



**American Hospital
Association**

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April 20, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Centers for Medicare & Medicaid Services' Wage Index Report, prepared by Acumen.

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) most recent report on the Medicare wage index, prepared by Acumen. The wage index is not functioning optimally and alternatives should be considered. Thus, we would like to express some of our thoughts and concerns about Acumen's alternative methodology for the wage index, as well as some of the broad principles that we feel should be used in developing, evaluating and implementing changes to the wage index.

Acumen's concept of an alternative methodology for the wage index, which is based on hospital-specific labor markets, as determined by the commuting patterns of hospital employees, is intriguing. In the past, we have expressed concerns that many of the current wage index geographic boundaries are unrealistic and that their structures create "cliffs" whereby adjacent areas have very different indices. By simply being on opposite sides of a geographic boundary, two hospitals can receive very different reimbursement, even though they are competing for the same workforce. On the other hand, use of the "smoothing" approach proposed by the Medicare Payment Advisory Commission, whereby wage index values or wages of neighboring areas are artificially constrained to allow only a certain percentage difference in wage indices, may mask actual variation in wages between areas. Acumen's methodology appears to do away with both of these boundary problems by creating hospital-specific wage indices that will vary to the extent that hospitals hire employees in different proportions from the same or different commuting areas. This is potentially a positive attribute of a wage index that is based on hospital-specific labor markets.



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While Acumen's concept is well thought and intriguing, it is presented as a theory only; most of the details the hospital field needs to fully and properly evaluate this concept are not presented in the report. Chief among these gaps is a full data analysis that shows the manner and extent to which hospital wage indices would change under this concept. Such an analysis is absolutely critical for evaluation of the concept, including evaluation of the potential biases or unintended consequences it may introduce. For example, if this concept were to substantially lower the wage indices of safety-net hospitals or isolated rural hospitals, it could potentially affect Medicare beneficiaries' access to care.

Also critical is a full analysis of potential volatility in wage indices from year-to-year under Acumen's concept. Current volatility makes it difficult for hospitals to estimate Medicare payments for budgeting purposes. This volatility could potentially increase under Acumen's concept – its dependence on employee commuting patterns means that employee turnover could substantially impact a hospital's wage index. In contrast, hospitals need wage indices that are relatively predictable from year-to-year to allow them to recruit and retain a consistent and experienced workforce by paying stable wages.

The key new data requirement in Acumen's concept is commuting data. The report discusses potentially using 2000 Census Transportation Planning Package data on all workers commuting between Census tracts. It also discusses an alternative option of directly collecting data from hospitals on the distribution of their employees' residences by ZIP code. The AHA has questions and concerns about both of these data options, some of which Acumen also shares. For example, in comparing the two data sources, an analysis of the relative accuracy of using Census tracts versus ZIP codes is critical. If the Census data were used, it would be necessary to evaluate how the commuting patterns of workers in all sectors compare to the commuting patterns of workers in the hospital sector. It would also be essential to evaluate whether the Census data, which are from 2000, are too old to be accurate and relevant. Finally, if the hospital data were used, a full analysis of how much burden this would entail for hospitals is needed. Reporting wage data is extremely complex and burdensome; adding an additional level of reporting may be problematic.

The AHA strongly believes that it is critical to maintain a wage index exception process that allows hospitals in areas with misrepresentative indices to seek redress. However, the report does not speak to whether or how reclassifications and exceptions would be considered. In fact, under Acumen's concept, many of the current exceptions to the wage index appear to not be applicable. For example, one of the current ways to obtain a reclassification is through the Medicare Geographic Classification Review Board. Under this method, hospitals apply to reclassify to and therefore obtain the wage index of an adjacent Metropolitan Statistical Area. In addition, the current outmigration adjustment allows wage indices for counties in lower wage index areas to be blended with higher wage index areas in proportion to the number of county residents who are hospital workers and who commute to the higher wage index areas. It is difficult to see how these reclassification policies would continue to exist under Acumen's concept, which creates hospital-specific wage indices.

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Many additional questions arise around the alternative methodology that are not addressed in the report. For example, how would the collection of wage data through the cost report change, if at all? Would the occupational mix adjustment continue? How would the alternative wage indices affect non-acute care general hospitals that are paid under the Medicare hospital wage index? The hospital field needs more complete information before it can fully respond to this concept.

In addition, whenever CMS implements changes to the wage index, there are several general principles that are important for the agency to consider. First, it is important to implement hold-harmless or transitional provisions. Wage index changes would likely redistribute large amounts of funds and hold-harmless or transitional provisions are necessary to allow hospitals to fully prepare for and adjust to the new system.

We also believe it is important for the wage index itself to be as accurate as possible by ensuring that both hospitals and Medicare are able to use consistent definitions, methodologies, rules and interpretations for the acquisition and application of wage data. When hospitals have compared the collection and processes of different fiscal agents used by Medicare, they have found differences in the collection and/or processing of the data that underlies the wage index.

Finally, in order to assure that the adjustments made by the Medicare wage index are correct, hospitals must be able to examine and verify the data used to construct the index. The wage index has a significant impact on the payment hospitals receive under the inpatient prospective payment system and the process must be transparent so that the data used may be examined and verified.

If you have any questions, please feel free to contact me or Joanna Hiatt Kim, senior associate director for policy, at (202) 626-2340 or jkim@aha.org.

Sincerely,

Rick Pollack
Executive Vice President