June 20, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW, Room 314-G
Washington, DC  20201

Dear Administrator Berwick:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the Wage Index Reform section of the Centers for Medicare & Medicaid Services (CMS) proposed rule, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates, 76 Federal Register 25788, (May 5, 2011).

AHCA is the nation’s leading long term care organization. AHCA and our membership of more than 11,000 non-profit and proprietary facilities are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation’s frail and elderly as well as people with disabilities who live in nursing facilities, assisted living residences, sub-acute centers, and homes for persons with developmental disabilities.

As noted in our comments over the years, AHCA believes that the current area wage index methodology for geographically adjusting Medicare payments is broken, especially for non-hospital providers, and that a new, more accurate wage index methodology is needed. Typically, hospitals can mitigate the effect of well documented shortcomings with the existing hospital wage index using numerous reclassification schemes. Unfortunately, skilled nursing facilities (SNFs) and other post-acute care providers cannot offset these inherent deficiencies in the hospital wage index. By relying on hospital cost report data and failing to incorporate data that reflect the price of labor across the various types of facilities, today’s area wage index methodology places SNFs and other post-acute care providers at a comparative and competitive disadvantage to hospitals, especially those that have been reclassified in their labor market areas. In these instances, SNFs face the same labor market wages as the reclassified hospitals but receive a lower wage adjustment. Long term care is a...
major economic driver of the U.S. economy – accounting for 1.1 percent of the nation’s Gross Domestic Product (GDP), contributing to 5.4 million jobs, supporting more than $205 billion in labor income, and generating $61 billion in tax revenues\(^1\) – which makes maintaining such an imbalance such an overwhelming concern for those communities still struggling in this weakened economy.

**Today’s Area Wage Index Methodology Is Broken**

The current area wage index methodology for adjusting Medicare payments is broken. It does not appropriately, nor adequately adjust Medicare payments for differences in wage rates across geographic regions for hospitals or, especially for post-acute care providers. The Medicare Payment Advisory Commission (MedPAC), Acumen LLC, the Institute of Medicine (IOM) and others have researched and described the deficiencies with the current data and methodology, and made recommendations on reforming the system.\(^2\) The research conducted for CMS by Acumen, LLC shows promise in terms of refining the area wage index. Work by the IOM suggests numerous implementable reforms that could significantly improve the hospital wage index, as well as a wage index for various long term and post acute care (LTPAC) settings. We encourage CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum.

MedPAC’s June 2007 *Report to the Congress: Promoting Greater Efficiency in Medicare* identifies several critical problems with the current area wage index methodology, including:

1. Large differences in wage indexes between adjoining geographic areas that have led to the establishment of numerous exceptions, which allow hospitals to be reclassified to other geographic areas;
2. Implementation of an additional annual occupational mix survey for each hospital to adjust the wage index for the skill level of employees;
3. Circularity in the establishment of the wage index, whereby hospitals located in markets with few providers have the ability to set or influence the wage index for their geographic area through business practices; and
4. Year-to-year volatility of the wage index within a geographic area that does not appear to be related to underlying changes in local labor market conditions.

---


Reclassification Puts SNFs & Other Post-Acute Care Providers at a Competitive Disadvantage

For years, AHCA has advocated that use of an area wage index methodology, which relies on hospital cost report data to create an index for SNFs and other post-acute care settings, is seriously flawed. Hospitals have been able to address to some extent weaknesses in the current methodology through extensive use of numerous hospital geographic reclassification adjustments. The issue is such that approximately forty percent of hospitals have exceptions and reclassifications. CMS’ failure to develop a SNF-specific area wage index and the limitations set by the Congress does not permit SNFs to make similar geographic reclassification adjustments to offset the deficiencies in the area wage index methodology. Consequently, a great divide now exists between the hospital and the SNF area wage indexes in those areas where hospitals have been reclassified. This divide seriously disadvantages SNFs and other post-acute care providers in terms of recruiting and retaining critical direct care staff and offering competitive and perhaps even adequate wages. Such well-documented, systemic weaknesses in the area wage index methodology and reclassification system should not be permitted to continue. Immediate action is needed to fix this inequitable system.

The Institute of Medicine & Geographic Adjustment in Medicare Payment

On June 1, 2011, the Institute of Medicine (IOM) released a report, which is entitled, *Geographic Adjustment in Medicare Payment: Phase 1: Improving Accuracy*. AHCA was pleased that the report identified key principles and made recommendations for reforming the hospital wage index and the physician geographic practice cost index. AHCA is also pleased that the IOM made recommendations for reform for facilities (other than short-term, acute care hospitals) such as skilled nursing facilities or other LTPAC providers. Any reform to the design, development, and implementation of the hospital wage index will eventually be applied to SNFs and other LTPAC settings.

AHCA is encouraged that the IOM recommendation includes data that would come from all health care providers. AHCA remains hopeful that CMS will soon develop a wage index representing the SNF setting that is based on all healthcare employer data and SNF-specific occupational mixes. Such an index for SNFs and other LTPAC settings would adjust for the price of labor and be reflective of the labor markets where we operate, as well as control for our setting specific occupational mixes.

A New Wage Index Methodology Is Needed

Given the extent of the problems with the current area wage index methodology and its lack of application in both hospital and especially LTPAC settings, AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets. We are encouraged that MedPAC, Acumen, and the IOM recognize that a system based solely
on hospital labor cost data is inappropriate. We ask that CMS consider recommendations from MedPAC, Acumen, and the IOM that call for the wages and benefits data, used to create an area wage index to better reflect the price of labor in a broader context, to include SNFs and other post-acute care settings. This coupled with national occupational mix data for each LTPAC setting would make for a much more accurate wage index.

**Wage Index Methodology: A Hospital Only Application?**

AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM. Using BLS-type wage data representing a broad range of care settings would greatly improve the current system and form a solid foundation for a new wage index. AHCA also supports the IOM recommendation, which would allow CMS full access to the BLS data needed to compute the wage index, to use data for all occupations and use fixed national occupational weights for each LTPAC setting to create an index that reflects the national labor share and provider type.

AHCA, however, has a concern regarding the use of Bureau of Labor Statistics (BLS) data to construct a hospital compensation index as recommended by Acumen and the IOM. Our principal concern relates to the sufficiency of the data of the various provider settings in the construction of the wage index for the various provider settings. For instance, the IOM study indicated that IOM did not test the accuracy of the BLS statistics for individual health care settings, such as SNFs. We are also concerned about the accuracy and transparency of the data used to make the adjustments. The IOM correctly noted that the geographic adjustment process should allow empirical review of the data and methods used to make the adjustment. Anonymous BLS survey data from a 3- to 5-year rolling sample of providers in various geographic markets does not allow for empirical review and identification and correction of outlier “erroneous” data.

AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis. For instance, CMS could implement and collect data for a BLS-type survey of certified providers, which could be supplemented with BLS survey data from other provider settings if necessary and as appropriate. Because such data would be collected from Medicare/Medicaid-certified providers, CMS could make the aggregated data available to the public for replication, review, and identification of data anomalies. Alternatively, the BLS survey could be modified to allow for the recording of some type of provider identifier (the Medicare/Medicaid federal provider number, for example), and CMS could require Medicare or Medicaid certified providers to provide this information on the BLS survey to allow CMS to utilize the data for development of the wage index. BLS and CMS could also work together to send the survey out to all Medicare or Medicaid providers annually, with an appropriate indicator for whether the particular provider survey was for the CMS sample frame, the BLS sample frame, or both. Doing so would help to achieve accuracy and transparency goals of the IOM, CMS, and providers and would help to ensure that the data,
methodology, and the wage index for each setting is appropriate, accurate, and reflective of geographic differences in the input price of labor.

Any New Area Wage Index Methodology Should Apply Across Health Care Settings

AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings.

AHCA is pleased with the IOM recommendation that CMS “should use respective labor share and occupation-specific weights” to develop the wage indexes for other non-inpatient prospective payment system (PPS) facilities. An appropriate wage index for the various LTPAC settings, however, goes beyond labor shares and weights, and should be based on data and reflect the price of labor for each LTPAC setting. The BLS collects wage data from 800 occupations and 450 industries. By using all health sector industry data, a wage index reflecting prevailing market wages can be constructed.

Resolving the Boundary Effect Problem

AHCA is broadly supportive of the Acumen and IOM proposals to adjust the wage index to better reflect commuting patterns of employees. Smoothing adjustments according to commuting patterns will go a long way toward ending the desire for geographic reclassification and create a more even playing field where SNFs and other LTPAC providers can compete with hospitals for skilled labor. It is critical that any such adjustment be built on more than hospital commuting patterns. Commuting patterns for health care workers employed by SNFs differ from those of hospital employees. CMS should collect the necessary data from SNF and other LTPAC providers to be able to construct specific commuting pattern adjustments based on provider type or commuting pattern adjustments across the entire healthcare sector. Hospitals are not the focal point of post-acute care labor markets, so any revisions to labor market definitions and commuting pattern adjustments should be appropriately applicable to hospitals and LTPAC settings alike.

We have carefully reviewed all of the current boundary solutions. If any one of them should be implemented, some sort of a phase-in approach would be necessary.

Concluding Thoughts

AHCA again appreciates the opportunity to comment on wage index reform. Clearly, the plethora of reclassification adjustments to circular hospital labor cost data is not the answer. Rather, we believe that a new, broadly applicable area wage index methodology, which does not disadvantage any one provider group, is needed for the Medicare payment system. Work
by Acumen and the IOM point the way toward reforming the system for geographic adjustments to Medicare payment rates. We strongly encourage CMS to review the IOM recommendations and work expeditiously to fix the broken area wage index methodology SNF and LTPAC providers must now use, and even out the field for all Medicare and Medicaid providers.

AHCA welcomes the opportunity to work with you as part of the solution. Please feel free to contact me or AHCA Director of Research, Peter Gruhn, at 202.898.2819 or pgruhn@ahca.org. We look forward to hearing from you on how we may assist CMS in its wage index reform efforts.

Sincerely,

Mark Parkinson
President & CEO
Summary of Recommendations

1. AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings.

2. AHCA encourages CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum.

3. Any reform to the design, development, and implementation of the hospital wage index must be eventually applied to SNFs and other LTPAC settings.

4. AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets.

5. AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM.

6. AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis.

7. AHCA supports the collection of information on commuting patterns for all LTPAC settings, and not just for hospital employees, in order to make adjustments to the wage index methodology to resolve the boundary effect issue.

8. CMS should phase-in any new wage index methodology, particularly one that resolves the boundary effect issue, to allow providers the opportunity to adjust their labor costs over time.