776	1.11	1.14	1.1157	-1.2%	$ (126,046)
Strafford County, New Hampshire	$ 6,099,769	1.0776	1.11	1.14	1.1157	-1.2%	$ (55,276)
Sullivan County, New Hampshire	$ 2,626,884	1.0817	0.93	1.05	1.0817	8.8%	$ 177,998
Addison County, Vermont	$ 2,205,193	0.9830	0.97	1.06	0.9830	4.9%	$ 82,195
Bennington County, Vermont	$ 3,322,190	0.9830	0.97	1.06	0.9830	4.9%	$ 123,830
Caledonia County, Vermont	$ 2,385,679	0.9830	0.97	1.06	0.9830	4.9%	$ 88,923
Chittenden County, Vermont	$ 9,017,482	0.9410	1.09	1.18	0.9937	6.6%	$ 457,095
Essex County, Vermont	$ 634,581	0.9830	0.97	1.06	0.9830	4.9%	$ 23,653
Franklin County, Vermont	$ 3,078,870	0.9410	1.09	1.18	0.9937	6.6%	$ 156,067
Grand Isle County, Vermont	$ 560,755	0.9410	1.09	1.18	0.9937	6.6%	$ 28,425
Lamoille County, Vermont	$ 1,590,293	0.9830	0.97	1.06	0.9830	4.9%	$ 59,276
Orange County, Vermont	$ 2,037,187	0.9830	0.97	1.06	0.9830	4.9%	$ 75,933
Orleans County, Vermont	$ 2,343,917	0.9830	0.97	1.06	0.9830	4.9%	$ 87,366
Rutland County, Vermont	$ 5,586,425	0.9830	0.97	1.06	0.9830	4.9%	$ 208,226
Washington County, Vermont	$ 4,428,146	0.9830	0.97	1.06	0.9830	4.9%	$ 165,053
Windham County, Vermont	$ 3,445,554	0.9830	0.97	1.06	0.9830	4.9%	$ 128,428

County and State Name	County Estimated 2006 Home Health Expenditures	Presumed CMS 50-50 Blend Transition Wage Index (from SNF Final Rule)	2006 BLS Adjusted Wage Index Over Actual: "BLS Ratio"	2006 Hospital Parity Ratio	50/50 Blend of 2006 MSA & CBSA as defined in State Coalition Proposal	% Chng Over Prior YR Index	Dollar Impact Over Prior Year Index
Windsor County, Vermont	$ 4,998,885	0.9830	0.97	1.06	0.9830	4.9%	$ 186,326
Alachua County, Florida	$ 11,159,629	-0.8%	1.05	1.00	0.9480	0.2%	$ 19,330
Baker County, Florida	$ 1,067,729	3.0%	0.95	1.00	0.8984	3.0%	$ 24,682
Bay County, Florida	$ 10,540,708	-1.5%	1.11	1.07	0.8313	2.3%	$ 188,306
Bradford County, Florida	$ 1,307,845	-1.1%	1.03	1.08	0.8784	0.7%	$ 7,290
Brevard County, Florida	$ 42,840,125	2.1%	1.04	1.00	0.9874	2.5%	$ 821,990
Broward County, Florida	$ 101,383,881	2.6%	0.99	1.01	1.0432	2.6%	$ 2,045,192
Calhoun County, Florida	$ 806,912	-1.1%	1.03	1.08	0.8784	0.7%	$ 4,497
Charlotte County, Florida	$ 17,169,584	-2.0%	0.99	1.00	0.9255	-2.0%	$ (259,786)
Citrus County, Florida	$ 14,121,344	-1.1%	1.03	1.08	0.8784	0.7%	$ 78,708
Clay County, Florida	$ 7,349,226	-2.6%	1.01	1.00	0.9295	-2.7%	$ (149,854)
Collier County, Florida	$ 22,421,101	-4.0%	0.96	1.00	1.0139	-4.0%	$ (683,362)
Columbia County, Florida	$ 3,718,797	-1.1%	1.03	1.08	0.8784	0.7%	$ 20,727
Dade County, Florida	$ 14,431,426	-1.2%	1.00	1.02	0.9750	-1.2%	$ (134,752)
De Soto County, Florida	$ 120,943,905	-1.1%	1.03	1.08	0.8784	0.7%	$ 674,102
Dixie County, Florida	$ 1,902,492	-1.1%	1.03	1.08	0.8784	0.7%	$ 10,604
Duval County, Florida	$ 1,155,044	-2.6%	1.01	1.00	0.9295	-2.7%	$ (23,552)
Escambia County, Florida	$ 40,694,393	-2.5%	1.07	1.06	0.8345	0.5%	$ 145,346
Flagler County, Florida	$ 19,430,820	0.5%	1.06	1.08	0.8994	1.1%	$ 156,984
Franklin County, Florida	$ 6,344,650	-1.1%	1.03	1.08	0.8784	0.7%	$ 35,363
Gadsden County, Florida	$ 778,723	0.4%	0.98	1.00	0.8688	0.4%	$ 2,280
Gilchrist County, Florida	$ 2,655,961	3.6%	0.94	1.00	0.9033	3.6%	$ 72,858
Glades County, Florida	$ 950,681	-1.1%	1.03	1.08	0.8784	0.7%	$ 5,299
Gulf County, Florida	$ 374,853	-1.1%	1.03	1.08	0.8784	0.7%	$ 2,089
Hamilton County, Florida	$ 1,027,458	-1.1%	1.03	1.08	0.8784	0.7%	$ 5,727
Hardee County, Florida	$ 754,222	-1.1%	1.03	1.08	0.8784	0.7%	$ 4,204
Hendry County, Florida	$ 1,300,318	-1.1%	1.03	1.08	0.8784	0.7%	$ 7,248
Hernando County, Florida	$ 1,651,423	2.3%	0.98	1.01	0.9233	2.3%	$ 29,374
Highlands County, Florida	$ 16,043,406	-1.1%	1.03	1.08	0.8784	0.7%	$ 89,421
Hillsborough County, Florida	$ 10,749,775	2.3%	0.98	1.01	0.9233	2.3%	$ 191,209
Holmes County, Florida	$ 53,381,548	-1.1%	1.03	1.08	0.8784	0.7%	$ 297,531
Indian River County, Florida	$ 1,409,839	3.8%	0.93	1.02	0.9056	3.8%	$ 41,530
Jackson County, Florida	$ 12,288,479	-1.1%	1.03	1.08	0.8784	0.7%	$ 68,492
Jefferson County, Florida	$ 3,357,870	-0.4%	1.01	1.00	0.8683	-0.4%	$ (11,385)
Lafayette County, Florida	$ 840,408	-1.1%	1.03	1.08	0.8784	0.7%	$ 4,684
Lake County, Florida	$ 303,458	-2.9%	1.02	1.00	0.9464	-2.9%	$ (6,651)
Lee County, Florida	$ 29,402,286	-0.2%	1.03	1.00	0.9413	0.4%	$ 100,001
Leon County, Florida	$ 43,928,930	0.4%	0.98	1.00	0.8688	0.4%	$ 128,635
Levy County, Florida	$ 8,607,693	-1.1%	1.03	1.08	0.8784	0.7%	$ 47,976
Liberty County, Florida	$ 2,643,918	-1.1%	1.03	1.08	0.8784	0.7%	$ 14,736
Madison County, Florida	$ 359,046	-1.1%	1.03	1.08	0.8784	0.7%	$ 2,001
Manatee County, Florida	$ 1,377,359	0.1%	0.98	1.00	0.9639	0.1%	$ 1,099
Marion County, Florida	$ 23,008,145	-2.5%	1.05	1.01	0.9043	-1.2%	$ (213,325)
Martin County, Florida	$ 30,085,376	0.8%	0.97	1.00	1.0123	0.8%	$ 177,098
Monroe County, Florida	$ 4,197,149	-1.1%	1.03	1.08	0.8784	0.7%	$ 23,394
Nassau County, Florida	$ 3,866,706	-2.6%	1.01	1.00	0.9295	-2.7%	$ (78,844)
Okaloosa County, Florida	$ 11,064,824	1.0%	1.09	1.00	0.8995	2.4%	$ 201,660

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Okeechobee County, Florida	$ 2,691,339	-1.1%	1.03	1.08	0.8784	0.7%	$ 15,001
Orange County, Florida	$ 45,709,105	-2.9%	1.02	1.00	0.9464	-2.9%	$ (1,001,753)
Osceola County, Florida	$ 10,582,107	-2.9%	1.02	1.00	0.9464	-2.9%	$ (231,916)
Palm Beach County, Florida	$ 102,126,172	-2.8%	0.99	1.00	1.0067	-2.8%	$ (2,232,938)
Pasco County, Florida	$ 36,055,587	2.3%	0.98	1.01	0.9233	2.3%	$ 641,329
Pinellas County, Florida	$ 81,880,611	2.3%	0.98	1.01	0.9233	2.3%	$ 1,456,430
Polk County, Florida	$ 38,753,174	-0.2%	1.05	1.02	0.9043	1.3%	$ 377,108
Putnam County, Florida	$ 5,351,817	-1.1%	1.03	1.08	0.8784	0.7%	$ 29,829
Johns County, Florida	$ 9,627,850	-2.6%	1.01	1.00	0.9295	-2.7%	$ (196,316)
St Lucie County, Florida	$ 18,321,316	0.8%	0.97	1.00	1.0123	0.8%	$ 107,849
Santa Rosa County, Florida	$ 7,460,590	-2.5%	1.07	1.06	0.8345	0.5%	$ 26,647
Sarasota County, Florida	$ 43,903,677	0.1%	0.98	1.00	0.9639	0.1%	$ 35,017
Seminole County, Florida	$ 17,157,578	-2.9%	1.02	1.00	0.9464	-2.9%	$ (376,023)
Sumter County, Florida	$ 3,247,973	-1.1%	1.03	1.08	0.8784	0.7%	$ 18,103
Suwannee County, Florida	$ 2,884,787	-1.1%	1.03	1.08	0.8784	0.7%	$ 16,079
Taylor County, Florida	$ 1,214,509	-1.1%	1.03	1.08	0.8784	0.7%	$ 6,769
Union County, Florida	$ 502,438	-1.1%	1.03	1.08	0.8784	0.7%	$ 2,800
Volusia County, Florida	$ 43,241,286	4.6%	0.97	1.01	0.9312	4.6%	$ 1,537,330
Wakulla County, Florida	$ 1,246,123	-0.4%	1.01	1.00	0.8683	-0.4%	$ (4,225)
Walton County, Florida	$ 2,279,603	-1.1%	1.03	1.08	0.8784	0.7%	$ 12,706
Washington County, Florida	$ 1,454,625	-1.1%	1.03	1.08	0.8784	0.7%	$ 8,108
Adams County, Ohio	$ 1,249,332	0.8874	0.99	1.05	0.8874	1.3%	$ 12,543
Allen County, Ohio	$ 4,463,911	0.9172	1.05	1.00	0.9256	0.0%	$ (802)
Ashland County, Ohio	$ 1,893,138	0.8874	0.99	1.05	0.8874	1.3%	$ 19,006
Ashtabula County, Ohio	$ 4,237,471	0.9005	1.11	1.05	0.9269	-3.7%	$ (120,611)
Athens County, Ohio	$ 1,840,411	0.8874	0.99	1.05	0.8874	1.3%	$ 18,477
Auglaize County, Ohio	$ 2,208,782	0.8973	1.09	1.05	0.9166	-1.0%	$ (16,842)
Belmont County, Ohio	$ 3,707,258	0.7161	1.09	1.12	0.7509	0.8%	$ 22,913
Brown County, Ohio	$ 1,599,645	0.9675	0.99	1.00	0.9675	0.8%	$ 10,179
Butler County, Ohio	$ 11,373,638	0.9283	1.00	1.00	0.9283	2.4%	$ 209,076
Carroll County, Ohio	$ 929,330	0.8935	1.02	1.00	0.8935	0.4%	$ 3,210
Champaign County, Ohio	$ 1,363,936	0.8874	0.99	1.05	0.8874	1.3%	$ 13,693
Clark County, Ohio	$ 6,455,258	0.8688	1.12	1.08	0.8946	-3.1%	$ (152,934)
Clermont County, Ohio	$ 4,714,981	0.9675	0.99	1.00	0.9675	0.8%	$ 30,003
Clinton County, Ohio	$ 1,520,434	0.8874	0.99	1.05	0.8874	1.3%	$ 15,264
Columbiana County, Ohio	$ 5,264,793	0.8837	1.08	1.05	0.9143	-3.9%	$ (158,790)
Coshocton County, Ohio	$ 1,463,854	0.8874	0.99	1.05	0.8874	1.3%	$ 14,696
Crawford County, Ohio	$ 2,242,152	0.9359	1.03	1.05	0.9468	4.0%	$ 68,699
Cuyahoga County, Ohio	$ 60,960,263	0.9198	1.07	1.00	0.9353	-2.8%	$ (1,327,776)
Darke County, Ohio	$ 2,089,122	0.8874	0.99	1.05	0.8874	1.3%	$ 20,974
Defiance County, Ohio	$ 1,464,576	0.8874	0.99	1.05	0.8874	1.3%	$ 14,704
Delaware County, Ohio	$ 2,699,004	0.9867	1.01	1.00	0.9867	1.2%	$ 24,229
Erie County, Ohio	$ 3,348,565	0.8970	0.97	1.01	0.8970	2.4%	$ 61,951
Fairfield County, Ohio	$ 4,344,203	0.9867	1.01	1.00	0.9867	1.2%	$ 38,998
Fayette County, Ohio	$ 1,051,423	0.8874	0.99	1.05	0.8874	1.3%	$ 10,556
Franklin County, Ohio	$ 33,152,917	0.9867	1.01	1.00	0.9867	1.2%	$ 297,611
Fulton County, Ohio	$ 1,757,756	0.9574	1.04	1.02	0.9655	1.4%	$ 18,586

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Gallia County, Ohio	$ 1,361,769	0.8874	0.99	1.05	0.8874	1.3%	$ 13,671
Geauga County, Ohio	$ 2,811,827	0.9198	1.07	1.00	0.9353	-2.8%	$ (61,244)
Greene County, Ohio	$ 4,162,521	0.9022	1.04	1.01	0.9114	-1.3%	$ (40,461)
Guernsey County, Ohio	$ 1,817,779	0.8874	0.99	1.05	0.8874	1.3%	$ 18,250
Hamilton County, Ohio	$ 35,032,765	0.9675	0.99	1.00	0.9675	0.8%	$ 222,924
Hancock County, Ohio	$ 2,333,258	0.8874	0.99	1.05	0.8874	1.3%	$ 23,425
Hardin County, Ohio	$ 1,158,322	0.8874	0.99	1.05	0.8874	1.3%	$ 11,629
Harrison County, Ohio	$ 792,359	0.8874	0.99	1.05	0.8874	1.3%	$ 7,955
Henry County, Ohio	$ 1,124,134	0.8874	0.99	1.05	0.8874	1.3%	$ 11,286
Highland County, Ohio	$ 1,614,332	0.8874	0.99	1.05	0.8874	1.3%	$ 16,207
Hocking County, Ohio	$ 1,003,510	0.8874	0.99	1.05	0.8874	1.3%	$ 10,075
Holmes County, Ohio	$ 765,875	0.8874	0.99	1.05	0.8874	1.3%	$ 7,689
Huron County, Ohio	$ 2,458,456	0.8874	0.99	1.05	0.8874	1.3%	$ 24,682
Jackson County, Ohio	$ 1,295,559	0.8874	0.99	1.05	0.8874	1.3%	$ 13,007
Jefferson County, Ohio	$ 4,225,024	0.7819	1.14	1.09	0.8236	-0.5%	$ (17,220)
Knox County, Ohio	$ 2,127,162	0.8874	0.99	1.05	0.8874	1.3%	$ 21,356
Lake County, Ohio	$ 9,780,614	0.9198	1.07	1.00	0.9353	-2.8%	$ (213,032)
Lawrence County, Ohio	$ 3,077,199	0.9477	1.03	1.00	0.9518	-0.5%	$ (11,367)
Licking County, Ohio	$ 5,297,104	0.9867	1.01	1.00	0.9867	1.2%	$ 47,552
Logan County, Ohio	$ 1,777,330	0.8874	0.99	1.05	0.8874	1.3%	$ 17,844
Lorain County, Ohio	$ 10,896,658	0.9198	1.07	1.00	0.9353	-2.8%	$ (237,340)
Lucas County, Ohio	$ 17,734,877	0.9574	1.04	1.02	0.9655	1.4%	$ 187,526
Madison County, Ohio	$ 1,544,029	0.9867	1.01	1.00	0.9867	1.2%	$ 13,861
Mahoning County, Ohio	$ 13,302,747	0.8726	1.11	1.02	0.8964	-5.8%	$ (593,272)
Marion County, Ohio	$ 2,588,469	0.8874	0.99	1.05	0.8874	1.3%	$ 25,987
Medina County, Ohio	$ 5,061,395	0.9198	1.07	1.00	0.9353	-2.8%	$ (110,242)
Meigs County, Ohio	$ 938,022	0.8874	0.99	1.05	0.8874	1.3%	$ 9,417
Mercer County, Ohio	$ 1,600,609	0.8874	0.99	1.05	0.8874	1.3%	$ 16,069
Miami County, Ohio	$ 4,154,576	0.9022	1.04	1.01	0.9114	-1.3%	$ (40,384)
Monroe County, Ohio	$ 689,552	0.8874	0.99	1.05	0.8874	1.3%	$ 6,923
Montgomery County, Ohio	$ 25,058,552	0.9022	1.04	1.01	0.9114	-1.3%	$ (243,576)
Morgan County, Ohio	$ 550,390	0.8874	0.99	1.05	0.8874	1.3%	$ 5,526
Morrow County, Ohio	$ 907,204	0.9391	0.89	1.00	0.9391	7.2%	$ 50,233
Muskingum County, Ohio	$ 3,644,707	0.8874	0.99	1.05	0.8874	1.3%	$ 36,591
Noble County, Ohio	$ 416,524	0.8874	0.99	1.05	0.8874	1.3%	$ 4,182
Ottawa County, Ohio	$ 1,939,847	0.9248	0.91	1.02	0.9248	5.6%	$ 83,088
Paulding County, Ohio	$ 714,351	0.8874	0.99	1.05	0.8874	1.3%	$ 7,172
Perry County, Ohio	$ 1,346,601	0.8874	0.99	1.05	0.8874	1.3%	$ 13,519
Pickaway County, Ohio	$ 1,782,386	0.9867	1.01	1.00	0.9867	1.2%	$ 16,000
Pike County, Ohio	$ 1,052,867	0.8874	0.99	1.05	0.8874	1.3%	$ 10,570
Portage County, Ohio	$ 5,132,372	0.8982	1.09	1.02	0.9153	1.1%	$ 42,534
Preble County, Ohio	$ 1,556,789	0.8993	0.97	1.01	0.8993	2.7%	$ 31,873
Putnam County, Ohio	$ 1,262,333	0.8874	0.99	1.05	0.8874	1.3%	$ 12,673
Richland County, Ohio	$ 5,808,779	0.8902	0.90	1.00	0.9946	9.2%	$ 411,817
Ross County, Ohio	$ 2,710,537	0.8874	0.99	1.05	0.8874	1.3%	$ 27,212
Sandusky County, Ohio	$ 2,148,350	0.8874	0.99	1.05	0.8874	1.3%	$ 21,568
Scioto County, Ohio	$ 3,606,666	0.8874	0.99	1.05	0.8874	1.3%	$ 36,209

County and State Name	County Estimated 2006 Home Health Expenditures	Presumed CMS 50-50 Blend Transition Wage Index (from SNF Final Rule)	2006 BLS Adjusted Wage Index Over Actual: "BLS Ratio"	2006 Hospital Parity Ratio	50/50 Blend of 2006 MSA & CBSA as defined in State Coalition Proposal	% Chng Over Prior YR Index	Dollar Impact Over Prior Year Index
Seneca County, Ohio	$ 2,639,271	0.8874	0.99	1.05	0.8874	1.3%	$ 26,497
Shelby County, Ohio	$ 1,514,414	0.8874	0.99	1.05	0.8874	1.3%	$ 15,204
Stark County, Ohio	$ 17,889,015	0.8935	1.02	1.00	0.8935	0.4%	$ 61,782
Summit County, Ohio	$ 22,420,196	0.8982	1.09	1.02	0.9153	1.1%	$ 185,803
Trumbull County, Ohio	$ 10,284,873	0.8726	1.11	1.02	0.8964	-5.8%	$ (458,682)
Tuscarawas County, Ohio	$ 3,748,718	0.8874	0.99	1.05	0.8874	1.3%	$ 37,635
Union County, Ohio	$ 983,286	0.9391	0.89	1.00	0.9391	7.2%	$ 54,445
Van Wert County, Ohio	$ 1,067,072	0.8874	0.99	1.05	0.8874	1.3%	$ 10,713
Vinton County, Ohio	$ 448,305	0.8874	0.99	1.05	0.8874	1.3%	$ 4,501
Warren County, Ohio	$ 4,779,338	0.9675	0.99	1.00	0.9675	0.8%	$ 30,412
Washington County, Ohio	$ 2,977,353	0.8270	1.00	1.02	0.8270	-0.2%	$ (4,966)
Wayne County, Ohio	$ 4,024,394	0.8874	0.99	1.05	0.8874	1.3%	$ 40,403
Williams County, Ohio	$ 1,501,172	0.8874	0.99	1.05	0.8874	1.3%	$ 15,071
Wood County, Ohio	$ 3,999,378	0.9574	1.04	1.02	0.9655	1.4%	$ 42,289
Wyandot County, Ohio	$ 957,043	0.8874	0.99	1.05	0.8874	1.3%	$ 9,608

Submitter : Dr. Karen Baranowski **Date:** 08/31/2005

Organization : Home Health & Hospice Care, Nashua, NH

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

The revision of MSA to CBSA has resulted in removing 4 counties in southern NH adjacent to the border with Mass. from the Boston MSA wage index. Home Health & Hospice Care is an $11 million dollar home care and hospice agency that was founded in 1883, serving 36 communities in southern NH and northern Mass. The agency has approximately 300 employees and owns one of only two hospice houses in NH. As southern NH is in essence a commuting distance to Boston, competition for professional staff is a major challenge to providing care. The proposed wage index change will result in further shortfalls in professional staff in NH, as it will result in a dramatic reduction in reimbursement, in an environment that is experiencing rising cost pressures in salaries, benefits and gasoline costs. Staff are migrating to Mass jobs to glean a higher salary. This agency has lost a number of nurses to Mass agencies, and to hospital positions paying higher wages. For example diabetic and wound care clinical educator positions have been vacant for over a year, and both former nurses are now employed in hospital systems in NH and Mass respectively.
HHHC has experience 4 successive years of double digit increases in health care benefit costs for employees, and gasoline costs are rising dramatically. It is virtually impossible for a non-profit to overcome continued Medicare cuts, keep pace with technologocal advances, provide care to increasing numbers of aged and assure desired clinical outcomes without relief from continued erosion of fiscal support.

GENERAL

GENERAL

Accordingly, we strongly endorse the modifications to the wage index proposed by the Joint State Coalition in their comment letter dated August 24, 2005. This proposal begins to address longstanding inequities in the wage index and establishes a framework to address parity with hospitals on labor costs.

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

The inability of home care to reclassify to adjacent counties (in the case of this agency to a Mass county) while the two hospital systems in this city have already reclassified to the Cambridge to Lowell, Mass county for a higher wage index will further increase the lack of parity in professional salaries. The rules governing Medicare reimbursement for home care that state the agency is reimbursed on the basis of where the patient lives is antiquated. Home care agencies are competing in the same employment market as adjacent hospitals for scarce nurses and therapists. It is of paramount importance that parity in reimbursement be achieved to strengthen the community home care infrastructure. Salaries for home care nurses lag behind as much as $2-3.00/hour from tertiary institutions in a competitive nursing shortage that is projected to last to 2025 or longer.
Health care benefits are more costly because agencies do not have the # of employees necessary to achieve a better insurance rates. Coupled with gasoline reimbursement pressures, CMS's actions will have the effect of driving a number of agencies out of business and weaken the community infrastructure for the aging and disabled populations.

Regulatory Impact Analysis

Regulatory Impact Analysis

Congress has long recognized that a strong community infrastructure is the most cost effective way to provide care for the aging demographic of "baby boomers". Home care delivers excellent health outcomes at little cost as compared to hospital admissions. If the proposed wage index changes go into effect, additional challenges in recruitment and retention of qualified staff will occur compromising access to care. Parity for professional staffing salaries will be further compromised due to the inability of home care to recruit and retain staff at similar levels to the adjacent hospitals, whom have all reclassified to a Mass MSA wage level.

Submitter : **Len Sawrey** **Date: 08/31/2005**

Organization : **Comunnity Home Health Hospice**

Category : **Home Health Facility**

Issue Areas/Comments

Background

Background

CMS-1301-P

GENERAL

GENERAL

See attached

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

Hospital Wage Index

CMS-1301-P-6-Attach-1.PDF

Community Home
Health & Hospice

Comfort Care Love

August 31, 2005

Dr. Mark B. McClellan, M.D, Ph. D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1301-P
P.O. Box 8016
Baltomore, MD 21244-8016

Re: **CMS-1301-P: Proposed Hospital Wage Index as Applied to HH PPS Episode Payment Amounts**

Dear Dr. McClellan:

Thank you for the opportunity to comment on the proposed wage index for Home Health Prospective System for calendar year 2006, as presented in CMS-1301-P.

We are concerned about the new classification of Cowlitz County, Washington from a rural designation to a new CBSA (31020). The proposed rate (.9523) is substantially below the Washington rural rate (1.0458). We have one hospital in Cowlitz County and they have been reclassified to CBSA 38900, which is the Portland, Oregon – Vancouver, Washington market area. Columbia County, Oregon and Skamania County Washington have also been included in CBSA 38900, these counties are rural, yet are receiving the higher urban rate (1.1260).

Our agency has to compete for access to the same workforce with the providers in CBSA 38900 and the local hospital. This classification would put us at a disadvantage recruiting and retaining staff.

Having only one hospital in our CBSA makes financial planning difficult by tying us to too small a data base and possibility of large variations in the wage index. We are endorsing the proposal put forth in CMS-1301-P page 40 to "...treat Micropolitan Areas as rural market areas under the HH PPS...". Allowing HH agencies to reclassification to the adjacent CBSA as hospitals can, would be better in addressing this issue long term.

Sincerely,

Len Sawrey
Director of Finance

1035 11th Avenue • PO Box 2067 • Longview, WA 98632 • (360) 425-8510 • Fax: (360) 425-4667
5501 NE 109th Court, Suite A • Vancouver, WA 98662 • (360) 253-4626 • Fax: (360) 253-4859

Submitter : **Janice Victory** **Date: 08/31/2005**

Organization : **Janice Victory**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Centers for Medicare and Medicaid Services:

I am a relative of a thyroid cancer patient, and I am writing to request that Thyrogen? (thyrotropin alfa for injection) be included in the list of drugs available through the Medicare competitive acquisition program (CAP) in 2006.

Thyrogen is crucial for the follow-up of her thyroid cancer treatment, in testing used to determine whether or not she is free of disease or whether her thyroid cancer has recurred or spread and requires further treatment.

It would reduce the quality of care for the Center for Medicare and Medicaid Services to deny access to Thyrogen through the Medicare Competitive Acquisition Program.

I am concerned that your proposed guidelines will exclude Thyrogen from the CAP. Medicare beneficiaries who have suffered from thyroid cancer need Thyrogen to be included in the Medicare Competitive Access Program (CAP).

I urge you to reconsider your guidelines. Please include Thyrogen (thyrotropin alfa for injection) in CAP as soon as possible. Allowing physicians to access Thyrogen through CAP will ensure that Medicare beneficiaries have access to the highest standard of thyroid cancer care without the financial and paperwork burdens that otherwise will occur.

Sincerely yours,

Janice Victory
1829 West Ave K-10
Lancaster, CA 93534

Submitter : **Mr. James T. Kirkpatrick** **Date: 09/01/2005**

Organization : **Massachusetts Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see Attachment

CMS-1301-P-8-Attach-1.DOC

Submitter : **Mr. Todd Rose** **Date: 09/02/2005**

Organization : **Visiting Nurse & Health Services of Connecticut, I**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

The wage indices for our area (Hartford, CT) have been consistently declining over the last few years despite increases in wage and benefit costs. The severe nursing and home health aide shortages in our area have necessitated overall agency wages to increase by an avearge of 5% per year. In order to comptete with area hospitals and recruit and retain skilled nursing staff we have had to increase nursing wages by 7.51% in Fiscal 2004 and 4.73% in Fiscal 2005 while our wage index decreased by 4.29% on January 1, 2005. We can not compete with hospitals in our area for skilled staff since they receive a wage index that is 4.8% higher than ours due to the protection of the rural floor. A protection we do not have. This inequity has effected us for years and as a result, even with raising skilled nursing wages as outlined above, we are not even close to being able to offer competitive salaries. We are interviewing and offering nurses with 3 years experience a starting salary of $27.50 an hour. They are refusing since hospitals are paying the same nurse $30 or more an hour.

Given Connecticut's high cost of living and Medicaid rates that are far below costs, it is difficult to provide a living wage for home health aides.

Accordingly, we strongly endorse the modifications to the wage index proposed by the Joint State Coalition in their comment letter dated August 24,2005. This proposal begins to address longstanding inequities in the wage index and establishes a framework to address parity with hospitals on labor costs.

Submitter : **Mr. richard block** **Date: 09/05/2005**

Organization : **Northwest Healthcare Alliance, Inc**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1301-P-10-Attach-1.DOC

Submitter : **Mr. Patrick Conole** **Date: 09/06/2005**

Organization : **Home Care Association of NYS**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

See attachment

GENERAL

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See attachement.

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

See attachement

Regulatory Impact Analysis

Regulatory Impact Analysis

See Attachment

CMS-1301-P-11-Attach-1.PDF

Submitter : **Mr. William Dombi** **Date: 09/06/2005**

Organization : **National Association for Home Care and Hospice**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1301-P-12-Attach-1.DOC

Submitter : **Mr. Christopher Attaya** **Date: 09/06/2005**

Organization : **Partners Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1301-P-13-Attach-1.DOC

Submitter : **Mrs. Joan Hull** **Date: 09/06/2005**

Organization : **Home Health VNA**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1301-P-14-Attach-1.DOC

Submitter : **Ms. Heather Vasek** **Date: 09/06/2005**

Organization : **Texas Association for Home Care**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

The Texas Association for Home Care is a nonprofit trade association representing more than 700 licensed home and community support services agencies throughout Texas that provide home health, hospice and personal assistance services.

GENERAL

GENERAL

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

We are gravely concerned regarding the impact of the proposed wage index methodology on Harrison, Henderson and Hood counties in Texas. While 23 counties in Texas will benefit from reclassification from rural to urban status, these three counties will see dramatic decreases in their wage index. At a bare minimum, the one year transition schedule for the FY 2006 hospice rates should also be adopted for FY 2006 home health rates in order to temporarily mitigate the impact of this change.

However, these proposed rules highlight the pressing need to re-examine the methodology for determining home health wage indices. We concur with many of the remarks submitted jointly by the Connecticut, Massachusetts, New Hampshire, Vermont, Florida, and Ohio home care associations, but also believe that there needs to be ongoing dialogue between state and national home care associations and CMS in order to determine a more appropriate methodology for home care. The recent spike in gas prices only highlights the unique costs and challenges in delivering Medicare home health services that are not faced by hospitals or other health care providers that CMS can no longer ignore.

Submitter : **Mr. Todd Stallings** **Date: 09/06/2005**

Organization : **Indiana Association for Home & Hospice Care**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

The problems with the wage index are many, but they all conspire to ensure that home health providers are not adequately reimbursed for their work. This is because the wage indices are becoming increasingly divorced from the actual economic reality faced by home health agencies for reasons. I would like to point out the following:

GENERAL

GENERAL

The Indiana Association for Home & Hospice Care (IAHHC) represents 150 providers of home health and hospice services in Indiana. These providers deliver care in all 92 of Indiana?s counties, many of which are rural in nature. IAHHC wishes to comment on the proposed update to the wage index for Medicare home health services.

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

The transition to core based statistical areas leads to inappropriate reclassifications that make it impossible to compete with neighboring urban areas.
It is difficult to understand how certain counties were selected for inclusion in certain CBSAs and how their wage index could reasonably be expected to decrease accordingly. For example, the Bloomington, IN MSA (1020) was reassigned as CBSA 14020 and was expanded to include Greene and Owen Counties as well as Monroe County. As a result, Greene and Owen Counties? wage index decreased from .8727 to .8456. These very obviously rural counties are in contrast to Grant County, which is an industrialized County that has close economic ties to Delaware County, IN. Yet, Grant County remains ?rural? (MSA 15 to CBSA 99915). Of course, in this scenario, Grant County also sees its wage index decrease, from .8727 to .8630.

One particularly egregious example is Madison County, IN. Madison County (City of Anderson, IN) is an industrialized and bedroom county adjacent to Marion County (Indianapolis). The providers in Madison County must compete with Marion County for professionals, including nurses and therapists. Its cost of providing care should be theoretically equivalent to that of Marion County, as it was when it was included in the Indianpolis MSA. Now, Madison County has been assigned to CBSA 11300, and a wage index of .8595, down from .9875, a 13% decrease.

The Hospital wage index is unfair to home health providers.
In theory, the wage index is supposed to measure the relative variation in the cost of labor faced by home health care providers. Since the advent of PPS in 2000, CMS has repeatedly asserted that the ?pre-reclassification, pre-floor? wage index based on hospital data is a viable measure of such variation for home health agencies. However, for many reasons, this is not a valid basis for home health.

One reason for this is the exclusion of Critical Access Hospitals (CAHs) from wage index calculations. In the hospital inpatient PPS final rule issued on August 1, 2003, CMS announced its decision to eliminate CAHs from the wage index calculation for FY 2004 and thereafter. At the time, the home health wage index was a year behind the hospital wage index, so home health felt the effects of this policy decision in FY 2005. This exclusion of 812 hospitals (over 1,050 today) has had the effect of significantly increasing the year-to-year swings in the pre-reclassification, pre-floor wage index. The exclusion of CAHs acts to systematically reduce wage indices in regions that are not populated by low-cost CAHs -- generally urban counties. Although CMS did analysis on the effect of this policy change on hospitals at the time it was made, it has not undertaken any analyses of the effects in subsequent time periods, nor has the impact on other provider groups been undertaken to our knowledge. The Medicare Payment Advisory Commission (MedPAC) has correctly pointed out that the CAH exclusion issue goes beyond inpatient hospitals, and affects other providers including home health agencies.

Over the years, hospitals have received many opportunities to deviate from the wage index for their areas, while home health is left using the original notion of the hospital wage index.

The estimated impact on Indiana counties is greater than that previously announced, and will be unfairly disastrous for providers in certain counties.
In all, sixty of ninety-two Indiana counties lose under the plan. Ten appear not to be impacted, and twenty-two counties gain. Moreover, Indiana as a whole loses an estimated nearly $456,000 in reimbursement. The top eight counties with the most increase gain a total of $787, 354, but the top eight counties with the greatest losses are expected to lose $1,009,597 in wage adjustments.

Regulatory Impact Analysis

Regulatory Impact Analysis

Madison County, cited previously, is expected to lose anywhere from $275,000 to $550,000 from this propoasl, the latter being greater than the cumulative effect on the entire state. Although options for phasing in the cut have been provided to other provider groups, no amount of phase-in can soften the blow of such an enormous, and apparently, arbitraty cut.

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Conclusions
The proposal to move to CBSAs should be suspended until additional analysis can be done and changes made to ensure that counties are appropriately classified.

Home Health Agencies should be allowed to petition for execption from their assigned wage index, just as hospitals do.
The hospital wage index should not exclude Critical access hospitals when used for the specific purpose of determining rates for other providers who operate in the same areas served by the CAHs.
One additional request:
The market basket index methodology fails to account for the large increases in transportation costs brought on by the rising cost of oil and gasoline. Unlike inpatient facilities, the home health care service delivery system is significantly affected by rising gasoline prices, particularly in rural and sparsely populated areas where the distance between patients can exceed 50 miles. However, even in metropolitan areas the cost of transportation has grown dramatically along with the price of gasoline.

Although this comment does not apply to the wage index, CMS should consider offering some relief to HHA providers for this dramatically increasing cost of serving beneficiaries.

Thank you for the opportunity to comment on the proposed changes.

Submitter : **Ms. Tracy Poole** **Date: 09/06/2005**

Organization : **American Association for Homecare**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

Submitter : **Mr. William Delahunt** **Date: 09/06/2005**

Organization : **Mr. William Delahunt**

Category : **Congressional**

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

I am writing on behalf of the home health agencies on Martha?s Vineyard and Nantucket, which are requesting a fairer and more accurate wage index in the Prospective Payment System Rate Update for 2006 (CMS-1301-P).

The Center for Medicaid and Medicare Services (CMS) proposes using the 2005 rural wage index for Massachusetts, which was based on the wage rate of Franklin Medical Center in western Massachusetts, to establish the 2006 wage index for these home health care agencies.

Using a wage index based on one rural hospital at the opposite end of Massachusetts is not a ?reasonable proxy? to use in setting the wage index for the two islands? home health care agencies. The Franklin County wage rate is far lower than the wage rates at the hospitals in Barnstable County, the nearest service area to the islands, according to CMS wage data. The Barnstable County hospitals? rates are close to the rates for the critical care hospitals on the two islands.

Thus it would be more fair and accurate to calculate the islands? home health agency rates on the basis of wage data at the hospitals in neighboring Barnstable County, or on adjusted wage data from the hospitals on the islands. A third option is to use the ?imputed? rural wage index to figure the wage index. Details of these methods are set forth more fully in the attached background memo from the Home and Health Care Association of Massachusetts.

This approach would give the three island home health agencies a wage index that more accurately reflects wages in their service area. The attached background sheet prepared by the Home & Health Care Association of Massachusetts provides additional detail.

I thank you for consideration of these comments. I am hopeful that CMS will take them into account and make appropriate changes to the final home health agencies payment rule.

Regulatory Impact Analysis

Regulatory Impact Analysis

Background Information and Approaches to Calculating
Home Health Rural Wage Index for Massachusetts

Medicare reimbursement rates for home health agencies are adjusted regionally by a Wage Index to account for variations in labor costs around the country. For Home Health Agencies, CMS uses a wage index calculated from hospital wage data. Until 2005, CMS based this calculation on all hospitals within a designated geographic region. Beginning in 2005, CMS has excluded wage data from Critical Access Hospitals in this calculation.

For many years, the ?Rural Massachusetts? geographic area has included Franklin County in the northwest area of the state, Martha?s Vineyard (Dukes County), and Nantucket County. Each of these counties had one hospital, so the Rural MA wage index was calculated using the data from all three.

The wage data from Franklin Medical Center has consistently been far lower than the wage data for Martha?s Vineyard and Nantucket Cottage hospitals. The following hospital wage data was reported by CMS in the Federal Register on August 11, 2004:

2003 average wage
Franklin Medical Center $24.62
Nantucket Cottage Hospital $31.13
Martha?s Vineyard Hospital $29.61

Wage data from the hospitals on Nantucket and Martha?s Vineyard has consistently been far more similar to wage data for the two hospitals on Cape Cod (Barnstable County) than to Franklin Medical Center:

2003 average wage
Falmouth Hospital $29.68
Cape Cod Hospital $31.10

Using wage data from the three rural hospitals, CMS calculated a Rural MA wage index in 2004 of 1.1288. By comparison, the 2004 wage index for Barnstable County was 1.3202.

For 2005, CMS stopped using data from Critical Access Hospitals, so the Rural MA wage index was based only on data from Franklin Hospital. For 2005, the Rural MA wage index dropped to 1.0217 ? a full 10% below the previous year.

For 2006, Franklin County will be incorporated into the Springfield metropolitan area, so there are no longer ANY non-Critical Access hospitals in rural MA. CMS has proposed to simply keep the 2005 rural wage index as a ?reasonable proxy? for 2006. We believe using old data from a single hospital in Franklin

County to set a wage index for Dukes and Nantucket Counties is by no means a ?reasonable? proposal.

There are three alternatives that we believe to be better proxies for calculating a rural wage index for MA:

? Use the 2003 wage data -- updated for inflation -- from Martha?s Vineyard Hospital and Nantucket Cottage Hospital (before they were designated CAHs) to establish a Rural MA wage index for home health. The estimated cost to the Medicare program based on CMS? 2004 Medicare utilization data for these two counties would be only about $300,000, or

? Use the wage data from the hospitals in neighboring Barnstable County as a reasonable proxy to calculate a Rural MA wage index. CMS? own data show that this is a much closer match than the wage data from Franklin Medical Center. Estimated cost: $360,000, or

? Use the ?imputed? rural wage index that CMS has calculated for Massachusetts hospitals. CMS developed this calculation as part of the rule setting inpatient hospital rates in order to establish a hospital rural ?floor? (Federal Register, August 11, 2004). This would raise the current index of 1.0217 to 1.0715. Estimated cost: $65,000.

Prepared by the Home & Health Care Association of Massachusetts
August 2005

Submitter : **Mr. Glenn Hackbarth** **Date: 09/06/2005**

Organization : **Medicare Payment Advisory Commission**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

See attachment

CMS-1301-P-19-Attach-1.PDF

Submitter : **Ms. Laura Friend** **Date: 09/06/2005**

Organization : **WV Council of Home Care Agencies**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

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See attached

CMS-1301-P-20-Attach-1.DOC

Submitter : **Mr. Thomas Galluppi** **Date: 09/06/2005**

Organization : **Illinois HomeCare Council**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

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See Attachment

CMS-1301-P-21-Attach-1.DOC

Submitter : **Ms. Ju-Ming Chang** **Date: 09/06/2005**

Organization : **Healthcare Association of New York State**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

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See Attachment

CMS-1301-P-22-Attach-1.DOC

Submitter : Phyllis Wang **Date:** 09/06/2005

Organization : NYS Association of Health Care Providers, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

Background

Background

Home Health Market Basket

Although required by law, HCP again opposes the implementation of the 0.8% reduction to the market basket. The financial viability of agencies continues to be compromised by ongoing reductions in reimbursement. If the market basket calculation reflects the cost to providers of efficiently providing home health services, the market basket should not be reduced. Home health agencies, which have only recently experienced the financial effects of the Interim Payment System (IPS), M0175, Partial Episode Payment (PEP) and Significant Change in Condition (SCIC) recoupments, continue to experience other financial pressures that are inherent in the health care environment, and thus, additional reductions in the market basket and PPS rates are inappropriate.

HCP was pleased last year that CMS chose to rebase and revise the home health market basket. This was an important step in ensuring that home care providers are adequately reimbursed. CMS has chosen not to rebase and the revise the home health market basket for 2006. HCP strongly urges CMS to revaluate this decision. HCP again recommends, as it did last year, that CMS develop a timely process to rebase and revise the home health market basket to ensure that the rising costs of delivering care and unique changes in the environment are captured each and every year. For instance, the current reimbursement structure has not captured this year's rapidly rising gasoline prices, which have resulted in new costs to home care agencies. To date there is not a mechanism to address new costs such as this.

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On behalf of the members of the New York State Association of Health Care Providers, Inc. (HCP), I am writing to provide comments on the proposed changes to the Home Health Prospective Payment System Rate Update for Calendar Year 2006. HCP is a statewide trade association representing home care and community-based providers through advocacy, information and education. Founded in 1974, HCP represents approximately 500 offices of Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Hospices and related health organizations throughout New York State. Through a strong network of regional chapters and an active State office in Albany, HCP is a primary authority of the health care industry.

General Comments

HCP recognizes that much of what CMS has included in the proposed regulation was dictated by the Medicare Prescription Drug, Improvement and Modernizations Act of 2003 (MMA), including the shift to a calendar year and reductions in the market basket, however, the proposed rule also includes changes in how CMS will calculate the wage index which will have a profound effect on the home care industry. The following are HCP's comments concerning these changes.

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

Wage Index

HCP continues to be extremely concerned about the wage index used for home health agencies. While HCP recognizes CMS' effort to use the most recent pre-floor, pre-classified wage index available, steps must still be taken to begin identifying home health specific data that can be used to ensure the accuracy of the wage index data currently being used. Further, as CMS works to make changes to how the wage index is calculated, HCP requests CMS eliminate the use of the pre-floor, pre-classified wage index and simply use the same wage index as it uses for hospitals. CMS' use of the a pre-floor, pre-classified wage index for home health agencies creates a significant disadvantage for these providers because they must compete for the same workforce as their neighboring hospitals while receiving considerably lower reimbursement based on the rate calculated by their pre-floor, pre-classified wage index.

In addition, in order to diminish the fluctuations that occur in the wage index for home health, a limit on the wage index fluctuation should be established and employed annually. Home health agencies are also at a disadvantage by CMS' refusal to consider requests from home health agencies to change their wage index designation. Hospitals are allowed to request such a change to secure a better rate, and thus, at a minimum CMS should permit a home health agency in the same region to secure the same change. Home health agencies compete with hospitals for the same workforce and remain at a competitive disadvantage because of the wage index limits. CMS has the discretion to make some of these modifications and should do so.

Regulatory Impact Analysis

Regulatory Impact Analysis

Labor Market Areas

HCP has considerable concerns with the proposed changes from the use of the Metropolitan Statistical Areas (MSAs) to the Core-Based Statistical Areas (CBSAs).

Specifically, HCP is very concerned that the change will have a significantly negative effect on New York's rural home health agencies. Further, when CMS issued the final rules that put the use of the CBSA into effect for hospitals and hospice, it allowed for transition periods to mitigate any adverse effect the changes would have on both industries. CMS states that it is not considering a similar transition period be applied for home health agencies. HCP strongly urges CMS to reconsider its decision.

In the proposed rule, CMS states that, 'Unlike the Inpatient Prospective Payment System (IPPS) and some of the other payment systems where each entity uses a single MSA, HHAs may use various wage indices to compute their payments based upon the location of the beneficiary. Therefore, we do not believe in the aggregate, HHAs would be impacted negatively by the new CBSA designations.' HCP disagrees with CMS? assertion, and rather, because many of New York?s rural home health agencies will face significant reductions in reimbursement as a result of the change in designation. Coupled with the elimination of the 5% rural add-on earlier this year, these agencies are facing unprecedented reductions in reimbursement, which will have a significantly harmful effect on their ability to continue to provide services.

HCP strongly urges CMS to implement a transition period for home health agencies similar to that put into effect for hospitals and hospice. Home health agencies must be given the same consideration relative to the changes in their wage index that hospitals and hospice have been given. Home health agencies must be given sufficient time to adjust to the new designations. HCP recommends CMS implement a three-year transition period for HH PPS that includes a mechanism that maintains the wage index at the rate it would have received prior to the implementation of the new designations, thus keeping those agencies that experience a drop in their wage indices as a result of the adoption of the new labor market areas whole. This will allow home health agencies to experience a smooth transition to the new designations.

Following the release of this proposed rule, HCP has participated in a number of discussions with CMS staff concerning the dramatic changes in the wage index and labor market areas that will be experienced by many of the regions in New York State. Based on these conversations, HCP understands that the wage index rates published in the HH PPS proposed rule will be changed to incorporate corrections to the wage index data and will mirror the final rates published in the PPS Skilled Nursing Facilities 2006 final rule. While the corrections may alleviate some problems with specific areas of New York State, HCP is still concerned about the wide fluctuations in the index from the previous year in which some areas will drop close to 7% and other areas will increase over 16%. In particular, the new data will harm New York's rural providers even more with shocking decreases of close to 3% in some areas. While a transition plan will alleviate some of the dramatic changes for this year, it is important for CMS to work on softening the wild fluctuations that affect agencies from year-to-year, including changes of large increases one year followed by large decreases in the next year.

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Outlier Fixed Dollar Loss Ratio

The change CMS made last year to the Outlier Fixed Dollar Loss Ratio, which allows more outlier episodes to qualify for extra payments, was a positive step and one that should be continued. HCP is pleased that CMS states in the proposed rule that it is continuing to analyze the need for such an update and will make the necessary updates if the data supports the need. Many agencies have been punished for taking high cost patients. They have been forced to absorb a portion of the costs associated with caring for this type of patient, but have not been able to access outlier payment assistance. Now, the ability to qualify for outlier payments may help alleviate these payment shortfalls.

Rural Add-On

HCP encourages CMS to join HCP in advocating for the re-establishment of the rural add-on for home health services furnished to beneficiaries living in rural areas. Agencies serving rural beneficiaries face many issues including workforce shortages and high travel time. The add-on becomes especially critical in light of the recent decreases in the wage index for rural areas in New York State coupled with dramatically increasing fuel costs.

If HCP can be of any assistance in evaluating specific components of the HH PPS, please do not hesitate to contact HCP staff or me.

Thank you in advance for consideration of HCP's comments.

Sincerely,

Phyllis A. Wang
President

Submitter : Karen Hinkle **Date:** 09/06/2005

Organization : Kentucky Home Health Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

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See Attachment

CMS-1301-P-24-Attach-1.DOC

CMS-1301-P-24-Attach-2.DOC

CMS-1301-P-24-Attach-3.DOC

Submitter : **Mr. Scott Amrhein** **Date: 09/06/2005**

Organization : **Continuing Care Leadership Coalition**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

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See Attachment

CMS-1301-P-25-Attach-1.DOC

Submitter : **Mr. William Dombi** **Date: 09/06/2005**

Organization : **National Association for Home Care and Hospice**

Category : **Health Care Provider/Association**

Issue Areas/Comments

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See attached. These are corrected comments from the earlier submission.

CMS-1301-P-26-Attach-1.DOC

Submitter : **Mrs. Debra Grabowski** **Date: 09/06/2005**

Organization : **VNA of Manchester & Southern New Hampshire**

Category : **Health Care Professional or Association**

Issue Areas/Comments

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See attached letter