Appendix A
Written Statements
(in chronological order)
March 29, 2012

Mr. Joseph R. Swedish
President and CEO
Trinity Health
27870 Cabot Drive
Novi, MI 48377

Dear Joe,

It’s been noted that you are in the Witness Protection Program due to your Chairmanship of the AHA Wage Index Task Force. I know your Task Force has had multiple inputs regarding this subject and while I’m certain much of this is repetitive, please let me share some of our experience in East Tennessee.

When I became the CEO of Covenant Health in 2000, the Area Wage Index for the Knoxville MSA was .9199. By 2009, it had been reduced to .7855 which is below the rural floor! This, of course, resulted in all of our hospitals, including our 3 urban tertiary facilities being paid at the rural floor. During this period we, and other hospitals/systems in our MSA, gave raises to our employees every year. In fact, we have the largest SEIU-organized hospital in Tennessee so wage rates have consistently increased. However, we aggressively attacked labor costs, eliminating higher paid overhead positions, reducing non-clinical positions, expanding spans of control, improving productivity, reducing employee benefits costs thru wellness investments, benefit redesign, etc. These cost reductions drove our wage index down even though the cost of living in the region compared to the national cost of living did not change significantly. A further consequence of these substantial reductions in Medicare reimbursement is the significantly reduced payments by commercial payers, Medicare HMO’s and TennCare, which all benchmark off of Medicare rates.

These collective reductions in reimbursement have been very significant and much larger than the labor and benefit cost reductions that drove this result. The net result of this has been devastating to our hospital market in which it is nearly impossible to achieve a margin despite the efficiency and effectiveness of hospital providers. This is evidenced by the fact that the East Tennessee Baptist Health System, which was very profitable in the
1990's was driven to the brink of bankruptcy by the mid 2000's. Catholic Healthcare Partners (CHP), which already had a large presence in East Tennessee, ultimately acquired the remnants of Baptist for assumption of debt. CHP, due primarily to these reimbursement reductions, began to experience large losses at its formerly successful hospitals resulting in a decision to sell to HMA in 2011. Their main reason for selling was that, despite the fact that their key operating metrics were some of the best in their system; the low reimbursement situation (driven by the Medicare wage index) made it "impossible to earn a margin or to generate capital for needed investments." Thus, the decision to sell. Collectively, the entire market of all hospitals in our region has had a negative operating margin for the last 6 years with no prospects for recovery unless something occurs on the wage index front.

What are the solutions? Clearly, too much of Medicare reimbursement is tied to the wage index. Energy costs, supplies, pharmacy, implants, medical devices, capital equipment, IT, physician recruitment, etc. all have increased just as they have across the nation and are an increasing part of the total cost picture. Secondly, hospitals should be rewarded for efficiency and those that do not aggressively deal with labor and benefit costs should not be protected by Medicare reimbursement.

As stated previously, Medicare reimbursement frequently drives commercial rates and, in some states, Medicaid rates further exacerbating the inappropriate reduction of reimbursement for cost reductions. Clearly, basing the labor portion of Medicare reimbursement on individual hospitals' behavior as opposed to some measure of cost of living in a region is not appropriate and creates unintended results.

In summary, please let us know if there is anything further we can do to communicate how damaging this has been to our region's hospitals and how it dis incentizes hospitals from reducing healthcare costs. Thank you for taking on this very important assignment.

Best wishes,

[Signature]

Anthony L. Spezia
President/CEO
July 31, 2012

Mr. Joseph R. Swedish
President and CEO
Trinity Health
27870 Cabot Drive
Novi, MI 48377

Rich Umbdenstock
President/CEO
American Hospital Association
Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004

RE: Wage Index

Gentlemen,

The latest wage index data for fiscal 2013 further exacerbates the devastating wage index problem with significant reductions to some of the lowest indices in the nation. The hospitals in major regions of Tennessee and Alabama are literally being destroyed by the wage index. The rural floor continues to drop as does the actual wage index for hospitals in these and other regions. There is no basis in cost-of-living or cost-of-wages data to support the 15-20% reduction in the wage index that has occurred at Covenant’s hospitals during my tenure as CEO of our system. The AHA Board must support a floor that will allow well-run hospitals to continue to provide services to our communities. This has reached the crisis stage with hospital closures likely to result. The negative implications, publicity, and other actions related to hospital closures due solely to a flawed reimbursement system, will not serve the hospital industry or AHA well.

While I am not privy to the alternatives being considered by the Wage Index Task Force or the AHA Board, an increased rural floor of .85 or so would provide some relief and could be justified based on objective BLS data. Additionally, AHA has taken strong positions on issues of equity (disparities in care, health coverage for all, etc.). This issue has become a matter of equity for a significant minority of hospitals who do not have “special deals” and corrective action on the part of AHA is critical. I have enclosed a copy of my original letter to the Wage Index Task Force as further background.

If there is anything that I or the other affected organizations can do, please let me know.

Very truly yours,

[Signature]

Anthony L. Spezia
President/CEO
Covenant Health
Richard J. Umbdenstock  
President/CEO  
American Hospital Association  
325 Seventh Street, N.W.  
Washington, DC 20004  

Dear Rich:

We are looking forward to your joining us for the November 5 meeting of the CHA Board. We know well the value of field unity and welcome the opportunity to discuss strategies to maintain it in the face of the difficult issues at hand. We look forward to discussing AHA and CHA priorities, specifically the work of the Area Wage Index Task Force, and also discussing the broader array of entitlement reform and potential deficit reduction issues facing hospitals.

The CHA Board determined that input should be solicited from the membership in preparation for sharing Connecticut’s perspective with you. As a first step, CHA’s Committee on Hospital Finance reviewed AHA’s payment policy advocacy issues, reviewed the Connecticut impact of various options, agreed on a position to recommend on AHA’s wage index task force policy, and weighed in on alternatives during its October meeting. The Committee’s discussion and decisions were reviewed with and confirmed by hospital CEOs, as well as the Executive Committee of the CHA Board. The Committee’s conclusions and recommendations are summarized on the attachment.

We recognize and appreciate the significant alignment between AHA and CHA in most federal issues areas. We also fully understand the value of and strength in unity—and the corresponding risk associated with splintering and competing factions. We work very hard to maintain unity within the state on divisive issues, and appreciate the success we have enjoyed as a result.

The problem for Connecticut hospitals is that unity with AHA on the Area Wage Index Task Force recommendation comes at too great a cost. Our consideration of the recommendation was done in the broader context of overall Connecticut hospital impact of existing and potential federal payment policy, and we simply cannot support it because of the extreme negative impact on Connecticut. Our specific concerns are described in the attached summary.

We look forward to your presentation and perspective, and to constructive dialogue regarding our concerns. Again, we much appreciate the opportunity for a substantive discussion with you on these critical issues at this critical time.

Sincerely,

Jennifer Jackson  
President and CEO
Conclusions and Recommendations of the Committee on Hospital Finance
of the Connecticut Hospital Association Board of Trustees

At its October meeting, the Committee on Hospital Finance of the CHA Board reviewed AHA’s payment policy advocacy issues, reviewed the Connecticut impact of various options, agreed on a position to recommend on AHA’s wage index task force policy, and considered various alternatives. The Committee’s discussion and decisions were reviewed with and confirmed by hospital CEOs, as well as the Executive Committee of the CHA Board.

The Committee concluded that there is alignment between AHA and CHA in many federal issues areas, including:
- the need for restoration of extenders, specifically for Medicare Dependent Hospitals and low volume hospitals;
- concern regarding the pending “sequester” cuts;
- the need to avoid alternative/additive cuts being considered in the areas of IME, update factor, GME, evaluation and management, and bad debt;
- the RAC program; and
- observation stays.

Where the alignment ceases is on wage index policy. The Committee’s consideration of the Wage Index Task Force recommendations was done in the broader context of overall Connecticut hospital impact of existing and potential federal payment policy.

Under existing law, from 2012-2021, cuts to Connecticut hospitals in Medicare payments (as a result of PPACA, sequestration cuts, CMS permanent coding cuts, and elimination of the Medicare-Dependent Hospital program) will total $3.6 billion.

If all the additional Medicare cuts under consideration are added (including E&M, coding, update factor, bad debt, elimination of Sole Community Hospital program, IME, DME, and the wage index recommendation), the cuts nearly double, totaling $6.5 billion over the same period.

The Committee also considered the impact of federal reimbursement policy on Connecticut hospitals over the past 16 years (1997 – 2013) and the projected impact over the next eight (2014 – 2021). The net impact to Connecticut through 2013, without implementing the AHA Area Wage Index proposal, is a cumulative loss of $1.3 billion relative to the national average.

If the changes are implemented as proposed by the AHA Area Wage Index Task Force, the national average increase becomes .10% higher, but it comes at a huge cost to Connecticut hospitals. Connecticut loses another .61% per year, which results in Connecticut receiving rates of increase ranging from 30% to 40% below the national rate of increase for nearly a quarter century.
Noting that Connecticut has received increases significantly below the nation for the past 16 years, and this wage index proposal, if implemented, would extend that deficit for the future, the Committee concluded that CHA should not support the AHA Area Wage Index Task Force recommendation because of the extreme negative impact on Connecticut of the recommendation.

The Committee was particularly concerned about the add-ons provided to index values below 1 and recommended that the current application of the index to a lower percent of the payment and the proposed exponential add-on should be removed.

In addition, the Committee made four recommendations pertaining to broader national hospital funding policy:

1. There should be a national strategy to assure that as the innovation and change envisioned by the PPACA are introduced to the financing system, no hospital receives less than a minimum increase in its overall Medicare funding during the transition.

2. There should be a review to assure that states, Medicaid, and exchanges are delivering on the promise of expanded access and adequate funding for the services purchased. In instances where these PPACA objectives are not being met, there must be a means for swift corrective action.

3. States choosing not to implement PPACA coverage expansion should not benefit from increased DSH funding. Untapped coverage expansion funds should be used to help states implementing the PPACA coverage expansion.

4. Alternatives to the sequester should not result in states experiencing a differentially negative impact.

October 2012
November 6, 2012

Richard Umbdenstock  
President and Chief Executive Officer  
American Hospital Association  
325 Seventh Street, N.W.  
Washington, DC 20004

Dear Mr. Umbdenstock:

This letter reflects Susquehanna Health's strong support of the findings and recommendations of the AHA Area Wage Index Task Force. I applaud your efforts to address the ongoing and critical flaws in the wage index system as pointed out by your task force and others - and urge you to continue to fight for a system that is more equitable.

The negative impact of an inequitable system is no better exemplified anywhere in the country than Williamsport, Pennsylvania. Susquehanna Health is surrounded by hospitals that receive higher wage reimbursement for providing the same care under the Medicare program. Additional funding provided by Section 508 was a temporary bridge passed by Congress to address this inequity until a fairer system could be put in place. For Susquehanna Health Section 508 leveled an 8% higher payment made to our closest and most able competitors. Unfortunately, that additional funding has been prematurely terminated resulting in an annual loss to Susquehanna Health of $3.3 million a year. As you can imagine this loss of funding has had an extremely destructive impact on our ability to maintain services to the patients and communities in central Pennsylvania that we serve. Moreover it will force reductions in staff at a time when we already are staffed extremely efficiently.

As you and your staff are aware, there have been several proposals to improve the Medicare wage index system. The MedPAC proposal offered in 2007 would have helped equalize the many cliffs and smoothed the edges of the wage index disparities here as well as other areas in Pennsylvania. Other proposals have been offered by HHS or CMS to no avail, as the hospital community has failed-despite agreeing the system is broken-to reach a compromise on a new system of wage index reimbursement under the Medicare program.

Over one third of the hospitals receive exceptions under the current system, and yet our "exception" via Section 508 funding was ended well before any agreement was struck on addressing the many disparities in the system. I firmly believe that, working together, we can do better, despite the shifting of resources that would need to take place under any changes or modification to the wage index system.
Your task force did an excellent job of identifying the problems with the current system. I would ask you, on behalf of the hundreds of hospitals that are shortchanged by the current system, to continue to make wage index reform a priority, understanding full well that you have many pressing issues as Congress returns for the lame duck session and into the 113th Congressional Session over the next two years. This inequity is catastrophic for the hospitals so impacted and in most cases exceeds many of the enacted and proposed cuts to the Medicare program. I know that is the case here at Susquehanna Health.

It is understandable that this is a contentious and divisive issue for the hospital community. Nevertheless, your task force identified principles and policy recommendations that could be implemented to improve the current system. One of my concerns is that whenever and whatever proposal has been offered in the past, AHA may choose not to support it or at least look at how it may be used as a starting point to reform the system. We must start somewhere. I ask that you make this a personal priority and provide renewed leadership to bring your member hospitals together in an ongoing effort to address this difficult issue. The status quo is unacceptable to me and others that labor under a playing field that is far from level. Let me be clear, any of the proposed solutions would have helped us here at Susquehanna Health.

In closing, I urge you to work with your state hospital association partners to find a solution to this issue. I encourage you to continue to make this an agenda item at AHA Board meetings with regular updates and direct senior staff to continue their work both on the task force and advocacy teams. I suggest you make this issue the focus of one of the meetings during the AHA Annual Meeting in 2013 when all of the state executives meet to discuss important issues. This is not the first divisive issue that AHA has had to negotiate amongst the states and its hospital members. With your commitment to find a solution and leadership to do so, working together, we can do so again. I would be pleased to serve in any capacity that you believe would further our efforts to move forward on this issue.

Sincerely,

Steven P. Johnson, FACHE
President and CEO

SPJ:emm
cc: Carolyn Scanlan
April 8, 2013

Benjamin K. Chu, M.D., Chairman
AHA Board of Trustees
Regional President
Southern California Kaiser Foundation Health Plan and Hospital
393 E. Walnut St.
Pasadena, CA 91188

Dear Dr. Chu,

On behalf of the New Jersey Hospital Association Board of Trustees, we are writing to express our deep concern over the AHA’s Area Wage Index Task Force principles to reform national area wage index policy. We understand the principles will be on the April AHA Board agenda. We respectfully, but strongly, urge the AHA Board to refrain from proceeding with these principles.

The AHA’s principles would have a significant financial impact on our mutual members. With one-third of New Jersey hospitals currently operating in the red, the dramatic changes in AWI policy advocated by AHA could cause very real financial harm to N.J. hospitals and further threaten access to care in our state. Our opposition, however, is based on much more than the local financial interests. The AHA principles lack sound public policy, are ill-advised in the current political climate, fail to provide real impact modeling to members and, in an effort to address one segment of membership, create even greater divisiveness among AHA’s membership.

To elaborate on our key concerns:

- There is a lack of sound public policy behind inherently contradictory AHA principles. One of the key principles adopted by the AHA Task Force on AWI is that there should be no exceptions to the new system. And yet, the AHA Task Force has adopted a very significant exception called “exponentiation” to artificially raise low AWI hospitals. The “exponentiation” principal states that “all wage indices of less than 1.000 would be raised to the power of 0.6848.” The cost of exponentiation would be $1.3 billion – far more than the $950 million cost of all of the current exceptions to the AWI system. This idea of “exponentiation” raised many questions at our Regional Policy Board and a number of dissenting votes on the Task Force. Many called it arbitrary; we call it a direct conflict of the Task Force’s stated policy position of “no exceptions.”

- The AHA Board said it would “assess the political climate” before proceeding with the principles. The political climate is now worse than ever. Sequestration has begun, and healthcare is more vulnerable than ever to Congress’ hunger for more cuts to pay for
deficit reduction. Floating such a redistributive set of principles to Congress will provide ample opportunity for them to skim funds for these purposes.

- The AHA Board said it would model the impact of the principles, but the modeling shared with the RPBs has many flaws. First, it does not show the compounding impact of the principles over five years (as AHA has routinely done when modeling the impact of other policy changes.) This understates the impact to New Jersey by two-thirds ($76 million vs. $228 million.) In addition, the methodology does not include outpatient care and distinct part units which further understates the impact. As you know, the modeling also fails to include the impact upon inpatient rehabilitation facilities long term care hospitals and inpatient psychiatric units which are key NJHA members. We, along with RPB 2, ask the AHA to also examine the impact of the policy change on individual member facilities. One of our members, for example, has said that the financial loss would be so severe that one of his hospitals would close if the Task Force’s principles were to be enacted.

- The principles divide the AHA membership. They redistribute money from some hospitals to other hospitals, from a couple of regions to other regions. RPBs 1 and 2 in the Northeast opposed the principles, and California expressed strong concerns regarding exponentiation. Regions 1, 2 and 3 have advised the AHA Board not to proceed with these principles. The redistributive nature of the principles pits member against member. Is this where AHA leadership wants us to be when we have larger issues ahead to confront as a healthcare community? We will be perfectly frank: This issue has already generated discussion among our delegation about other policies that funnel federal dollars into certain regions or certain classes of hospital. We worry that AHA’s entry into this complex issue could lead to larger policy questions and membership challenges ahead.

We share similar roles as Board members in our respective organizations, and we empathize with the challenges you are facing in responding to members with very different positions. But as you consider your next steps, we feel we would be remiss if we didn’t express to you the depths of the concern we have heard from our mutual members in New Jersey over the AHA’s Task Force current position. Such a position, if adopted by the AHA Board will divide our membership at a time when unity is so important.

We would be very happy to talk with you further about the issue. Please feel free to contact either of us at your convenience. We can be reached at 609) 978-8908 jcoyle@meridianhealth.com, or cryan@njha.com (609) 275-4241.

Sincerely,

Joseph P. Coyle, Chairman
NJHA Board of Trustees, President and CEO,
Southern Ocean Medical Center

Elizabeth A. Ryan, Esq.
President & CEO
New Jersey Hospital Association
AHA Board of Trustees Officers
Benjamin K. Chu, M.D., Chairman
AHA Board of Trustees

James H. Hinton, Chairman-Elect
AHA Board of Trustees

Teri G. Fontenot, Immediate Past Chair
AHA Board of Trustees

Richard J. Umbdenstock, President & CEO, AHA
Officer, AHA Board of Trustees

Christopher J. Durovich, President & CEO, Children’s Medical Center of Dallas
Officer, AHA Board of Trustees

Jonathan B. Perlin, M.D., Ph.D., President, Clinical and Physician Services Group
& Chief Medical Officer, HCA
Officer, AHA Board of Trustees

Mary Starmann-Harrison, President & CEO, Hospital Sisters Health System
Officer, AHA Board of Trustees
April 22, 2013

Benjamin K. Chu, M.D., Chairman
AHA Board of Trustees
Regional President, Southern California
Kaiser Foundation Health Plan and Hospital
393 E. Walnut Street
Pasadena, CA 91188

Dear Dr. Chu:

On behalf of our sponsors, the Sisters of Charity of Saint Elizabeth, the Board of Trustees, and the St. Joseph’s Healthcare System family, we would like to express our strong opposition to the AHA’s Area Wage Index Task Force’s recommended principles to reform the national area wage index policy. It is our understanding that the AHA’s Board will consider the task force recommendation at their April meeting. We respectfully ask that the AHA Board not move forward with implementing the Task Force’s recommendations given the devastating impact they will have on our institution, employees and patients, as well as on one of the poorest communities in northern New Jersey which we serve.

St. Joseph’s Healthcare System, which is comprised of St. Joseph’s Regional Medical Center and St. Joseph’s Wayne Hospital as well as St. Joseph’s Children’s Hospital, is the 5th largest provider of hospital acute care services in the State of New Jersey and the 2nd largest provider of charity care and Medicaid services with over 250,000 clinic visits per year.

St. Joseph’s is currently faced with over $26.2 million in revenue reductions as a result of the sequestration fix, cuts in indirect medical education, coding offsets, and the elimination of funding support for bad debt.

If the reforms to the area wage index policy advocated by the Task Force were to be implemented as recommended we would have no choice but to discontinue many of the essential services we currently provide to New Jersey’s poor.

Additionally, it is our belief that the principles advocated by the AHA fall far short of sound public policy and are full of contradictions. One such contradiction is that a key principle adopted by the Task Force is that there be no exceptions to the new systems of reform. Yet, exponentiation is a significant exception that artificially raises low wage indexed hospitals. This exception will cost over $1.3 billion, which is far more than the $950 million cost of the current exceptions in the system.
Also, the modeling done by the AHA to assess the impact of the recommended principles understates the full impact to New Jersey hospitals, and does not include the impact on outpatient care, rehabilitation facilities, and impatient psychiatric units, all of which are critical to our financial stability. The total financial impact of the reforms to our institution over 5 years is $8.6 million.

We recognize the challenges you face as you attempt to be responsive to the different needs of your membership. But, given the devastating impact the policy changes recommended by the Task Force would have on patient care in New Jersey, we feel compelled to voice our concern.

Thank you for your consideration and attention to this matter. If we at St. Joseph’s can be of any assistance as you take on this challenge, please call. I can be reached at 973-754-2010.

Sincerely,

William A. McDonald
President and CEO

cc: Jonathan B. Berlin, M.D., Ph.D.
Christopher J. Durovich
Teri G. Fontenot
James H. Hinton
Mary Starmann-Harrison
Richard J. Umdenstock
Richard P. Miller
President and Chief Executive Officer

April 22, 2013

Benjamin K. Chu, M.D.
Chairman, AHA Board of Trustees
Regional President
Southern California Kaiser Foundation Health Plan & Hospital
393 E. Walnut Street
Pasadena, CA 91108

Subject: AHA Area Wage Index Task Force Principles

Dear Dr. Chu:

On behalf of Virtua and its 8,000 employees, I am writing to express opposition to AHA’s Area Wage Index (AWI) Task Force principles to reform national area wage index policy. I understand that these principles will be on the AHA Board of Trustees’ agenda for consideration later this week and I urge the Board to refrain from endorsing the principles.

I have voiced my concerns about AHA’s proposed principles while participating in meetings of AHA’s Health Systems Governing Council.

AHA’s principles would have a significant negative impact on Virtua – an impact inaccurately depicted by AHA’s modeling. AHA calculated the total five-year impact to Virtua to be -$3,194,766. In fact, the true impact to Virtua would be three times greater at -$9,571,323. AHA’s model simply compared year five inpatient PPS Operating Payments to year one payments, but did not calculate the total cumulative impact of the losses that Virtua would incur in each of the five years that AHA modeled.

In addition, I am concerned that AHA’s AWI principles lack sound public policy, are ill advised in the current political climate and would, if adopted, create great divisiveness among AHA’s members.

AHA’s proposed principles are inherently contradictory. One of the key principles is that there should be no exceptions. At the same time, the principles include a huge exception called “exponentiation” to artificially raise low AWI hospitals at a cost of $1.3 billion from all other hospitals.

In addition, I fear that adoption of AHA’s AWI principles would leave healthcare more vulnerable than ever to Congress’ deficit reduction initiatives. Presenting Congress with such a redistributive set of principles will provide Senators and Representatives with ample opportunity to skim funds from Medicare payments for their own initiatives.

401 Route 73 North, Lake Center Bldg, 50, Suite 401, Marlton, NJ 08053
Phone: (856) 355-0004 Fax: (856) 355-0012 www.virtua.org
Furthermore, AHA's proposed principles divide the membership at a time that we need to be more united than ever before. The principles redistribute money from some hospitals to other hospitals and from some regions to other regions. I have learned that members of the NJ Congressional Delegation are already aware that this issue is dividing AHA's membership – and they did not learn that from us.

Until now, I have been proud for Virtua to be a member of AHA. However, if AHA proceeded to adopt a position on AWI principles that would be so adverse to the health system for which I am responsible, and so adverse to other hospitals in NJ as well as hospitals in a number of other states, regretfully I would have to seriously reconsider Virtua's participation in the American Hospital Association.

I would be happy to speak with you further about this matter. Thank you for your consideration of my concerns.

Sincerely,

[Signature]

Richard P. Miller
President & CEO

Copies to:

James H. Hinton, Chairman-Elect
AHA Board of Trustees

Teri G. Fontenot, Immediate Past Chair
AHA Board of Trustees

Richard J. Umbdenstock, President & CEO, AHA
Officer, AHA Board of Trustees

Christopher J. Durovich
Officer, AHA Board of Trustees

Jonathan B. Perlin, M.D., Ph.D.
Officer, AHA Board of Trustees

Mary Starmann-Harrison
Officer, AHA Board of Trustees

Carolyn Forcina
Regional Executive, AHA

Elizabeth Ryan
President & CEO, New Jersey Hospital Association
April 22, 2013

Benjamin K. Chu, M.D., Chairman
AHA Board of Trustees
Regional President, Southern California
Kaiser Foundation Health Plan and Hospital
393 E. Walnut Street
Pasadena, CA 91188

Dear Dr. Chu:

On behalf of our sponsors, the Sisters of Charity of Saint Elizabeth, the Board of Trustees, and the St. Joseph’s Healthcare System family, we would like to express our strong opposition to the AHA’s Area Wage Index Task Force’s recommended principles to reform the national area wage index policy. It is our understanding that the AHA’s Board will consider the task force recommendation at their April meeting. We respectfully ask that the AHA Board not move forward with implementing the Task Force’s recommendations given the devastating impact they will have on our institution, employees and patients, as well as on one of the poorest communities in northern New Jersey which we serve.

St. Joseph’s Healthcare System, which is comprised of St. Joseph’s Regional Medical Center and St. Joseph’s Wayne Hospital as well as St. Joseph’s Children’s Hospital, is the 5th largest provider of hospital acute care services in the State of New Jersey and the 2nd largest provider of charity care and Medicaid services with over 250,000 clinic visits per year.

St. Joseph’s is currently faced with over $26.2 million in revenue reductions as a result of the sequestration fix, cuts in indirect medical education, coding offsets, and the elimination of funding support for bad debt.

If the reforms to the area wage index policy advocated by the Task Force were to be implemented as recommended we would have no choice but to discontinue many of the essential services we currently provide to New Jersey’s poor.

Additionally, it is our belief that the principles advocated by the AHA fall far short of sound public policy and are full of contradictions. One such contradiction is that a key principle adopted by the Task Force is that there be no exceptions to the new systems of reform. Yet, exponentiation is a significant exception that artificially raises low wage indexed hospitals. This exception will cost over $1.3 billion, which is far more than the $950 million cost of the current exceptions in the system.

Sponsored by the Sisters of Charity of Saint Elizabeth

16
Benjamin K. Chu, M.D.
April 22, 2013     Page 2

Also, the modeling done by the AHA to assess the impact of the recommended principles understates the full impact to New Jersey hospitals, and does not include the impact on outpatient care, rehabilitation facilities, and impatient psychiatric units, all of which are critical to our financial stability. The total financial impact of the reforms to our institution over 5 years is $8.6 million.

We recognize the challenges you face as you attempt to be responsive to the different needs of your membership. But, given the devastating impact the policy changes recommended by the Task Force would have on patient care in New Jersey, we feel compelled to voice our concern.

Thank you for your consideration and attention to this matter. If we at St. Joseph’s can be of any assistance as you take on this challenge, please call. I can be reached at 973-754-2010.

Sincerely,

William A. McDonald
President and CEO

cc: Jonathan B. Berlin, M.D., Ph.D.
    Christopher J. Durovich
    Teri G. Fontenot
    James H. Hinton
    Mary Starmann-Harrison
    Richard J. Udenstock
April 23, 2013

Chairman Benjamin K. Chu, MD
and Officers of the Board of Trustees
The American Hospital Association
325 7th St NW
Washington, DC 20004

Dear Chairman Chu and Officers of the Board:

It has come to our attention that the recommendations made by the AHA’s Medicare Area Wage Index Task Force may be considered for endorsement by the AHA Executive Committee and the full AHA board at their respective meetings on April 26-27. The 51 hospitals in New York’s Hudson Valley and Long Island regions, which will be grievously affected by this proposal, are strongly opposed. On their behalf, I urge you to reject the task force recommendations.

While far from perfect, the current Medicare AWI reflects that hospitals in some parts of the country must pay significantly higher labor rates than others. The proposed solution would redistribute approximately $1.2 billion annually from hospitals facing high labor costs to hospitals with lower labor costs. This contradicts the very intent of the program by, in essence, providing bonuses to certain groups of hospitals that are not supported by those hospitals’ actual labor expenditures.

The impact of this redistribution on the negatively affected institutions was dramatically understated in the data that was distributed to Regional Policy Board members late last year. That analysis did not incorporate the compounding effect of the cuts on loser institutions. Our own analysis indicates that the true five-year cost of this proposal to the hospitals in this region is nearly $60 million, approximately triple the amount indicated in the task force reports. It is a staggering amount of money for institutions in this area, but is even more so when you consider that $50 million of those cuts come from just eight institutions. That a national association would choose to make winners and losers of its own member institutions, frankly, is stunning.

The potential consequences of moving forward on this proposal are equally as dangerous. If the amount of funding available for wage index adjustments is insufficient to address the national range of labor costs, the solution is not to slice the pie into ever smaller pieces, so to speak — it’s to make the pie bigger. This should be the focus of our advocacy. More to the point, the national membership association representing hospitals should not be going to Congress and CMS unsolicited with the suggestion that a substantial group of its members can withstand another $1.2 billion in cuts.
It is disappointing that the task force focused on narrowing the corridor between the highest and the lowest wage areas nationwide, but did not address the policies that have led to the byzantine legacy of reclassifications and other exceptions to the AWI. A better target for reform would have been CMS's definitions of metropolitan statistical areas, which have led to the kinds of wage index "cliffs" that sharply disadvantage some hospitals. Eliminating the regulatory reclassification process in favor of county-specific wage indexes ignores labor market patterns and inevitably will lead to an even greater demand for legislative rifle-shot provisions. For all of the disruption this proposal would cause if enacted, in a few years, we could end up where we started.

For these reasons, I urge the AHA executive committee and board to reject this proposal. With all of the financial threats facing hospitals today, we need to present a united front to federal legislators and regulators in defense of the hospital sector. Moving ahead with a proposal that unnecessarily divides us will weaken our ability to be successful on all of our advocacy priorities.

I would welcome the opportunity to discuss this matter with you further. Please feel free to reach me on my mobile phone at (631) 334-8323 or kdahill@nshc.org.

Respectfully,

Kevin W. Dahill
President and CEO
Suburban Hospital Alliance of NYS, LLC
NorMet Hospital Association
Nassau-Suffolk Hospital Council
Benjamin K. Chu, M.D.
Chairman, AHA Board of Trustees
Regional President
Southern California Kaiser Foundation Health Plan and Hospital
393 E. Walnut Street
Pasadena, California 91188

Dear Dr. Chu:

I write as the immediate past Chairman of the New Jersey Hospital Association (NJHA) to respectfully, but strongly, urge the American Hospital Association (AHA) Board to refrain from proceeding to consideration of the recommendations of the AHA Task Force to amend current Medicare policy related to the Area Wage Index (AWI). The Task Force recommendations are not based on sound principles and will have a devastating impact on hospitals in the northeast and California. I share the concerns expressed by my colleagues, current NJHA Chairman Joseph Coyle and NJHA President Betsy Ryan, in a letter addressed to you and dated April 8 that the Task Force proposal is internally inconsistent, exposes the hospital community to further and deeper statutorily imposed reimbursement cuts from lawmakers and will prove to be deeply divisive to the AHA and, ultimately, damaging to hospitals.

As you know, one of the key principles identified by the Task Force is to move to an AWI system with no exceptions. However, the Task Force recommendation to impose “exponentiation” will, in fact, provide significant exception to those hospitals with wage indices of less than 1.00. The Task Force has recommended that such hospitals be raised to the power of 0.6848. This practice will provide an exception to an estimated 66% of hospitals in the country and will cost $1.3 billion.

Conversely, our current system provides an exception to approximately 38% of the hospitals in the United States and costs an estimated $950 million. The Task Force recommendation to impose “exponentiation” is internally inconsistent with its stated principles as it will expand the number of hospitals that receive exemptions and increase costs.

In this current political environment where deficit reduction is paramount, healthcare providers are particularly vulnerable to additional cuts imposed by the Congress, which is looking for “pay-fors” to reverse sequestration and is seeking additional opportunities to cut federal Medicare expenses. Proposing a redistributive set of principles to lawmakers will provide yet
another opportunity for Congress to skim funds for so-called “deficit reduction” purposes and further reduce payments to providers.

Finally, the principles put forth by the Task Force simply redistribute money from one region of the country to another. Should AHA support this proposal, it effectively will be advocating against its own members in the highly populated northeast, a practice that will be clearly divisive and disruptive to the AHA and its agenda.

As a longstanding NJHA Board Member and former Chair, I empathize with the challenges you face responding to the divergent needs of a diverse membership. I would be remiss, however, if I did not convey my grave concern that taking action on the Task Force recommendations on Medicare AWI will needlessly divide our membership at a time where unity is so critically important.

Sincerely,

Audrey Meyers
President and CEO

cc: Richard Umbdenstock, President & CEO, AHA
    Betsy Ryan, President & CEO, NJHA
Dear Mr. Umbdenstock,

Based on the Task Force’s recommendations, our hospital will see reduced Medicare payments. It would appear that hospitals with relatively low wage indexes and high Medicare populations will see a reduction in their MC payments. This just isn’t fair.

Of course, I am unaware of all the factors that the Task Force had to deal with….but it would seem to me that those hospitals with higher wage indexes and lower Medicare populations (ie Metropolitan hospitals) could weather slight decreases in their Medicare reimbursements versus Rural hospitals suffering. I’m sure that I’m over simplifying, but thought I should voice my concern. Thanks for considering a remedy for our situation.

Stuart Hill

White County Medical Center  l  3214 East Race Ave.  l  Searcy, AR 72143

501-380-1004  l  shill@wcmc.org
June 4, 2013

Mr. Richard Umdenstock  
President and Chief Executive Officer  
American Hospital Association  
325 Seventh Street, N.W.  
Washington, DC 20004  

The Indiana Hospital Association (IHA) appreciates the opportunity to provide comments on the American Hospital Association’s Area Wage Index Task Force recommendations. IHA appreciates the work of the AHA’s Task Force and the apparent effort that the members of the task force made to fully understand the issue, as well as forward recommendations for the future.

A group of IHA members recently met to discuss the draft report from AHA’s task force. Those members included:

- Tim Flesch, Chair  
  St. Mary’s Medical Center, Evansville
- Tim Balasia  
  The Methodist Hospitals, Gary and Merrillville
- Jay Collins  
  Indiana University Health, Indianapolis
- Wayne Hutson  
  Union Hospital, Terre Haute
- Gary Marker  
  St. Vincent Health, Indianapolis
- Scott Mundell  
  Franciscan St. Margaret Hospitals, Hammond and Dyer
- Jim Myers  
  Indiana University Health, Bloomington
- Mary Ann Shacklett  
  Community Foundation of Northwest Indiana, Munster
- Rhonda Utter  
  Indiana University Health, Indianapolis

At the conclusion of the meeting, the following observations and recommendations were made, broken down generally by the major areas addressed by the AHA report.

**Migration**

- IHA believes that the theory of accounting for the migration of workers into the determination of wage index is reasonable to pursue.
- However, there is great concern with using Census Data from 2000 to estimate the impact of healthcare workers migrating to work.
- Furthermore, we are also concerned with using more recent Census data that apparently is not limited to healthcare workers.
- IHA is interested in understanding the impact of in-migration as well as the modeled out-migration.
- IHA believes that the proper source for migration data should be through the Medicare Cost Report on an annual basis.

**Urban to Rural Conversions**

- IHA believes that urban hospitals converting to rural status should be precluded from having their wage information included in any statewide rural floor calculation for a set number of years.
Rural Floor Inclusions
IHA believes that the budget neutrality associated with urban hospitals with wage indices less than their state’s rural wage index should be applied at the state level, rather than the national level.

Facilities Included in Wage Index Calculation
- IHA believes that only inpatient PPS hospitals be included in the calculation of the wage index.
- Furthermore, if DPU psych, rehabs, etc. are excluded from the calculation, there needs to be some means to exclude psych and rehab information for hospitals that do not have separate distinct part units, as their AHW may be negatively impacted.

Phase-In
- IHA believes that any changes to the wage index system should be phased-in.
- However, IHA believes that a five-year phase-in may not be adequate. IHA suggests a ten-year phase-in.

Stop-Loss and Stop-Gain
- IHA supports the implementation of a stop-loss and stop-gain for those cases where a hospital’s wage index reflects either a significant decrease or increase from the prior year.
- IHA believes that the stop-loss and stop-gain limitation should be adjusted if the phase-in period is changed. For example, if the phase-in is changed to ten years, the stop-loss and stop-gain should be reduced to 1.5%.
- IHA would be interested in modeling a tiered stop-loss and stop-gain scenario. For example, a 3% decrease in a wage index has a significantly greater impact on a hospital with 70% Medicare utilization than a hospital with a 30% Medicare utilization.

Smoothing Adjustment
- IHA believes the theory of “smoothing” the difference between the wage indices of contiguous wage index areas.
- However, IHA believes that the suggested 10% difference threshold is much too great. IHA recommends that the smoothing threshold be 5%. Allowing a 10% difference to be acceptable perpetuates the cliff effect currently in effect.

Exponential Smoothing
- IHA is generally in favor of adjusting the wage indices less than 1.0 using a factor of .6848.

Reclassifications and Exceptions
- IHA believes that any wage index system is not going to be able to perfectly address all differences between hospitals and wage index areas. As such, a process of reclassifications and exceptions should be maintained.
- A process should be determined for those hospitals “catastrophically impacted” by any change in the wage index system. A definition of “catastrophically impacted” will need to be developed. For example, even after the 5 year modeled phase-in with a 3% stop loss
provision, the hospitals in Lake County will continue to see their wage index drop after the 5 year period.

- In order to lessen the number of reclassification requests that must be processed, hospitals that meet certain qualifications should be granted reclassification status for more than the current three year period. For example, if a hospital has demonstrated through two consecutive reclassification requests that it meets reclassification criteria, then that hospital might be granted a six year reclassification status.

Other

- IHA would be interested in knowing how the wage indices coincide with the cost-of-living adjustment for each MSA. In particular, IHA would like to know if the wide discrepancies in wage indices across the country are supported by similar wide discrepancies in cost-of-living adjustments.

- IHA believes that theoretically having only one FI/MAC responsible for all wage index collection and review is appropriate. However, there must be some assurance that within that FI/MAC the individuals responsible for auditing and reviewing the wage index data use the same criteria.

Again, thank you for the opportunity to comment on AHA’s Area Wage Index Task Force draft report.

Very truly yours,

David Wiesman
Vice President

cc: Joanna Kim
Vice President, Payment Policy
To whom it may concern,

In response to your request for comments on the AHA wage index recommendation, please find below comments from the above referenced provider.

While I agree with most of the AHA recommendations to improve the current Medicare Area Wage Index (AWI), I have the following issues with the items listed below:

Applying an Exponential Floor is arbitrary and has nothing to do with actual provider or area wage levels. Based on the example provided by the AHA, the area with the lowest AWI would receive a wind fall of 31% at the expense all providers getting their payments reduced by 1.2% There would be nothing fair about this adjustment and it doesn’t support the AHA agreed upon purpose for wage index reform which was to account for geographic differences in wages across labor markets.

I agree that the current system of reclassifications and exceptions should be replaced but that should include the statutory reclassifications also because they are arbitrary and have nothing to do with actual wage levels. An out-commuting adjustment would be a good replacement but a 10 percent smoothing adjustment is arbitrary also.

To address the year-to-year volatility, a 3 percent stop-loss and stop gain would be ok but probably would be necessary if a 3 year rolling average “Average Hourly Wage”(which is already calculated by CMS) was used to calculate the AWI.

Using the BLS data with an adjustment for benefits would probably be the easiest for everyone if a system could be put in place to require that the information be reported to BLS and there was some process put in place for providers to verify the accuracy of the reported data.

Hans Schermerhorn
Hans Schermerhorn
Sr. Govt. Reimb. Advisor
Gwinnett Hospital System
Office: 678-312-5622
Fax: 770-339-3459
hschermerhorn@gwinnettmedicalcenter.org
June 18, 2013

AWI Advisory Review Committee
American Hospital Association
325 7th Street, N.W.
Washington, D.C.

RE: AHA Principles and Recommendations on AWI Reform

Dear Committee Members:

Thank you for this opportunity to share our thoughts on the AHA’s principles and recommendations for reforming area wage index policy. It’s a complex issue – a controversial issue – and we respect the work that has gone into this process by the AHA Board, the AWI task force and the AHA staff. We especially appreciate the AHA’s willingness to introduce added opportunities for member education and feedback. We have availed ourselves of those opportunities for member engagement, and it’s clear to us that there is no consensus on this issue – not only in New Jersey but also in many other states and regions. And while we certainly appreciate AHA’s efforts to achieve consensus, in its ongoing absence we urge you to avoid approving any policy direction that would further divide the field. This is a pivotal time for healthcare providers, with difficult battles ahead including Medicare and Medicaid DSH cuts, additional deficit reduction cuts, the sustainable growth rate and the ongoing rollout of ACA implementation. We question the wisdom of introducing even greater revenue volatility into a climate that already is simmering with looming revenue pressures for healthcare providers. Rather than invest energy, resources and political capital on an issue that divides us, let’s focus the collective clout of the nation’s hospital and broader healthcare community on other critical issues on which we all can agree.

Our opposition to the AWI proposal is built on several policy arguments, as well as one practical argument: the fact that New Jersey hospitals stand to lose more than $228 million in federal funds over five years if the AHA’s proposal were to be adopted as part of federal policy. For added perspective: The loss of $228 million in federal funds would come to a state where the average statewide operating margin is 3 percent (compared with a national average of 5.5 percent) and where 11 hospitals have closed their doors in the last decade. In addition, the unknown impact on post-acute providers, which NJHA has in significant numbers as core members, is of great concern. We must oppose any action by AHA that could cause such significant harm to New Jersey’s healthcare organizations and the patients and communities that depend on them.

As for the policy points, our opposition centers on four main concerns:

- The AHA proposal is built on inherently contradictory principles. One of the key principles adopted by the AHA Task Force is that there should be no exceptions to the new system. And yet, the AHA Task Force has adopted a very significant exception called “exponentiation” to artificially raise low AWI hospitals. The “exponentiation” principal states that “all wage indices of less than 1.000 would be raised to the power of 0.6848.” The cost of exponentiation would be $1.3 billion – far more than the $950 million cost of all of the current exceptions to the AWI system. The proposal prioritizes one group of hospitals over another group – with little basis or explanation. And, the
exponentiation exception would apply to 66 percent of the field, compared with just 38 percent of hospitals that currently receive an exception.

- In addition, the exponentiation provision would in essence duplicate an existing Medicare adjustment for low-wage index hospitals created under the Medicare Modernization Act. The labor-related portion of Medicare payments for hospitals with a wage index less than 1.0 is only 62 percent, compared with 68.8 percent for hospitals with a wage index greater than 1.0. This adjustment drives approximately $400 million annually in additional Medicare payments to the same group of hospitals that also stand to benefit from the exponentiation exception.

- The AHA was unable to model the impact of the task force’s proposal on distinct part units and post-acute providers, nor did it quantify the impact of outpatient activity at PPS hospitals. And yet, all would have their Medicare reimbursements affected if the AHA’s proposal were adopted into federal policy. That is simply too large of an information gap – one that could affect a significant part of AHA’s membership – to proceed with this proposal.

- The AHA Board said it would “assess the political climate” before proceeding with the principles. The political climate is now worse than ever. Large Medicaid and Medicare DSH cuts loom. In addition, the issue of expanding site-neutral payments could well result in a $2 billion impact in a single year. Sequestration has begun, and healthcare is more vulnerable than ever to Congress’ hunger for more cuts to pay for deficit reduction. Floating such a redistributive set of principles to Congress will provide ample opportunity for them to skim funds for these purposes.

New Jersey is arguably the most unique market in the country, particularly for hospital labor. New Jersey has the highest population density in the nation. Those residents can commute with ease within our state and across our borders into New York City – the nation’s largest city – and Philadelphia, the nation’s fifth largest city. We must compete with those major metropolitan areas for our employees. Across those markets, 173 acute care hospitals – along with many, many more post-acute providers – vie for limited labor resources. In addition, New Jersey’s teaching hospital density is akin to other major metro areas. Sixty-two percent of New Jersey hospitals have teaching programs, on par with cities such as Boston (63 percent) and Philadelphia (56 percent.)

Clearly, a one-size-fits-all approach to AWI fails to reflect the competitive realities of our uniquely situated state.

As AHA member organizations, there is much that we share, including the overriding goal of delivering healthcare services that are high in quality and value and accessible to all. The AHA proposal on area wage index threatens that goal for New Jersey’s healthcare providers. We urge you to abandon these divisive principles and concentrate the industry’s energy and focus on other healthcare policy challenges where industry consensus will yield successful results.

Very Truly Yours,

Jason Coe, MBA
President
June 21, 2013

American Hospital Association
Liberty Place, Suite 700
325 Seventh Street NW
Washington DC 20004-2802

Re: AHA Area Wage Index Task Force Subcommittee Recommendation

To Whom It May Concern:

Baystate Franklin Medical Center (BFMC) appreciates this opportunity to provide comments and feedback on the recommendations of the American Hospital Association (AHA) Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is an extraordinarily complex system that has very significant impact on hospital reimbursement. We support a comprehensive review and reform of the wage index system. However, because of the importance, complexity, and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the nature, timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

We outline below the seven Task Force recommendations, our position and, where applicable, the specific reasons behind our concerns. We urge the AHA Area Wage Index Task Force Subcommittee to give serious consideration to our comments.

Of the seven recommendations of the Task Force, BFMC and our members support four recommendations: these are as follows:

- **Recommendation #1:** To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
- **Recommendation #2:** To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.
- **Recommendation #4:** To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a
single year. These policies should apply both during and after the five-year transitional period.

- Recommendation #7: The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment

BFMC does not support three of the recommendations; these are:

- Recommendation #3: To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Recommendation #3 was not modeled by the Task Force because the data required to do so is either not available or incomplete—which begs the question of whether this recommendation should have been included at all. This recommendation needs to be modeled and studied further.

The AWI is a relative measure that compares hospitals to each other. The AWI is currently based on Worksheet S-3 of the hospital cost report as well as on a special occupational mix survey of hospitals.

By including inpatient rehabilitation facilities, inpatient psychiatric facilities and long-term care hospitals in the wage index data, the new AWI will distort the comparison of hospital to each other. These facilities have very different wage and fringe benefits packages from acute hospitals.

The recommended change would not help limit year-to-year volatility in individual hospitals’ wage indices.

Recommendation #5: To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which is exists cannot be quantified” (June 4 2013 conference call); and that the exponential floor adjustment was “arbitrary but appealing” (June 4 2013 conf call). We are very troubled that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.
➢ The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for hospitals with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from BFMC and other hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This is neither fair nor logical.

➢ Hospitals with AWI less than 1 have had other “protections” in place for years such as their lower labor share (62% versus 69.6%) and the frontier wage index. There is no evidence that these protections have helped low-AWI hospitals increase their AHW at a higher rate than the national average. If this is the case, the Task Force should not expect that the exponential floor adjustment will achieve a different result.

➢ Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications.

➢ Other factors, not the Medicare AWI (which has a four year lag), determine the wages that BFMC pays their employees. BFMC offers higher wages because of competitive forces—we not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

➢ The exponential adjustment is a very expensive redistributive experiment – one we cannot afford.

➢ The exponential adjustment would not improve the fairness and accuracy of the wage index because the methodology is not empirically justified.

➢ The exponential adjustment contradicts the task force’s principle that the wage index methodology should be as consistent and understandable as possible.

Recommendation #6: The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

We commend the Task Force for correctly recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. The inclusion of outmigration and smoothing adjustments in the AWI needs further review and analysis using up-to-date data. Currently, up-to-date data does not exist to model the impact on individual hospitals. In our opinion, to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact would be wrong.
Congress should not eliminate the current system of reclassification and exceptions until a new AWI methodology has been developed after complete analysis of its impacts and appropriate input from the hospital industry.

Sincerely,

Jerry C. Johnson
Jerry A. Johnson
Director, Payment Systems
June 21, 2013

American Hospital Association
Liberty Place, Suite 700
325 Seventh Street NW
Washington DC 20004-2802

Re: AHA Area Wage Index Task Force Subcommittee Recommendation

To Whom It May Concern:

Baystate Medical Center (BMC) appreciates this opportunity to provide comments and feedback on the recommendations of the American Hospital Association (AHA) Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is an extraordinarily complex system that has very significant impact on hospital reimbursement. We support a comprehensive review and reform of the wage index system. However, because of the importance, complexity, and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the nature, timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

We outline below the seven Task Force recommendations, our position and, where applicable, the specific reasons behind our concerns. We urge the AHA Area Wage Index Task Force Subcommittee to give serious consideration to our comments.

Of the seven recommendations of the Task Force, BMC and our members support four recommendations: these are as follows:

- **Recommendation #1:** To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
- **Recommendation #2:** To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.
- **Recommendation #4:** To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period.
• **Recommendation #7:** The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment

BMC does not support three of the recommendations: these are:

• **Recommendation #3:** To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Recommendation #3 was not modeled by the Task Force because the data required to do so is either not available or incomplete—which begs the question of whether this recommendation should have been included at all. This recommendation needs to be modeled and studied further.

The AWI is a relative measure that compares hospitals to each other. The AWI is currently based on Worksheet S-3 of the hospital cost report as well as on a special occupational mix survey of hospitals.

By including inpatient rehabilitation facilities, inpatient psychiatric facilities and long-term care hospitals in the wage index data, the new AWI will distort the comparison of hospital to each other. These facilities have very different wage and fringe benefits packages from acute hospitals.

The recommended change would not help limit year-to-year volatility in individual hospitals’ wage indices.

**Recommendation #5:** To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which is exists cannot be quantified” (June 4 2013 conference call); and that the exponential floor adjustment was “arbitrary but appealing” (June 4 2013 conf call). We are very troubled that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.
- The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for hospitals with AWI less than 1, potentially
to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from BMC and other hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This is neither fair nor logical.

- Hospitals with AWI less than 1 have had other “protections” in place for years such as their lower labor share (62% versus 69.6%) and the frontier wage index. There is no evidence that these protections have helped low-AWI hospitals increase their AHW at a higher rate than the national average. If this is the case, the Task Force should not expect that the exponential floor adjustment will achieve a different result.

- Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications.

- Other factors, not the Medicare AWI (which has a four year lag), determine the wages that BMC pays their employees. BMC offers higher wages because of competitive forces—we not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

- The exponential adjustment is a very expensive redistributive experiment – one we cannot afford.

- The exponential adjustment would not improve the fairness and accuracy of the wage index because the methodology is not empirically justified.

- The exponential adjustment contradicts the task force’s principle that the wage index methodology should be as consistent and understandable as possible.

- **Recommendation #6: The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.**

We commend the Task Force for correctly recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. The inclusion of outmigration and smoothing adjustments in the AWI needs further review and analysis using up-to-date data. Currently, up-to-date data does not exist to model the impact on individual hospitals. In our opinion, to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact would be wrong.
Congress should not eliminate the current system of reclassification and exceptions until a new AWI methodology has been developed after complete analysis of its impacts and appropriate input from the hospital industry.

Sincerely,

[Signature]

Jerry A. Johnson
Director, Payment Systems
June 21, 2013

American Hospital Association
Liberty Place, Suite 700
325 Seventh Street NW
Washington DC 20004-2802

Re: AHA Area Wage Index Task Force Subcommittee Recommendation

To Whom It May Concern:

Baystate Mary Lane Hospital (BMLH) appreciates this opportunity to provide comments and feedback on the recommendations of the American Hospital Association (AHA) Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is an extraordinarily complex system that has very significant impact on hospital reimbursement. We support a comprehensive review and reform of the wage index system. However, because of the importance, complexity, and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the nature, timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

We outline below the seven Task Force recommendations, our position and, where applicable, the specific reasons behind our concerns. We urge the AHA Area Wage Index Task Force Subcommittee to give serious consideration to our comments.

Of the seven recommendations of the Task Force, BMLH and our members support four recommendations: these are as follows:

- **Recommendation #1**: To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
- **Recommendation #2**: To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.
- **Recommendation #4**: To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a
single year. These policies should apply both during and after the five-year transitional period.

- **Recommendation #7**: The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment.

BMLH *does not support three of the recommendations*: these are:

- **Recommendation #3**: To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Recommendation #3 was not modeled by the Task Force because the data required to do so is either not available or incomplete—which begs the question of whether this recommendation should have been included at all. This recommendation needs to be modeled and studied further.

The AWI is a relative measure that compares hospitals to each other. The AWI is currently based on Worksheet S-3 of the hospital cost report as well as on a special occupational mix survey of hospitals.

By including inpatient rehabilitation facilities, inpatient psychiatric facilities and long-term care hospitals in the wage index data, the new AWI will distort the comparison of hospital to each other. These facilities have very different wage and fringe benefits packages from acute hospitals.

The recommended change would not help limit year-to-year volatility in individual hospitals’ wage indices.

**Recommendation #5**: To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which is exists cannot be quantified” (June 4 2013 conference call); and that the exponential floor adjustment was “arbitrary but appealing” (June 4 2013 conf call). We are very troubled that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.
The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for hospitals with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from BMLH and other hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This is neither fair nor logical.

Hospitals with AWI less than 1 have had other “protections” in place for years such as their lower labor share (62% versus 69.6%) and the frontier wage index. There is no evidence that these protections have helped low-AWI hospitals increase their AHW at a higher rate than the national average. If this is the case, the Task Force should not expect that the exponential floor adjustment will achieve a different result.

Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications.

Other factors, not the Medicare AWI (which has a four year lag), determine the wages that BMLH pays their employees. BMLH offers higher wages because of competitive forces—we not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

The exponential adjustment is a very expensive redistributive experiment—one we cannot afford.

The exponential adjustment would not improve the fairness and accuracy of the wage index because the methodology is not empirically justified.

The exponential adjustment contradicts the task force’s principle that the wage index methodology should be as consistent and understandable as possible.

**Recommendation #6:** The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

We commend the Task Force for correctly recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. The inclusion of outmigration and smoothing adjustments in the AWI needs further review and analysis using up-to-date data. Currently, up-to-date data does not exist to model the impact on individual hospitals. In our opinion, to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact would be wrong.
Congress should not eliminate the current system of reclassification and exceptions until a new AWI methodology has been developed after complete analysis of its impacts and appropriate input from the hospital industry.

Sincerely,

Jerry A. Johnson
Director, Payment Systems
Richard P. Miller
President and Chief Executive Officer

TO: AHI Advisory Review Committee
American Hospital Association

FROM: Richard P. Miller
President & Chief Executive Officer
Virtua

COPY TO: Elizabeth Ryan
President & Chief Executive Officer
New Jersey Hospital Association
Joanne Carrocino
Member, AHA Board of Trustees
President & Chief Executive Officer
Cape Regional Medical Center

DATE: June 21, 2013

SUBJECT: AHI Area Wage Index Task Force Principles

On behalf of Virtua and its 8,500 employees, I am writing to express our strong concerns with AHI’s Area Wage Index (AWI) Task Force principles to reform national area wage index policy. Virtua is the largest health system in Southern New Jersey and one of the largest in the state. AHI’s AWI principles will, therefore, not only have a significant negative impact on all hospitals in our state, but also they will have a significant negative impact on Virtua.

Please know that I have voiced my concerns about AHI’s proposed principles while participating in meetings of AHI’s Health Systems Governing Council and in letters to the officers of the AHI Board of Trustees.

I am concerned with AHI’s AWI principles for the following reasons:
1. They lack sound public policy and are inherently contradictory.
2. They would cause significant financial harm to NJ’s hospitals, including Virtua.
3. They are ill advised in the current political climate.
4. If adopted, they would create greater divisiveness among AHI’s members.

The balance of this letter describes these four concerns.
1. **The principles lack sound public policy and are inherently contradictory.**

AHA’s proposed principles are inherently contradictory. One of the key principles is that there should be no exceptions. At the same time, the principles propose a very significant exception called “exponentiation” to artificially raise low AWI hospitals.

The “exponentiation” principal states that “all wage indices of less than 1.000 would be raised to the power of 0.6848.” The cost of exponentiation would benefit 60 percent of the nation’s hospitals at a cost of $1.3 billion. Meanwhile, the current AWI system of reclassifications affects 38.7 percent of hospitals at a cost of $950 million. The net result: AHA’s proposed policy of “no exceptions” would actually expand exceptions to more hospitals at greater cost.

2. **The principles would cause significant financial harm to NJ’s hospitals, including Virtua.**

The AHA’s principles would have a significant negative financial impact on New Jersey hospitals, Medicare reimbursement by $228 million over five years. With one-third of New Jersey hospitals currently operating in the red, the dramatic changes in AWI policy advocated by AHA could cause very real financial harm to NJ hospitals and further threaten access to care in our state.

AHA’s principles would have a significant negative financial impact on Virtua – an impact inaccurately depicted by AHA’s modeling. AHA calculated the total five-year impact to Virtua to be - $3,194,766. In fact, the true impact to Virtua would be three times greater at - $9,571,323. AHA’s model simply compared year five Inpatient PPS Operating Payments to year one payments, but did not calculate the total cumulative impact of the losses that Virtua would incur in each of the five years that AHA modeled.

Our opposition, however, is based on more than the state’s financial interests.

In New Jersey, about 77 percent of hospitals will receive some type of exception under the current system in FY2014 – demonstrating New Jersey’s unique competitive environment and the importance of this policy for Garden State providers and patients.

3. **The principles are ill advised in the current political climate.**

I fear that adoption of AHA’s AWI principles would leave healthcare more vulnerable than ever to Congress’ deficit reduction initiatives. Presenting Congress with such a redistributive set of principles will provide Senators and Representatives with ample opportunity to reallocate funds from Medicare payments for their own initiatives.
4. **If adopted, they would create greater divisiveness among AHA’s members.**

AHA’s proposed principles, if adopted, would divide the membership at a time when we need to be more united than ever before. The principles redistribute money to some hospitals at the expense of other hospitals and redistribute money to hospitals in some regions at the expense of hospitals in other regions of our country.

Thank you for your consideration of Virtua’s concerns.
June 21, 2013

Benjamin K. Chu, M.D.
Chairman
American Hospital Association Board of Trustees
325 7th Street, N.W.
Washington, DC 20004-2802

Dear Chairman Chu and Trustees:

I have reviewed the AHA Area Wage Index Task Force recommendations and I am concerned that two of the recommendations do not reflect the best interests of Massachusetts hospitals and of Southcoast Hospitals Group.

First, we oppose Recommendation 6, which suggests that Congress should eliminate the current system of reclassification and exceptions, except when reclassifications are done in a non-budget-neutral manner. This recommendation suggests that in a well-constructed wage index system there should be no need for hospital reclassification. We strongly disagree. In our view, it is not possible to create a wage index system that treats every hospital with complete fairness. Anomalies in populations and conditions are inevitable, and when they arise, hospitals need the recourse of a fair reclassification process. We believe that Southcoast operates under one such anomaly as we cannot possibly compete on equal footing with providers in Boston without the opportunity to reclassify. Supporting the task force’s recommendation to eliminate the opportunity to reclassify would be a direct vote against Southcoast Hospitals Group and all other hospitals in similar situations throughout our country.

We also oppose the recommendation to eliminate the rural floor— a view I am sure we share with hospitals in a number of states. All other budget-neutral adjustments in the Medicare program are applied, and have always been applied, on a nationwide level. CMS’s targeting of the rural floor for state-wide budget neutrality was an exception to that norm; the ACA simply restored nation-wide budget neutrality to the rural floor.

Second, we oppose Recommendation 5, which states that Congress should increase the wage indexes that are less than 1.0. As this recommendation would be carried out in a budget neutral manner, hospitals with a wage index less than 1.0 would see significant increases in their wage index while other hospitals would experience an unjustified drop in their wage index. These changes would take place regardless of either hospital’s labor market. This policy would remove significant funding from hospitals that are clearly in high wage areas for all wages, not just health care. For example, for hospitals in wage index areas such as Boston, where the cost of living is 30% greater than the U.S. average, this would be especially harmful.

I appreciate your attention to these concerns and welcome any questions you may have about Southcoast’s position on these issues of great importance.

Sincerely,

Keith A. Hovan
CEO & President
Southcoast Health System & Southcoast Hospitals Group

101 Page Street
New Bedford, Massachusetts 02740
Telephone 508-961-5555
June 24, 2013

via e-mail: AWI@aha.org

Medicare Area Wage Index Review Committee
American Hospital Association
Liberty Place, Suite 700
325 Seventh Street, NW
Washington, D.C. 2004-2802

RE: Comments on AHA Medicare Area Wage Index Task Force Recommendations

Dear Committee Members:

On behalf of its member hospitals and, specifically, on behalf of its Medicare Area Wage Index Task Force, the Mississippi Hospital Association (MHA) submits the following comments on the AHA Medicare Area Wage Index Task Force Report and Recommendations. We appreciate the opportunity to do so and thank you for allowing us input into your deliberative process.

Generally, MHA supports the nine Principles and is generally inclined to agree with the recommendations of the AHA Task Force based on the financial impact study on Mississippi hospitals. We submit the following specific comments for your consideration:

MHA urges AHA to support efforts to require that CMS improve the consistency and accuracy of collection and processing of wage index data by establishing uniform standards and consistently and uniformly enforcing standards across all IF/MACs. We are not convinced that moving the collection and processing to one IF/MAC will adequately address the problem if CMS continues not to enforce its collection and processing standards.

MHA urges AHA to support efforts to require that Critical Access Hospitals fully complete wage data on their cost reports. Rural hospitals in Mississippi compete with Critical Access Hospitals in the labor market; thus, their wage data should be included in the wage index calculation.

MHA strongly supports an exponential adjustment for hospitals with a labor index of less than one (1). As a rural state, every hospital in Mississippi has an area wage index of less than one (1). It is important to our hospitals that the floor increase so that they can attract and keep a qualified health care labor force in our state.
MHA strongly opposes use of Bureau of Labor Statistics (BLS) data to calculate the wage index. For the reasons cited in the AHA Task Force Report, MHA agrees that BLS data is not a reliable source of data regarding hospital labor costs. We support continued use of the cost report to collect labor data.

In addition to the above comments on the Report and Recommendations, we would urge the AHA Task Force to address the percentage of the Medicare payment attributed to labor share. The experience of MHA member hospitals indicates that labor costs are less than 50%. We propose that 62% and 68% are both too high. We urge AHA to consider a recommendation that CMS be required to use each hospital’s actual labor percentage.

Again, we thank you for the opportunity to provide input into your deliberative processes. We will continue to follow the progress of the AHA Recommendations.

Sincerely,

Sam Cameron
President and CEO
Mississippi Hospital Association
June 24, 2013

Benjamin K. Chu, M.D., Chairman
AHA Board of Trustees
Regional President
Southern California Kaiser Foundation Health Plan and Hospital
393 E. Walnut Street
Pasadena, California 91188

Dear Dr. Chu:

I am writing to you as the President and CEO (Interim) of University Hospital (UH) in Newark, New Jersey to formally express UH’s opposition to the American Hospital Association (AHA) draft principles for reforming the federal area wage index system.

I was pleased to learn that the AHA Board has decided to create an AWI Advisory Review Committee to gather additional member feedback on this important issue prior to voting on the principles.

As I have written to you previously, I believe these principles to be divisive to the AHA membership as they will redistribute funds among different regions and providers. If implemented, the AHA task force principles and recommendations would have a serious financial impact on New Jersey hospitals if they were to become part of the federal area wage index policy. When taking into account the compounding impact of the principles over five years, total losses to NJ hospitals are estimated at $228 million. This modeling does not even capture the impact upon inpatient rehabilitation facilities long term care hospitals and inpatient psychiatric units.

At University Hospital, total impact by Year 5 is estimated at $13.3 million. As you may know, UH is a designated Level 1 trauma center and the largest provider of uncompensated care in the state of New Jersey. The challenges which face UH in the current health care environment are immense, as it must care largely for underserved and uninsured populations in New Jersey. The financial impact of the AHA’s principles on University Hospital would be significant and threaten access to care for our community.
June 24, 2013

I am hopeful that the AHA will consider these comments regarding the wage index policy with the goal of improving the fairness of the policy without causing serious financial harm to individual states and facilities. Thank you for your consideration.

Sincerely,

[Signature]

James R. Gonzalez, MPH, FACHE
President and CEO (Interim)
University Hospital

C: Ms. Betsy Ryan, Esq., President and CEO, New Jersey Hospital Association
June 24, 2013

Dear Members of the AHA Medicare Area Wage Index Task Force,

Thank you for the opportunity to comment on the recommendations you have drafted to reform the Medicare Area Wage Index. I am writing on behalf of Sturdy Memorial Hospital, a small, acute care, community hospital in southeastern Massachusetts. Medicare patients represent over 40% of our business and all government payers represent over 60%. The Medicare Area Wage Index calculation affects payment for the vast majority of our government payer business and it is very important to us that any reform is done in a thoughtful and fair manner. We support many of the recommendations but there are two that we find very concerning.

One recommendation we feel is unfair is Recommendation #3 which would include skilled nursing facilities, long term and psychiatric hospital information in the wage data set. In our service area, there is one acute hospital, one psychiatric hospital and 4 or 5 skilled nursing facilities. Psychiatric hospitals and skilled nursing facilities do not employ the range of highly paid, specialized employees (imaging and lab techs, ICU, operating room and ECC nurses) employed by acute hospitals. As a result, wage indexes at non-acute facilities are lower. The fact that we have a high non-acute to acute facility ratio will likely decrease our wage index, but does not change the fact that we compete to hire these high salary skilled employees with acute facilities in proximate services areas which may have a lower non-acute to acute ratio. A similarly unfair redistributive effect could occur between areas of the country with higher or lower non-acute to acute care facility ratios. We ask that you withdraw Recommendation #3.

Another recommendation that we are highly concerned about is Recommendation #5 which uses an exponential methodology to artificially increase wage indexes less than 1. By definition comparing the average salary in each wage area to the national weighted average is going to result in wage areas representing close to half of all hours worked by employees of acute care providers with wage indexes less than one. To our knowledge, there is no study that shows that health care providers in low wage index areas of the country are particularly disadvantaged compared to other area businesses. Nor have we heard that there is any proven correlation between wage index and hospital profitability. It is entirely likely that the wage index variation between areas of the country is real. To artificially increase the wage index for areas with indexes less than one creates a large redistribution – larger than the current system of exceptions that the recommendations are proposing to replace. We honestly do not understand the rationale behind propping up all the wage indexes that are less than the average. We strongly request that you withdraw Recommendation #5.

We generally support the other recommendations. With regard to Recommendation #6, we support the smoothly adjustment to avoid wage index cliffs between consecutive wage areas, but
are concerned that allowing non-budget-neutral reclassifications will result in increased lobbying to Congressional delegations and ultimately a system with a multitude of exceptions much like we have today.

Again, thank you for the opportunity to provide feedback on the recommendations drafted by the task force. We agree with the majority of the recommendations, but do have significant concerns about two of them as outlined above. If you have any questions related to our comments, please feel free to contact me at (508) 236-8175.

Sincerely,

Amy Pfeffer
Director, Budget and Reimbursement
Sturdy Memorial Hospital
June 24, 2013

To: The AHA Area Wage Index Task Force Subcommittee

HealthAlliance Hospital appreciates this opportunity to provide comments on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is a complex system that has very significant impact on hospital reimbursement in every state. We support a comprehensive review and reform of the wage index system. However, because of the importance and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

In Massachusetts, the impacts of changes to the Medicare wage index system extend beyond Medicare. These changes impact not only Medicare operating, capital, outpatient and post-acute facilities reimbursement as well as Medicare Advantage payments, but would also impact Medicaid reimbursement since Commonwealth of Massachusetts uses the geographic reclassifications approved by CMS to adjust Medicaid payments to hospitals.

HealthAlliance Hospital has reviewed the Task Force’s report and recommendations. We outline below the seven Task Force recommendations, our position and the specific reasons behind our concerns.

Of the seven recommendations of the Task Force, HealthAlliance Hospital supports four recommendations:

- **Recommendation #1**: To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
- **Recommendation #2**: To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, a phase-in or a transitional period of at least 5 years should be included.
- **Recommendation #4**: To ensure that hospitals do not experience excessive year-to-year volatility budget-neutral 3 percent stop-loss and stop-gain policy that would limit the amount by which a hospital’s wage index could decrease or increase per year.
- **Recommendation #7**: The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment.
We have reservations about three of the recommendations:

- **Recommendation #3**: To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Post-acute providers tend to have lower average hourly wages than acute care providers and since post-acute providers currently have their Medicare reimbursement adjusted for labor costs using the IPPS AWI (without applying any exceptions), we are concerned that, if adopted, this recommendation would lower the AWI for both post-acute and acute providers.

Recommendation #3 was not modeled by the Task Force. This raises the question of whether this recommendation should have been included at all. We believe that the potential negative unintended consequences of recommendation #3 are unknown at this point—and the 3% stop loss provision is not sufficient justification for the inclusion of a completely untested recommendation. This recommendation needs to be modeled and studied further.

- **Recommendation #6**: The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

We commend the Task Force for recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. We can support the inclusion of outmigration and smoothing adjustments in the AWI reform recommendations. However, we note that these adjustments are difficult to replicate and hospitals would therefore have trouble verifying the accuracy of the wage index that is assigned to them. This appears inconsistent to the task force’s principle that the wage index data and methodology should be fairly easy to administer, transparent and understandable as possible.

It is also unclear what the size of the budget neutrality offset to fund the outmigration and smoothing adjustments would be. Additional information and data about these adjustments should be provided to AHA members.

We disagree with the Task Force on preserving non-budget neutral exceptions that could lead hospitals to secure their own “special deals” in Congress which will increase complexity, add administrative burden and decrease the integrity of the wage index system.

- **Recommendation #5**: To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments.
Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- One of the Task Force’s principles is that the current system of exceptions is “unacceptable”, and recommendation #6 specifically seeks to eliminate all budget-neutral exceptions. Yet, at the same time, recommendation #5 would put in place a new budget neutral ‘exception’-the exponential floor- which would increase the AWI for 67% of all hospitals. Hospitals with AWI less than 1 would get an arbitrary increase in their AWI every year, which would continue without any application process or oversight.

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which it exists cannot be quantified and that the exponential floor adjustment was arbitrary but appealing”. We are concerned that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.

- The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for providers with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing significant Medicare funding from hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This doesn’t appear fair or logical.

- Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications. For our state, MHA computed the cost of the exponential floor budget neutrality adjustment by applying a 1.2% reduction to all PPS payments for providers that use the IPPS wage index. The impact was negative $66.3m a year.

- Hospital leaders have pointed out that other factors, not the Medicare AWI (which has a four year lag), determine the wages that they pay their employees. Hospitals in high wage areas offer higher wages because of competitive forces—they not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

- The exponential floor adjustment would raise the AWI of low wage hospitals, but could very well have no impact on the rate at which their AHW changes—thereby resulting in no improvement in their baseline AWI. Since the exponentiation formula works in a manner that as the AHW approaches 1.000, the percentage by which the exponentiation increases the baseline AWI declines. But if there is no link between the wage index and wages paid by a hospital, we could end up with an AWI death spiral where the high wage hospitals have to keep funding the exponential floor with no end in sight.
Further, there is no evidence, according to the AHA that there is a correlation between the wage index that a hospital receives and its margins. High AWI hospitals can have low margins and vice versa. We therefore question the very premise implementing this adjustment for low-AWI hospitals given the lack of evidence that such an action would improve their bottom lines.

In our view, the exponential adjustment is a very expensive redistributive recommendation. We request that the AHA Task Force not move forward with this recommendation.

Comments on the Impact Analysis:

The AHA made available a hospital specific and statewide impact analysis of the recommendations to members. We have concerns about the methodology, data and gaps in the AHA analysis—and we believe that the AHA analysis may be significantly understating the impact of the recommendations. We note that the AHA statewide impacts did not include the impact of the recommendations on post-acute providers, IPPS capital payments, Medicare Advantage payments and outpatient payments, all of which are impacted by changes in the wage index.

In its impact modeling, AHA also did not account for compounding: in other words, the AHA impact shows a first year impact for Massachusetts (at 20% implementation) of -$50m; but the second year impact is also shown to be -$50m (at 40%); and in years 3, 4 and 5, the annual impact remains at about -$50m a year, despite the fact that the transition stages in those years are 60%, 80% and 100% respectively. If we assume that the -$50m impact in year 1 is correct (though it reflects only IPPS operating payments), the total 5 year impact could be a loss of $750m in inpatient operating payments alone (when compared to today), and not of negative $246m as AHA has stated.

The Massachusetts Hospital Association conducted a separate analysis using the best available data. Their preliminary analysis indicates that the negative impact on Massachusetts would be negative $457m annually (in contrast to the AHA’s estimate of negative $247m) and even if we factor out the effect of losing the Massachusetts rural floor, the state would still be impacted by over -$191 million per year.

There are significant gaps in the AHA analysis—other payment systems impacted by AWI changes are not modeled, the impact of including post-acute data in the IPPS AWI is not included etc.—our current understanding is that these gaps will remain, and the review process will simply reaffirm that the gaps exist, and not actually attempt to fill them in.

In addition, there is an unprecedented degree of uncertainty in the methodology and the impact of individual recommendations—for example, what data is being used for the out commuting
adjustment (can the AHA make available the data underlying this adjustment at a CBSA level)? Can the AHA share the out-commuting budget neutrality adjustment for this?

In our opinion, to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact would be wrong. We realize that trying to establish a national consensus on such a complex matter as the Area Wage Index is a major challenge and we commend AHA for taking that challenge. Based on that philosophy and after listening to the comments of other states and hospitals that share our concerns, we respectfully urge the AHA Board of Trustees to address all the concerns that we have outlined above.

Sincerely,

Michael Cofone, Corp. V.P. Strategic Planning and Chief Financial Officer
HealthAlliance Hospital
June 25, 2013

Dr. Benjamin K. Chu, M.D.
Chairman of the Board of Trustees
American Hospital Association
325 Seventh Street, N.W.
Liberty Place, Suite 700
Washington, D.C. 20004-2802

Dear Dr. Chu:

On behalf of our more than 200 member hospitals and 23 health systems, the Illinois Hospital Association (IHA) appreciates the opportunity to submit comments regarding AHA’s Medicare Area Wage Index Task Force final report. We also received AHA’s model of the estimated financial impact of the Task Force’s recommendations on our individual hospital members beginning in 2014. As a member of the AHA Task Force, I fully appreciate the breadth of perspectives on the area wage index and its impact on the hospital community. The AHA team deserves recognition for navigating the complex discussions and for conducting numerous analyses to inform the final outcome. 

As expected, within Illinois (and within every state, presumably), there are financial “winners” and “losers,” although the aggregate Illinois impact is a virtual break-even. After reviewing the final report and the results of the model, IHA is focusing on mitigating the impact of hospitals that sustain the largest financial losses over the five-year estimate period, as emphasized by our comments and suggestions below. From our initial review, hospitals experiencing the largest reduction in dollars appear to be those that had previously benefitted from a reclassification. However, as we suggest below, it is not possible to link components of our members’ net gains or losses to specific variables modeled from the information we received.

After reviewing the final report and the initial financial impacts of the model, we support some approaches and have concerns about others. Following are short summaries of both, as well as brief discussions of other issues presented for the Task Force’s future consideration:

**FINAL REPORT/MODEL RESULTS SUPPORTED BY IHA:**

- **Reducing the length of time between the reporting of the wage index supporting data time period and its implementation in the wage index process (currently set at four years):** One of the suggestions raised in the final Task Force report was to improve the timing of the source data used in determination of the wage index values. Currently, a four-year lag exists between the time...
period for which the wage index information applies and the IPPS fiscal year in
which the wage index will be applied to payments. For example, the sources of
the data used to set the FFY2014 Medicare wage indices are the FFY2010
Medicare cost reports. This approach is erroneous for the following reasons:

- The economics of the community and/or the county in which a hospital
  (or hospitals) operate can change greatly during that time. A major
  employer can discontinue operations; a severe storm can ravage homes
  and businesses; populations can shift; etc. IHA is concerned that these
  or other changes that can affect the community’s economy and provider
  operations in that community are not considered in the current wage
  index process.
- During the four-year period, an individual hospital’s wage and
  compensation policies may change significantly. For example, that
  hospital may be acquired by another hospital or choose to become part
  of a health care system; it may implement an employee incentive
  compensation program; or it may add or discontinue services. Any of
  these situations would render wage information gleaned four years ago
  obsolete.

IHA therefore recommends that the use of the latest available cost report data
(in most cases, this should be within two years of application) be implemented.
While it is not possible at this time to estimate the impact on specific wage
index values, this is a more practical approach.

- **Establishment of multiple rural wage indices within states if appropriate:**
  IHA supports the Task Force approach that results in creation of multiple wage
  indices within an individual state for rural areas, as opposed to the single use,
  state rural wage index now in place. For example, rural hospitals in southern
  Illinois would not consider rural hospitals in the central or northern parts of the
  state as competitors for labor, regardless of the operational similarities or
  differences among those hospitals. In addition, application of the “smoothing”
  adjustment will minimize differences in wage index values among rural areas
  that cross neighboring states, thereby reducing one state’s competitive
  advantage over another.

- **Decision to continue using hospitals’ Medicare cost reports as the source of
  the wage index data, in lieu of the Bureau of Labor Statistics (BLS) for
  health care professions:** While the BLS data includes wage and benefit
  information for all health care occupations (including those in non-hospital
  settings such as schools or public health departments), Medicare cost reports
  are audited and adjusted (if necessary) by Medicare Administrative
  Contractors. This audit process gives additional credibility to the cost report
  data.

- **A county-specific, hold-harmless agreement to minimize excessive increases
  or decreases in the wage index values from one year to the next (i.e., the stop**
**loss/gain:** While the choice of 3% as the stop loss/gain adjustment can be debated, having a “hold-harmless” adjustment cannot be discounted. Even with a five-year transition, some drastic changes in the wage index values of certain Core-Based, Statistical Areas will occur, and this adjustment helps to mitigate that impact.

- **A five-year transition to aid in our hospitals’ adaptation to the new process:** Transitions have been used throughout the history of the Medicare Inpatient Prospective Payment System (IPPS). With a significant portion of the Medicare IPPS payment based on the wage index, a five-year transition, as suggested by the Task Force, is fair. IHA also recommends that once the components of the reformed wage index are finalized, the transition should begin no sooner than 1-2 years after, to allow for the necessary education and information to be disseminated to IHA members and stakeholders.

**FINAL REPORT/MODEL RESULT CONCERNS FOR IHA:**

- **Need for greater detail emphasizing each recommendation’s specific impact on the model results:** As CMS implements changes to the Medicare IPPS on an annual basis, IHA prepares estimated financial impacts for its members, listing an impact for each payment variable, such as the wage index change, documentation and coding, market basket, etc. However, the model impact reports received by IHA do not specify the net dollar impact of such variables as the stop loss/gain, smoothing adjustment, loss of reclassified status, etc. for each individual hospital. Having access to this information would clarify which assumptions have the greatest financial impact and also assist in determining the impacts of other “what-if” scenarios (such as reducing the smoothing adjustment from 10% to 5%).

- **Must provide adequate “hold harmless” provisions to protect those hospitals that are disproportionately harmed by any change in the process:** Any change in the wage index process must build in safeguards to protect hospitals with the high-end, wage index values so they do not get overly harmed in converting to a new system. Several “hold harmless” provisions are built into the wage index reform process, including:
  - A 3% stop loss/stop gain;
  - A 10% “smoothing adjustment”;
  - An “out-commuting” adjustment”; and
  - An audit process where a specific provider can review and amend its data.

Each of the above provisions would have to be evaluated individually to determine if changes in the formulas would results in a more equitable redistribution of dollars.
**Post-Acute Providers:** IHA has certain concerns expressed on behalf of our free-standing, post-acute providers (Rehabilitation, Behavioral Health, Skilled Nursing, or Home Health). Is there any information that we can share with them? To what extent will changes in the hospital’s wage index impact these sub-providers? Can the Task Force use the focus on the current wage index process to design a survey instrument that more accurately represents a specific group of post-acute providers?

**FINAL REPORT/MODEL RESULTS REQUIRING FURTHER ANALYSIS:**

- **While not completely supporting the total elimination of reclassifications or exemptions, a more equitable and less complex process to obtain and/or validate them is necessary:** The current process of obtaining a CBSA reclassification or exemption has benefitted some of our hospitals in the past. While IHA has previously encouraged hospitals to seek reclassification to another CBSA if they believe that they meet the necessary criteria, we also acknowledge that the regulations governing the current process are cumbersome and confusing. Reclassification and exemption criteria as applied by the Medicare Geographic Reclassification Review Board (MGRRB) should be more transparent. More analysis and discussion is needed to fully determine to what extent a reclassification is warranted, and how the current criteria used to approve a reclassification can be improved.

- **Need to conduct an ongoing evaluation of any significant changes in the wage index process:** Because this is a highly complex and radical change, a review process (i.e., 36 months) should be implemented. One of the main reasons for a five-year transition is to minimize the negative impact this change could have on a specific provider. There may even be sensitivity to review the process in annual increments, soliciting feedback from industry providers.

- **Impact of changes in the wage index development process on current Medicare cost reporting requirements:** Implementation of the changes as recommended by the Task Force would affect the cost reporting process and sources of data. Examples of additional data that may be required include information to support a CBSA reclassification request or compensation and benefits information specific to sub-providers or units. Again, IHA believes that the Medicare cost report is still the best source of data used in the wage index process. While the subject of revisions to the current Medicare cost reporting process is outside the scope of the Wage Index Task Force’s work, in order to address one of the shortcomings of the current system, wage index information specific to sub-providers would have to be identified. This could only be accomplished with an expansion to Worksheet S-3 of the Medicare cost report.
Is the impact model flexible enough to permit timely and accurate results of additional “what if” scenarios? The model should be flexible enough so that as changes to existing assumptions or any new assumptions are discussed, the specific impact to those modifications can be measured. Would the Task Force be willing to share the model with the individual Task Force members or with the individual state hospitals associations (i.e., IHA) so that the impacts could be more thoroughly analyzed?

Impact of 2010 Census data: The final report of the Task Force makes no mention of using 2010 Census data, which would impact the model results significantly. Just last month, CMS released its proposed FFY2014 Medicare Inpatient Acute payment rule, which includes a discussion of the wage index process. In that rule, CMS acknowledges that the 2010 Census data is available, but the results cannot be incorporated into the 2014 wage index values due to timing issues. However, the agency intends to structure the FFY2015 wage index based on the 2010 data. The use of updated Census Bureau data would be expected to change several of the current designations of Core-Based, Statistical Areas (CBSAs). As a result, the financial estimates as illustrated in this model would have to be re-run to accommodate those changes. Has the Task Force considered the ramifications of using the 2010 Census data?

Impact of Medicare wage index reform on other payers: Although this issue was not raised in the Task Force final report, it bears mentioning in light of the current Illinois Medicaid payment reform taking place. The AHA model provides an estimate of the impact on Medicare payments, given certain changes in the wage index methodology. However, consideration must be given as to the extent to which the Medicare wage index methodology (current or revised) will be incorporated (if at all) into a reformed Medicaid APR-DRG payment system, and how the impact on non-Medicare payers will be estimated for member hospitals.

Correlation between of the Occupational Mix survey on this process: AHA staff noted that the work of the task force, including modeling, was done with no regard of any impact of the occupational mix survey; i.e., the use of the occupational mix survey instrument and its incorporation into the wage index values would continue as is. AHA’s rationale is that occupational mix has no impact on the process of wage index reform. While that may be true, has AHA run any simulations that address the impact of the current occupational mix process? And would this be the proper time for the Task Force to thoroughly review the occupational mix survey instrument and recommend changes in conjunction with the revised wage index process?

Coordination with other organizations also analyzing the wage index process, such as the Institute of Medicine (IOM), the Medicare Payment Advisory Commission (MedPAC) or CMS (Acumen): No mention is made in the final
June 25, 2013

Task Force report of collaboration with other entities to develop a reformed process. Nor is collaboration reflected in either the Task Force principles or recommendations. IHA would like to raise the issue of the Task Force examining some of the work done by others for purposes of consistency in approach.

IHA appreciates the difficult task before the Task Force to reform the Medicare wage index process, while trying to minimize the inevitable negative financial impact for some providers at the same time. We hope that through continued discussions and modeling, we can continue to build on the body of work done by the Wage Index Task Force up to this point, while working to improve the financial structure of the Medicare program.

Sincerely,

Maryjane A. Wurth
President & CEO
June 25, 2013

To: The AHA Area Wage Index Task Force Subcommittee

Holyoke Medical Center (HMC) appreciates this opportunity to provide comments and feedback on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

HMC is an acute care urban community hospital located in the City of Holyoke in Hampden County, Massachusetts, with 198 beds and 10 bassinets. HMC was established in 1893 with funding from committed business leaders to take care of sick and poor citizens. Since that time, HMC has provided continuous healthcare leadership and quality care to the local and surrounding communities. Citizens of Holyoke, Chicopee, Easthampton, Granby, South Hadley, South Hampton, and West Springfield make up its primary service area. HMC has received national recognition for high quality services, ranging from certification as a Breast Cancer Center to awards for consistently superior care and treatment of stroke patients.

In Massachusetts, the impacts of changes to the Medicare inpatient wage index system extend beyond Medicare reimbursement: these changes impact not only Medicare inpatient operating, inpatient capital; outpatient and post-acute facilities reimbursement as well as Medicare Advantage payments, but would also impact Medicaid reimbursement since MassHealth uses the geographic reclassifications approved by CMS to adjust MassHealth payments to hospitals.

Utilizing the model prepared by AHA, HMC would stand to lose $7,000,000 over the five years if AHA’s recommendations are accepted. This does not include the lost reimbursement from Medicare Advantage Programs or MassHealth. This reduction in reimbursement on a safety net hospital such as Holyoke Medical Center would be catastrophic.

Although HMC can support some of the proposals, HMC has some concerns including:

Recommendation #3: To help limit year-to-year volatility in individual hospitals’ wage indices. Congress should include all hospitals and hospital-distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals in the wage index data set.

Wages in hospital-distinct-part units are paid on a different scale than those of hospital providers due to many factors such as schedules, patient load, patient intensity, and training. Therefore, wages for distinct-part units should not be combined with that of hospitals unless it has been determined through appropriate modeling, which HMC understands has not been done, that doing so will not artificially deflate hospital wage indexes.
Recommendation #6: The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10 percent smoothing adjustment.

Continuing reclassifications on a case-by-case basis seems to be inconsistent with what AHA is proposing under these recommendations. Continuation of case-by-case reclassifications can and will result in reimbursing providers differently that may be competing for the same labor force. HMC has had to compete in a marketplace in which, due to an arbitrary calculation, a facility not more than 15 miles away was being reimbursed at a higher wage index. As a result, HMC has not been able to compete on wage rates.

HMC appreciates being able to comment on these proposed recommendations and hopes that any recommendations that are put forward meet the needs of the hospital community and do not further disadvantage one facility over another.

Sincerely,

[Signature]

Paul M. Silva
Vice President and CFO

PS/jn
June 25, 2013

AHA Medicare Area Wage Index Task Force
155 N. Wacker Drive
Chicago, Illinois 60606

SUBJECT: AHA Medicare Area Wage Index (AWI) Task Force – Comment Letter

Dear AHA Medicare AWI Task Force Members:

On behalf of WellStar Health System and its member providers; WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, WellStar Paulding Hospital, WellStar Windy Hill Hospital and WellStar Medical Group (over 500 physicians), I would like to first commend the AHA Task Force for taking up the unenviable duty of addressing the inequities inherent in the application of the Medicare AWI.

Second, WellStar Health System would like to note the following comment from the AHA Medicare AWI Task Force draft report:

"While promoting efficient, affordable and high-quality health care is a laudable goal, the Task Force agreed that the purpose of the wage index should continue to be to account for geographic differences in wages across labor markets. Promoting efficiency and value are laudable goals that Medicare and the hospital field should unequivocally strive to achieve."

The AHA Medicare AWI Task Force through this statement correctly acknowledged efficiency and value as laudable goals but did not recommend changes to reward hospitals that provide cost effective health care services.

Not addressing this issue allows the current Medicare AWI structure to continue to be an obstacle to providers in certain major metropolitan areas in the country to fairly compete for highly skilled health care employees – since competition for these workers is national not local.

For this reason, WellStar Health System would like to propose the creation of an Urban Medicare Wage Index Floor of 1.0 for Core-Based Statistical Areas (CBSA’s) located in a metropolitan area with a population of at least 5 million per the latest US Census Bureau data and to be funded via a separate appropriation (non-budget neutral).

We believe that this proposal would reward efficient, affordable and high quality health care to providers in major metropolitan areas in the Southeastern part of the country that do the best job of controlling labor cost on an annual basis. We respectfully request that our stated proposal be included in the final recommendation that the AHA Medicare AWI Task Force presents to the Congress of the United States. Please contact me at 770-792-5036 or jim.budzinski@wellstar.org if you have any questions.

Sincerely,

Jim Budzinski
Executive V.P. and CFO
TO: AHA Medicare Area Wage Index Task Force  
FROM: Mark Doak, President  
DATE: June 25, 2013  
RE: June 2012 Task Force Draft

Thank you for the opportunity to review and comment on the most recent draft. The Task Force has a huge responsibility to review and offer proposed revisions for a financial distribution methodology which touches the majority of hospitals. There are no easy answers. I applaud the AHA and the Task Force for their efforts.

Davis Health System is composed of a 90-bed sole community provider (which is affected by the proposal) and a 12-bed critical access hospital both located in rural West Virginia. We receive the rural wage index which has decreased from .79 in 2005 to .73 in 2012. The continual decline in the wage index translates into fewer dollars which further depresses wages and the corresponding wage index. My specific comments are:

**Premise Considerations:**

**Circularity:**

(1) The current healthcare environment is leading to more mergers and financial pressures are leading to hospital closures. **The future will see fewer hospitals.** Fewer hospitals will lead to more market areas with one or two hospitals. (As the hockey player Wayne Gretsky stated, “Skate to where the puck will be – not where it is”).

(2) Circularity is more than one or two hospitals affecting the wage index. It is also a low wage index for a geographic region, resulting in low wages, resulting in a lower future wage index. The WV rural wage index is a prime example.

**Employee Benefits:**

The Task Force discussed employee benefits within the healthcare industry and that any wage index analysis must include this effect. As the insurance exchange is implemented, health insurance (a major component of employee benefits) will become more standard throughout all businesses. Therefore, the concern over variances in employee benefits will decrease over time.
Specific Draft Comments

Figure 1 of the Draft. Did the Committee consider the computation of the PPS Base Rate? Is the 68.8% adjustment for Wage Index greater than 1.0 versus 62% for wage index less than 1.0 appropriate/relevant? It would seem the higher adjustment for those with a wage increase greater than 1.0 provides higher reimbursement which allows higher wages and therefore increases the variance between low wage index hospitals and high wage index hospitals. Information to review the reasonableness of 68.8% vs. 62.0% is readily available from cost reports.

Wage Index Purpose. Maintaining the purpose of the wage index to account for geographic wage index difference seems appropriate. There may be some circular thoughts to consider in this purpose. Hospitals can only pay wages if funds are available for the wages. The disparity between low wage index areas and high wage index area has increased over the years. Therefore the wage index itself has created geographic wage differences – as opposed to the market area. This is noted in Appendix B Option 1 – BLS Data. The standard deviation under the current wage index is .1675 while the standard deviation for BLS is .1474. Since hospitals compete for talent on a regional and nationwide basis, how do we justify a higher geographic standard deviation?

The wage index is lower and higher in various geographic areas. Consideration should be given that it is not the local market which has created these variances, rather the wage index itself. Therefore, the historic flaws in the wage index must be corrected though future wage index adjustments. Comments throughout the paper seem to indicate that several members have strong feelings current wages in geographic areas are correct and adjustments are not necessary.

Circularity – High and low wage index. Currently the disparity between the high and low wage index is 134%. Has the Committee considered a goal in this area? That disparity should be not more than 100% or the standard deviation between the high and low should be no more than -1200. The disparity has accumulated over the years. It seems there should be something to measure the success of the initiatives proposed by the Task Force.

Rural Imputed Floor A conclusion is presented that rural wages should always be lower than urban wages. If not, then the urban wages should be adjusted to the rural wages. One way adjustments are always difficult to understand. In the interest of fairness, this should be a two way street – or eliminated completely.

Calculation of the Rural Floor As has been mentioned earlier, wage data is 4 years old. Currently if a hospital closes, the data of the closed hospital continues to be included in the computation for the next four years. Why does a hospital close – due to
financial reasons? The low wages of this financially distressed hospital continue to affect other hospitals for many years to come.

Appendix B. Distribution of hospitals by wage index. Based on wages, the national wage index for all hospital should be 1.000 – 50% of wages are above this and 50% are below. It is assumed the computation for this is correct. Since the charts show the mean at .9620, the majority of the hospitals have a wage index less than 1.0000. In fact, 69% of the 3,372 hospitals are less than 1.0000. Did the Task Force have discussions around the distribution of health care wages verses the distribution of health care facilities? Is there a goal as to the number of health care facilities below or above 1.000? Again, something to measure the success of the Task Force efforts.

Overall

The Task Force must be commended for the knowledge and understanding which has been gained from their efforts. While moving towards an improved system, the Task Force hesitated in recommending a system which removes many of the current flaws. The hesitation can be summarized as follows:

- Continuation of the existing wage/benefit reporting which relies on limited hospitals in geographic areas and a four-year delay rather than using existing general industry wage data which is more reflective of the area market and is updated timely.
- Replacing all of the geographic reclassification and other mechanisms with an “out computing” mechanism requiring an updating/implementation of information which currently is not available. This will result in another round of discussions as to the accuracy of the data. Plus, the updating/implementation requires funding which the Federal Government does not have.

There is time to step back and rethink how to approach the wage index. On the June 18th call, it was indicated it would be several years before the first year of any transition would begin. Let’s use the solid basis of information which has been gathered to outline a proposal which does account for geographical differences and addresses the serious flaws in the current system.

The final recommendation should transition from geographic wage differences which “currently” exist to the geographic differences which “should” exist. The proposed draft begins with the comment that the current wage index is seriously flawed. Let’s work towards a system that appropriately recognizes and distributes reimbursement for wages.
The Task Force has accumulated valuable information to address a wage index process which is not working. Thank you for your efforts.

Sincerely,

Mark Doak
President

Footnotes:

Davis Impact:
In the impact analysis, Davis Memorial will move from .7384 (one of the lowest in the nation) to .8082, an increase in wage index of almost 9%. In the first year, wage reimbursement will decrease by $1,483. The cumulative 5-year effect is $17,000 on annual base wages and benefits of almost $40 million. Nothing changed except the appearance of the wage index numbers.

MS DRGs:
MS DRGs was identified as a method to better report patient acuity. This was quickly moved forward and implemented. The effect was to move reimbursement from rural hospitals to urban hospitals. This was accomplished under the umbrella that hospitals providing higher acuity should be paid more. The wage index policy is flawed which means the distribution of wage reimbursement is flawed. Two thirds of hospitals have a wage index below 1.00. Most are rural facilities. We should be moving quickly to a system which provides fair reimbursement – just as we did with MS DRGs.

Minimum Wage:
The federal government sets a minimum wage (floor) for the entire country. There is no geographic adjustment. Any change to minimum wage has an impact on rural facilities with low wage indexes. Wages must be increased with no corresponding increase in reimbursement. The wage index should follow this philosophy and establish a floor.
To: The AHA Area Wage Index Task Force Subcommittee

Dear Sir or Madame,

Hallmark Health System, Inc. (Hallmark) appreciates this opportunity to comment on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index (AWI) system. We commend AHA’s efforts to reform the current AWI in a comprehensive, transitional manner to ultimately reflect the relative differences hospitals face with respect to hospital labor costs. However, at this time we do have concerns that the good intentions of the AHA AWI Task force are based on incomplete or untested data and could become subject to inconsistencies, and a new set of exceptions.

Hallmark supports four of the seven recommendations of the Task Force as follows:

- **Recommendation #1:** To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
- **Recommendation #2:** To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.
- **Recommendation #4:** To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period.

**Recommendation #7:** The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment

Hallmark is concerned about Recommendation #3 and Recommendation #6:

- **Recommendation #3:** To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Post-acute providers tend to have lower average hourly wages than acute care providers as the skill set in an acute care setting for Nurses and Technologists is going to cost an acute care hospital more than a post-acute provider. We favor keeping a distinction between the acute care and post-acute providers as it currently exists.

We also understand that Recommendation #3 was not modeled by the Task Force because the data required to do so is either not available or incomplete. Hallmark believes that the potential negative unintended consequences of recommendation #3 are unknown at this point, and the financial stability of any category of provider should not adversely affected by a hasty
implementation of Recommendation #3. This recommendation should be modeled and studied further.

Where the Task Force report states that recommendation #3 is intended to mitigate the impact of small sample size and volatility, AHA might consider a hold harmless provision that would limit the application of this recommendation only in labor market areas that meet specific criteria and would be helped by the inclusion of post-acute providers’ wage data.

- **Recommendation #6:** The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

We believe that these adjustments, in particular the smoothing adjustment, are difficult to replicate and hospitals will have trouble verifying the accuracy of the wage index that is assigned to them. It contradicts the task force’s principle that the wage index data and methodology should be as consistent, easy to administer, transparent and understandable as possible.

It is also unclear what the size of the budget neutrality offset to fund the outmigration and smoothing adjustments would be. Additional information and data about these adjustments should be provided to AHA members.

We disagree with the Task Force on preserving non-budget neutral exceptions—this is inconsistent with the Task Force principle that having so many exceptions is an issue in the current AWI system. It would also, we fear, lead to a race among hospitals to secure their own “special deals” in Congress which will increase complexity, add administrative burden and decrease the integrity of the wage index system.

Hallmark strongly objects to Recommendation #5:

- **Recommendation #5:** To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

The reasons for our opposition to recommendation #5 as outlined below:

1.) One of the Task Force’s principles is that the current system of exceptions is “unacceptable”, and recommendation #6 specifically seeks to eliminate all budget-neutral exceptions. However, recommendation #5 would put in place a new budget neutral ‘exception’—the exponential floor—which would increase the AWI for 67% of all hospitals. This is inconsistent with the intent to eliminate budget neutral exceptions.
Hospitals with AWI less than 1 would get an arbitrary increase in their AWI every year, which would continue in perpetuity without any application process or oversight.

2.) According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which it exists cannot be quantified” (June 4 2013 conference call); and that the exponential floor adjustment was “arbitrary but appealing” (June 4 2013 conf call). It is troubling that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.

3.) The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for providers with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. The market areas should be respected.

4.) Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications.

5.) It remains unclear to us why a struggling community hospital like ourselves should have to sustain deep Medicare payment cuts, which will be devastating to us, in order to subsidize an arbitrary adjustment for hospitals in other states in perpetuity.

6.) Hospital leaders have pointed out that other factors, not the Medicare AWI (which has a four year lag), determine the wages that they pay their employees. Hospitals in high wage areas offer higher wages because of competitive forces—they not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

7.) The exponential floor adjustment would raise the AWI of low wage hospitals, but could very well have no impact on the rate at which their AHW changes—thereby resulting in no improvement in their baseline AWI. Since the exponentiation formula works in a manner that as the AWI approaches 1.000, the percentage by which the exponentiation increases the baseline AWI declines. But if there is no link between the wage index and wages paid by a hospital, we could end up with an AWI death spiral where the high wage hospitals have to keep funding the exponential floor with no end in sight.

8.) Further, there is no evidence, according to the AHA (June 4, 2013 conference call) that there is a correlation between the wage index that a hospital receives and its margins—high AWI hospitals can have low margins and vice versa. We therefore question the very premise implementing this adjustment for low-AWI hospitals given the lack of evidence that such an action would improve their bottom lines.
In our view, Hallmark believes that the exponential adjustment is an expensive redistributive experiment. We request that the AHA Task withdraw this recommendation.

Regarding the Impact Analysis:

The AHA made available a hospital specific and statewide impact analysis of the recommendations to members. Hallmark has concerns about the methodology, data and gaps in the AHA analysis—and we believe that the AHA analysis may be significantly understating the impact of the recommendations. We note that the AHA statewide impacts did not include the impact of the recommendations on post-acute providers, IPPS capital payments, Medicare Advantage payments and OPPS payments, all of which are impacted by changes in the IPPS wage index.

In its impact modeling, AHA also did not account for compounding: in other words, the AHA impact shows a first year impact for Massachusetts (at 20% implementation) of -$50m; but the second year impact is also shown to be -$50m (at 40%); and in years 3, 4 and 5, the annual impact remains at about -$50m a year, despite the fact that the transition stages in those years are 60%, 80% and 100% respectively. If we assume that the -50m impact in year 1 is correct (though it reflects only IPPS operating payments, as stated above), the total 5 year impact should be a loss of $750m in inpatient operating payments alone (when compared to today), and not of negative $246m as AHA has stated.

By comparison, the Massachusetts Hospital Association (MHA) conducted a separate analysis on the impact using the best available data. Their preliminary analysis indicates that the negative impact on Massachusetts would be negative $457m annually (in contrast to the AHA's estimate of negative $247m) and even if we factor out the effect of losing the Massachusetts rural floor, the state would still be impacted by over -$191 million per year.

Hallmark is concerned about the significant gaps in the AHA analysis—other payment systems impacted by AWI changes are not modeled, the impact of including post-acute data in the IPPS AWI is not included etc.—our current understanding is that these gaps will remain, and the review process will simply reaffirm that the gaps exist, and not actually attempt to fill them in.

Questions remain regarding the methodology and the impact of individual recommendations—for example, how is the 10% smoothing called for in recommendation #6 actually being applied? Can wage indices be either increased or reduced to achieve the smoothing, or just increased? If the modeling only allows wage indices to be increased to achieve smoothing, what is the budget neutrality adjustment required for this? Similarly, for the out commuting adjustment, what data is being used (can the AHA make available the data underlying this adjustment at a CBSA level)? Can the AHA share the out-commuting budget neutrality adjustment for this?
In Hallmark's opinion, it would be wrong to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact. We commend AHA for trying to establish a national consensus on such a complex matter as the Area Wage Index. We respectfully urge the AHA Board of Trustees to address our concerns that we have outlined above in respect to Recommendations numbers 3 and 6, and to firmly reject Recommendation 5 dealing with "circularity."

Thank You. Hallmark appreciates the opportunity to express our concerns regarding AHA's AWI recommendations.

Sincerely,

Michael S. Turilli  
Vice President, Finance  
Hallmark Health System, Inc.  
170 Governors Avenue  
Medford, MA 02155
I am strongly in favor of the AHA proposal to start over with the area wage index. I have been a CEO in 2
different upstate NY hospitals for more than 25 years. During this time I have seen many hospitals across
the country get re-classified, often for reasons that seem incomprehensible. What happened in
Massachusetts was the final straw. We must have a more rational system. In our particular case due to
the fact we are 2 miles too far to the East we cannot be re-classified into the Syracuse MSA resulting in a
difference in our wage index factor of more than 14%. Differences of this magnitude are not fair or
sustainable and jeopardize care in the low cost areas.

I fully agree that it is time for change.

Richard Ketcham FACHE
President /CEO
St. Elizabeth Medical Center
Office: 315-734-4978
Fax: 315-235-7498
rketcham@stemc.org
June 25, 2013

To: The AHA Area Wage Index Task Force Subcommittee

The Massachusetts Hospital Association, representing its AHA members, appreciates this opportunity to provide comments and feedback on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is an extraordinarily complex system that has very significant impact on hospital reimbursement in every state. We support a comprehensive review and reform of the wage index system. However, because of the importance, complexity, and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the nature, timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data and assumptions followed by a comprehensive modeling of the impact.

In Massachusetts, the impacts of changes to the Medicare inpatient wage index system extend beyond Medicare reimbursement: these changes impact Medicare inpatient operating; inpatient capital; outpatient and post-acute facilities reimbursement; as well as Medicare Advantage payments, and would also impact Medicaid reimbursement since MassHealth uses the geographic reclassifications approved by CMS to adjust MassHealth payments to hospitals.

There are 64 acute care hospitals in Massachusetts; of these hospitals, 70% have a public payer mix (i.e. Medicare and Medicaid charges) of more than 50%. And 28% of acute care hospitals had a negative operating margin in 2012.

According to the 2013 AHA Hospital Statistics publication, 29% of all Massachusetts hospitals are post-acute providers (defined here as Rehab hospitals, Psych hospitals and Acute LTC hospitals). Massachusetts has a disproportionately high percentage, nearly double, of post-acute providers as a percent of total hospitals-- the national average is 16%.

<table>
<thead>
<tr>
<th>Description</th>
<th>MA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>15</td>
<td>424</td>
</tr>
<tr>
<td>Rehabilitation (IRF)</td>
<td>8</td>
<td>198</td>
</tr>
<tr>
<td>Children’s rehabilitation</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Acute long-term Care (LTACH)</td>
<td>8</td>
<td>263</td>
</tr>
<tr>
<td>Total # Post-Acute</td>
<td>32</td>
<td>885</td>
</tr>
<tr>
<td>Total # Hospitals</td>
<td>109</td>
<td>5724</td>
</tr>
<tr>
<td>Post- Acute Providers as % of total</td>
<td>29.4%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>
Post-acute providers in Massachusetts have an even higher public payer mix than acute care hospitals: LCTHs have an 80% public payer mix; IRFs have a public payer mix of 59% and Psych hospitals 53%.

**ANALYSIS OF RECOMMENDATIONS**

We have reviewed the Task Force’s report, studied the recommendations, analyzed their impact and sought member feedback. We outline below the seven Task Force recommendations, our position and, where applicable, the specific reasons behind our concerns. We urge the AHA Area Wage Index Task Force Subcommittee to give serious consideration to our comments.

*Of the seven recommendations of the Task Force, Massachusetts’ hospitals support four recommendations without reservation; we have reservations about two recommendations and strongly object to one recommendation."

**I. Support without reservation:**

- **Recommendation #1:** To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.

- **Recommendation #2:** To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.

- **Recommendation #4:** To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period.

- **Recommendation #7:** The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment

**II. Reservations regarding two of the recommendations:**

- **Recommendation #3:** To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Post-acute providers tend to have lower average hourly wages than acute care providers and since post-acute providers currently have their Medicare reimbursement adjusted for labor costs using the IPPS AWI
(without applying any exceptions), our members are very concerned that, if adopted, this recommendation would lower the AWI for both post-acute and acute providers.

Why do we believe this? MHA conducts an annual salary survey that collects wage data from both acute and post-acute hospitals in the state—a key finding from the survey is that the average hourly wages for registered nurses at acute care facilities are 27% higher than at post-acute facilities. Using this database we found that the weighted average hourly wage at post-acute hospitals in Massachusetts was $25.89/hr compared with $33.19/hr at acute hospitals. We also determined that 7% of all provider wages were paid at post-acute facilities versus 93% at acute care hospitals. This results in a combined weighted average hourly wage that is 1.6% lower than that using acute care provider data alone. To compute the reimbursement impact of this lower (combined) average hourly wage for each payment system that uses the IPPS wage index, we applied the appropriate labor share to this decline of 1.6%, and applied this to projected 2013 payments for each payment system. The result was a $58m decline in payments to acute and post-acute providers in Massachusetts.

We acknowledge that both our data and methodology differ from that which would be used by CMS if the agency were to include post-acute data in the AWI. However, our analysis does provide a directional sense of the impact. Further, in states such as Massachusetts which have a disproportionately higher number of post-acute hospitals, the fact that the national average hourly wage (the denominator in the AWI calculation) would also decline is unlikely to mitigate the negative impact of diluting the numerator (the combined AHW of both acute and post-acute facilities).

Recommendation #3 was not modeled by the Task Force because the data required to do so is either not available or incomplete—which begs the question of whether this recommendation should have been included at all. A similar concern was raised during the June 11th 2013 AHA member conference call, when a caller asked whether the Task Force recommendations included any safeguards against causing undue harm to post-acute providers due to recommendation #3. The answer provided was that recommendation #4 provides for a 3% stop loss. However, as the caller noted, the stop loss would not protect skilled nursing facilities, home health agencies and hospices. In any case, we believe that the potential negative unintended consequences of recommendation #3 are unknown at this point—and the 3% stop loss provision is not sufficient justification for the inclusion of a completely untested recommendation. As we strive to provide more coordinated care in an integrated delivery system, we cannot afford to jeopardize the financial stability of any category of provider. This recommendation needs to be modeled and studied further.

Since the Task Force report states that recommendation #3 is intended to mitigate the impact of small sample size and volatility, an option to consider might be a hold harmless provision which would limit the application of this recommendation only in labor market areas that meet specific criteria and would be helped by the inclusion of post-acute providers’ wage data.

- Recommendation #6: The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.
We commend the Task Force for correctly recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. We support the inclusion of outmigration and smoothing adjustments in the AWI reform recommendations. However, we note that these adjustments, in particular the smoothing adjustment, are difficult to replicate and hospitals would therefore have trouble verifying the accuracy of the wage index that is assigned to them. It contradicts the task force’s principle that the wage index data and methodology should be as consistent, easy to administer, transparent and understandable as possible.

It is also unclear what the size of the budget neutrality offset to fund the outmigration and smoothing adjustments would be. Additional information and data about these adjustments should be provided to AHA members.

We disagree with the Task Force on preserving non-budget neutral exceptions—this is contradictory to the Task Force principle that having so many exceptions is an issue in the current AWI system. It would also, we fear, lead to a race among hospitals to secure their own “special deals” in Congress which will increase complexity, add administrative burden and decrease the integrity of the wage index system.

III. Strongly object to one recommendation.

Recommendation #5: To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- One of the Task Force’s principles is that the current system of exceptions is “unacceptable”, and recommendation #6 specifically seeks to eliminate all budget-neutral exceptions. Yet, at the same time, recommendation #5 would put in place a new budget neutral ‘exception’-the exponential floor-which would increase the AWI for 67% of all hospitals. Hospitals with AWI less than 1 would get an arbitrary increase in their AWI every year, which would continue in perpetuity without any application process or oversight.

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which it exists cannot be quantified” (June 4 2013 conference call); and that the exponential floor adjustment was “arbitrary but appealing” (June 4 2013 conf call). We are very troubled that the Task Force would recommend a questionable and massively redistributive “fix” for an issue for which the wage index is not known to be causal. Additionally, since circularity has not been quantified, the recommended formula for exponentiation (raising the baseline AWI to the power 0.6848), by AHA’s own admission, is arbitrary and we believe unjustified.

- The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially
increase the wage index for providers with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This is neither fair nor logical.

- Hospitals with AWI less than 1 have had other “protections” in place for years such as their lower labor share (62% versus 69.6%) and the frontier wage index. There is no evidence that these protections have helped low-AWI hospitals increase their AHW at a higher rate than the national average. If this is the case, the Task Force should not expect that the exponential floor adjustment will achieve a different result.

- Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications. For our state, we computed the cost of the exponential floor budget neutrality adjustment by applying a 1.2% reduction to all PPS payments for providers that use the IPPS wage index. The impact was negative $66.3m a year.

- Hospital leaders have pointed out that other factors, not the Medicare AWI (which has a four year lag), determine the wages that they pay their employees. Hospitals in high wage areas offer higher wages because of competitive forces—they not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

- It remains unclear to us why a struggling community hospital in Massachusetts should have to sustain deep Medicare payment cuts, which could be devastating for some of our hospitals, in order to subsidize an arbitrary adjustment for hospitals in other states in perpetuity.

- The exponentiation formula works in a manner such that, as the AWI approaches 1.000, the percentage by which the exponentiation formula increases a hospital’s baseline AWI declines. Therefore in theory, over time, the dollars needed to fund the exponentiation should decline. In practice, however, this may not be the case: the exponential floor adjustment would raise the AWI of low wage hospitals, but could very well have no impact on the rate at which their AHW changes (as noted, hospital leaders have pointed to factors other than the AWI when it comes to determining wages). If the rate of change in the AHW of low wage hospitals continues to lag behind the change in national AHW, there will be little to no increase in the baseline AWI of these hospitals. In such a situation, we could end up with an AWI death spiral where the high wage hospitals have to keep funding the exponential floor with no end in sight.

- Further, there is no evidence, according to the AHA (June 4, 2013 conference call) that there is a correlation between the wage index that a hospital receives and its margins—high AWI hospitals can have low margins and vice versa. We therefore question the very premise implementing this adjustment for low-AWI hospitals given the lack of evidence that such an action would improve their bottom lines.
In our view, the exponential adjustment is subject to contradictions, creates new issues and is very costly to hospitals in states where labor costs are high through no fault of their own. Putting in such a provision in perpetuity is not warranted and we request that the AHA Task Force not move forward with this recommendation.

**Comments on the Impact Analysis**

The AHA made available a hospital specific and statewide impact analysis of the recommendations to its members. MHA has concerns about the methodology, data and gaps in the analysis—and we believe that the analysis may be significantly understating the impact of the recommendations. The AHA statewide impacts did not include the impact of the recommendations on post-acute providers, IPPS capital payments, Medicare Advantage payments and OPPS payments, all of which are impacted by changes in the IPPS wage index.

In its impact modeling, AHA also did not account for compounding: in other words, the impact analysis shows a first year impact for Massachusetts (at 20% implementation) of -$50m; but the second year impact is also shown to be -$50m (at 40%); and in years 3, 4 and 5, the annual impact remains at about -$50m a year, despite the fact that the transition stages in those years are 60%, 80% and 100% respectively. If we assume that the -50m impact in year 1 is correct (though it reflects only IPPS operating payments, as stated above), the total 5 year impact should be a loss of $743m in inpatient operating payments alone (when compared to today), and not of negative $246m as AHA has stated. This is illustrated in the chart below.

<table>
<thead>
<tr>
<th>Implementation Year</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase In Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ (48)</td>
</tr>
<tr>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td>$ (49)</td>
<td>$ (49)</td>
</tr>
<tr>
<td>60%</td>
<td>$ (49)</td>
<td></td>
<td>$ (49)</td>
<td>$ (49)</td>
<td>$ (49)</td>
</tr>
<tr>
<td>40%</td>
<td>$ (50)</td>
<td>$ (50)</td>
<td>$ (50)</td>
<td>$ (50)</td>
<td>$ (50)</td>
</tr>
<tr>
<td>20%</td>
<td>$ (50)</td>
<td>$ (50)</td>
<td>$ (50)</td>
<td>$ (50)</td>
<td>$ (50)</td>
</tr>
<tr>
<td>Actual Total Impact After 5 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ (743)</td>
</tr>
</tbody>
</table>

Massachusetts' Impact in Millions of Dollars

Since additional data from the AHA was not available, MHA conducted a separate analysis using the best available data. Our preliminary analysis indicates that the negative impact on Massachusetts would be negative $457m annually (in contrast to the AHA’s estimate of negative $247m) and even if we factor out the effect of losing the current rural floor provision, the state would still be impacted by over -$191 million per year.
### Table: Massachusetts’ Annual Impact in Millions

<table>
<thead>
<tr>
<th>Component</th>
<th>Impact in Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Rural Floor (IP)</td>
<td>$(188)</td>
</tr>
<tr>
<td>Loss of Rural Floor (OP)</td>
<td>$(78)</td>
</tr>
<tr>
<td>Loss of Reclassifications</td>
<td>$(66.7)</td>
</tr>
<tr>
<td>Impact of 1.2% BN adjustment for Exponential Floor</td>
<td>$(66.3)</td>
</tr>
<tr>
<td>Impact of adding post-acute data to AWI</td>
<td>$(58)</td>
</tr>
<tr>
<td>Total impact including the impact of losing the RF</td>
<td>$(457)</td>
</tr>
<tr>
<td>Total w/o including the impact of losing the RF</td>
<td>$(191)</td>
</tr>
</tbody>
</table>

We have shared and discussed our methodology with the AHA, and have sought further information about the variations—but have not received any additional data.

In April, the AHA advised us that outside consultants would be asked to review the methodology and to confirm the validity of its results. As explained on the group conference call, the charge to these consultants is to “check if the modeling does what it is supposed to do”—which in our view addresses only part of the problem. We are concerned that there are significant gaps in the analysis—other payment systems impacted by AWI changes are not modeled, the impact of including post-acute data in the IPPS AWI is not included etc.—our current understanding is that these gaps will remain, and the review process will simply reaffirm that the gaps exist, and not actually attempt to fill them in, even directionally.

In addition, there is a worrisome degree of opacity in the methodology and the impact of individual recommendations—some examples follow:

- How is the 10% smoothing called for in recommendation #6 actually being applied?
- Can wage indices be either increased or reduced to achieve the smoothing, or just increased?
- If the modeling only allows wage indices to be increased to achieve smoothing, what is the budget neutrality adjustment required for this?
- Similarly, for the out-commuting adjustment, what data is being used (can the AHA make available the data underlying this adjustment at a CBSA level)?
- Can the AHA share the out-commuting budget neutrality adjustment for this?
Summary

We know from experience that trying to establish a national consensus on such a complex matter as the Area Wage Index is a major challenge and we commend AHA for taking on that challenge. But, in our members’ opinion, to endorse and advocate for the recommended changes in the wage index system without a more complete understanding of the potential impact would be wrong. At the state association level, we too have challenges in crafting a consensus on complex and controversial issues. And, we know from experience that building a consensus around proposals that will significantly harm a significant number of members is counterproductive. Based on that philosophy and after listening to the comments of other states that share our concerns, we respectfully urge the AHA Board of Trustees to address all the concerns that we have outlined above and in particular, to firmly reject Recommendation #5 dealing with “circularity.”

Respectfully,

Lynn Nicholas, FACHE
President & CEO
Massachusetts Hospital Association
June 26, 2013

American Hospital Association
Area Wage Index Review Committee
325 7th Street, N.W.
Washington, DC
20004-2802

Dear AWI Review Committee:

On behalf of the New Jersey Council of Teaching Hospitals Board of Trustees, we are writing to express our profound concern over the AHA’s Area Wage Index Task Force principles to reform national area wage index policy. We understand the principles will be deliberated on the July 11, 2013 by the AWI Advisory Review Committee. We respectfully, but intensely, urge the AWI Advisory Review Committee to review all the ramifications of these principles and recommend to the AHA Board to not endorse the principles as outlined.

The AHA’s principles would have a significant financial impact on our mutual members. With one-third of New Jersey hospitals currently operating in the red, the dramatic changes in AWI policy advocated by AHA could cause very real financial harm to N.J. hospitals and further threaten access to care in our state. Our opposition, however, is based on much more than the local financial interests. The AHA principles lack sound public policy, are ill-advised in the current political climate, fail to provide real impact modeling to members and, in an effort to address one segment of membership, create even greater divisiveness among AHA’s membership.

To elaborate on our key concerns:

- There is a lack of sound public policy behind these contradictory AHA principles. One of the key principles adopted by the AHA Task Force on AWI is that there should be no exceptions to the new system. And yet, the AHA Task Force has adopted a very significant exception called “exponentiation” to artificially raise low AWI hospitals. The “exponentiation” principal states that “all wage indices of less than 1.000 would be raised to the power of 0.6848.” The cost of exponentiation would be $1.3 billion – far more than the $950 million cost of all of the current exceptions to the AWI system. This idea of “exponentiation” raised many questions and a number of dissenting votes on the Task Force. Many called it arbitrary; we call it a direct conflict of the Task Force’s stated policy position of “no exceptions.”

- The AHA Board said it would “assess the political climate” before proceeding with the principles. The political climate is now worse than ever. Sequestration has begun, and healthcare is more vulnerable than ever to Congress’ hunger for more cuts to pay for deficit reduction. Floating such a redistributive set of principles to Congress will provide ample opportunity for them to skim funds for these purposes.
• The AHA Board said it would model the impact of the principles, but the modeling shared has many flaws. First, it does not show the compounding impact of the principles over five years (as AHA has routinely done when modeling the impact of other policy changes.) This understates the impact to New Jersey by two-thirds ($76 million vs. $228 million.) In addition, the methodology does not include outpatient care and distinct part units which further understates the impact. As you know, the modeling also fails to include the impact upon inpatient rehabilitation facilities, long term care hospitals and inpatient psychiatric units which are key NJCTH members. We, along ask the AHA to also examine the impact of the policy change on individual member facilities. One of our members, for example, has said that the financial loss would be so severe that one of its hospitals would close if the Task Force’s principles were to be enacted.

• The principles divide the AHA and our membership. It redistributes money from some hospitals to other hospitals, from a couple of regions to other regions. The redistributive nature of the principles pits member against member. Is this where AHA leadership wants us to be when we have larger issues ahead to confront as a united healthcare community? This issue has already generated discussion among our members about other policies that funnel federal dollars into certain regions or certain classes of hospital. We worry that AHA’s entry into this complex issue could lead to larger policy questions and membership challenges ahead.

We empathize with the challenges you are facing in responding to members with very different positions. But as you consider your next steps, we feel would be remiss if we didn’t express to you the depths of the concern that have been expressed by our mutual members in New Jersey. AHA’s current position, if recommended by the AWI Review Committee and adopted by the AHA Board will create a significant split in our membership at a time when unity is so important.

We would be very happy to talk with you further about the issue. Please feel free to contact either of us at your convenience. We can be reached at david.shulkin@atlantichealth.org or dbriggs@njcth.org (609) 659-9614

Sincerely,

David Shulkin, MD
Chairman
NJCTH Board of Trustees
President and CEO
Morristown Medical Center

Deborah S. Briggs, BSN, MBA
President and CEO
New Jersey Council of Teaching Hospitals
To: The AHA Area Wage Index Task Force Subcommittee

UMass Memorial Medical Center appreciates this opportunity to provide comments on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is a complex system that has very significant impact on hospital reimbursement in every state. We support a comprehensive review and reform of the wage index system. However, because of the importance and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

In Massachusetts, the impacts of changes to the Medicare wage index system extend beyond Medicare. These changes impact not only Medicare operating, capital, outpatient and post-acute facilities reimbursement as well as Medicare Advantage payments, but would also impact Medicaid reimbursement since Commonwealth of Massachusetts uses the geographic reclassifications approved by CMS to adjust Medicaid payments to hospitals.

UMass Memorial Medical Center has reviewed the Task Force’s report and recommendations. We outline below the seven Task Force recommendations, our position and the specific reasons behind our concerns.

Of the seven recommendations of the Task Force, UMass Memorial Medical Center supports four recommendations:

- **Recommendation #1**: To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
- **Recommendation #2**: To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, a phase-in or a transitional period of at least 5 years should be included.
- **Recommendation #4**: To ensure that hospitals do not experience excessive year-to-year volatility budget-neutral 3 percent stop-loss and stop-gain policy that would limit the amount by which a hospital’s wage index could decrease or increase per year.
- **Recommendation #7**: The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment.

We have reservations about three of the recommendations:

- **Recommendation #3**: To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the
Post-acute providers tend to have lower average hourly wages than acute care providers and since post-acute providers currently have their Medicare reimbursement adjusted for labor costs using the IPPS AWI (without applying any exceptions), we are concerned that, if adopted, this recommendation would lower the AWI for both post-acute and acute providers.

Recommendation #3 was not modeled by the Task Force. This raises the question of whether this recommendation should have been included at all. We believe that the potential negative unintended consequences of recommendation #3 are unknown at this point—and the 3% stop loss provision is not sufficient justification for the inclusion of a completely untested recommendation. This recommendation needs to be modeled and studied further.

- **Recommendation #6:** The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

We commend the Task Force for recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. We can support the inclusion of outmigration and smoothing adjustments in the AWI reform recommendations. However, we note that these adjustments are difficult to replicate and hospitals would therefore have trouble verifying the accuracy of the wage index that is assigned to them. This appears inconsistent to the task force’s principle that the wage index data and methodology should be fairly easy to administer, transparent and understandable as possible.

It is also unclear what the size of the budget neutrality offset to fund the outmigration and smoothing adjustments would be. Additional information and data about these adjustments should be provided to AHA members.

We disagree with the Task Force on preserving non-budget neutral exceptions that could lead hospitals to secure their own “special deals” in Congress which will increase complexity, add administrative burden and decrease the integrity of the wage index system.

- **Recommendation #5:** To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to, the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:
One of the Task Force’s principles is that the current system of exceptions is “unacceptable”, and recommendation #6 specifically seeks to eliminate all budget-neutral exceptions. Yet, at the same time, recommendation #5 would put in place a new budget neutral “exception”-the exponential floor- which would increase the AWI for 67% of all hospitals. Hospitals with AWI less than 1 would get an arbitrary increase in their AWI every year, which would continue without any application process or oversight.

According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which it exists cannot be quantified and that the exponential floor adjustment was arbitrary but appealing”. We are concerned that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.

The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for providers with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing significant Medicare funding from hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This doesn’t appear fair or logical.

Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications. For our state, MHA computed the cost of the exponential floor budget neutrality adjustment by applying a 1.2% reduction to all PPS payments for providers that use the IPPS wage index. The impact was negative $66.3m a year.

Hospital leaders have pointed out that other factors, not the Medicare AWI (which has a four year lag), determine the wages that they pay their employees. Hospitals in high wage areas offer higher wages because of competitive forces—they not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

The exponential floor adjustment would raise the AWI of low wage hospitals, but could very well have no impact on the rate at which their AHW changes—thereby resulting in no improvement in their baseline AWI. Since the exponentiation formula works in a manner that as the AWI approaches 1.000, the percentage by which the exponentiation increases the baseline AWI declines. But if there is no link between the wage index and wages paid by a hospital, we could end up with an AWI death spiral where the high wage hospitals have to keep funding the exponential floor with no end in sight.

Further, there is no evidence, according to the AHA that there is a correlation between the wage index that a hospital receives and its margins. High AWI hospitals can have low margins and vice versa. We therefore question the very premise implementing this
adjustment for low-AWI hospitals given the lack of evidence that such an action would improve their bottom lines.

In our view, the exponential adjustment is a very expensive redistributive recommendation. We request that the AHA Task Force not move forward with this recommendation.

Comments on the Impact Analysis:

The AHA made available a hospital specific and statewide impact analysis of the recommendations to members. We have concerns about the methodology, data and gaps in the AHA analysis—and we believe that the AHA analysis may be significantly understating the impact of the recommendations. We note that the AHA statewide impacts did not include the impact of the recommendations on post-acute providers, IPPS capital payments, Medicare Advantage payments and outpatient payments, all of which are impacted by changes in the wage index.

In its impact modeling, AHA also did not account for compounding: in other words, the AHA impact shows a first year impact for Massachusetts (at 20% implementation) of -$50m; but the second year impact is also shown to be -$50m (at 40%); and in years 3, 4 and 5, the annual impact remains at about -$50m a year, despite the fact that the transition stages in those years are 60%, 80% and 100% respectively. If we assume that the -50m impact in year 1 is correct (though it reflects only IPPS operating payments), the total 5 year impact could be a loss of $750m in inpatient operating payments alone (when compared to today), and not of negative $246m as AHA has stated.

The Massachusetts Hospital Association conducted a separate analysis using the best available data. Their preliminary analysis indicates that the negative impact on Massachusetts would be negative $457m annually (in contrast to the AHA’s estimate of negative $247m) and even if we factor out the effect of losing the Massachusetts rural floor, the state would still be impacted by over -$191 million per year.

There are significant gaps in the AHA analysis—other payment systems impacted by AWI changes are not modeled, the impact of including post-acute data in the IPPS AWI is not included etc.—our current understanding is that these gaps will remain, and the review process will simply reaffirm that the gaps exist, and not actually attempt to fill them in.

In addition, there is an unprecedented degree of uncertainty in the methodology and the impact of individual recommendations—for example, what data is being used for the out commuting adjustment (can the AHA make available the data underlying this adjustment at a CBSA level)? Can the AHA share the out-commuting budget neutrality adjustment for this?
In our opinion, to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact would be wrong. We realize that trying to establish a national consensus on such a complex matter as the Area Wage Index is a major challenge and we commend AHA for taking that challenge. Based on that philosophy and after listening to the comments of other states and hospitals that share our concerns, we respectfully urge the AHA Board of Trustees to address all the concerns that we have outlined above.
I am submitting my comments on behalf of Baylor Health Care System. First I would like to thank AHA and members of the Task Force for the time and effort in the extensive analysis undertaken to define and examine the many issues related to the Medicare Area Wage Index.

I am definitely in agreement with the principles adopted by the group, and believe that they are all valid and good guidelines to use when addressing wage index reform. While the recommendations will not fix the problems entirely, they are a big step in the right direction. I agree with all of the recommendations. Please see my comments below for each recommendation which the task force is making.

**Principles:**
1. Comprehensive reform of the wage index is absolutely necessary.
2. Wage index reform must be implemented in a transitional and budget-neutral manner.
3. The wage index should reflect, as accurately as possible, relative differences in the labor costs hospitals face in a market area.
4. The wage index data and methodology should be as consistent, easy to administer, transparent and as understandable as possible.
5. The wage index system should minimize large year-to-year volatility in individual hospitals’ wage index values.
6. The wage index should seek to minimize circularity and, thereby, seek to limit the possibility of creating unjustifiably large differences between the highest and lowest wage indices.
7. While certain adjustments to the wage index may be necessary to accurately capture differences in labor costs across hospitals, the current system of reclassifications and exceptions is unacceptable.
8. The wage index system should account for the fact that labor markets cannot realistically be defined as hard boundaries.
9. The wage index system should use labor markets that are defined broadly enough to encompass all hospitals competing for the same workers, but narrowly enough to avoid encompassing hospitals with wage costs that vary widely.

**Wage Index Recommendations**
The Task Force agreed that it is unlikely that any set of recommendations would completely “fix” the wage index system for the hospital field, and agree with that statement. However, they felt very strongly that there are specific recommendations that would categorically improve the system for the field as a whole.

The Task Force makes the following recommendations on the inpatient hospital wage:

1. To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing. This would eliminate the current inequities in the interpretation and application utilized by the various MACs, which result in wage indexes which are not comparable or equitable.

2. To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, Congress should phase-in reform using a transitional period of at least five years.
3. To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set. This would increase the base used to compute the wage index and better represent the market of providers which compete for the same labor pool.

4. To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period. In addition to promoting stability in hospitals’ Medicare rates, this would also decrease the need for an overall budget neutrality adjustment.

5. To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments.

6. Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10 percent smoothing adjustment. This is a much better way to adjust for variances between geographically close labor markets with differing wage indexes. I think it comes closer to estimating the impact of a labor market which is willing to travel in order to earn a higher wage. It also takes into account some neighboring hospitals that are located in different market areas but that compete for the labor, and ensures against substantial differences in their wage indexes.

7. Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment. This is necessary in order to implement recommendation #6.

I believe that the recommendations address the current major problems inherent in the wage index process.

Pam Barnes
V.P., Reimbursement Services
Baylor Health Care System
214-820-7268 Telephone
214-820-7950 Fax
June 27, 2013

To: AHA AWI Task Force Subcommittee

Cooley Dickinson Hospital appreciates this opportunity to provide comments on the recommendations of the AHA Area Wage Index (AWI) task Force to reform the Medicare Wage Index System. Cooley Dickinson is a 142 bed community hospital located in western Massachusetts and is located in a region of the state that has the lowest Medicare reimbursement in the state.

The Medicare AWI is an extremely complex system that impacts reimbursement at every hospital in the country. Cooley Dickinson understands and supports the need for a comprehensive review and reform of the wage index system, however, due to the impact of the wage index every effort should be made to reach consensus on the nature, timeline and process of AWI reform. Any analysis done should be completed with data that is complete and accurate and followed by a comprehensive testing of the impact.

We agree with many of the proposed recommendations, but have concerns with two of them. Recommendation #3 proposes to have Congress include all hospitals and hospital distinct part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities and long-term care hospitals, in the wage index data set. Acute care facilities, such as Cooley Dickinson, have to pay wages higher than non-acute facilities due to the higher complexity of cases and the highly skilled workers that are needed to care for these patients. To include non-acute facilities in the wage data set would dilute the wage index and result in lower payments for all. In Massachusetts, registered nurses are paid 27% higher than nurses in the post-acute care facilities. Massachusetts also has a disproportionately higher percentage of post-acute providers as a percent to total hospitals.

Cooley Dickinson also has concerns with Recommendation #6 which asks Congress to eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment. We understand the need for outmigration and smoothing adjustments, however, the smoothing adjustment would be difficult to replicate and we would have difficulty verifying the accuracy of the wage index that is assigned to them. The proposed idea of preserving non-budget neutral exceptions brings us back to a wage index system of exceptions, a system that you are proposing to revise due to the many exceptions that currently exist.

While we have concerns with Recommendations #3 and 6, we cannot support Recommendation #5. This recommendation is asking Congress to increase the wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. As with recommendation #5, the AHA task force is proposing to have a system with exceptions and adjustments. This again is in opposition to your stated principle of revising the AWI system due to its many exceptions and adjustments. While the AHA admits that there is evidence that "circularity" exists, the extent to which it does cannot be quantified. Massachusetts is a very expensive state to live in and hospitals must pay competitive wages to maintain its workforce. We not only compete with other hospitals for labor, but with high tech, research and biomedical companies. Massachusetts is a small state and in western Massachusetts we have to also compete with hospitals in the Hartford, CT area for labor. Due to the size of the state, healthcare employees can easily commute to many geographic areas and hospitals in the western region have to compete with hospitals in the central region which then competes with hospitals in the Boston area. It's a domino effect and we cannot afford to have our wage index lowered to increase the wage index of some area in another part of the country which does not have a high cost of living nor has the same highly skilled companies competing for labor. The impact of this recommendation, as stated in your report, would be to redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications.

Build Partners    Extend Trust    Change Now    Own It    Model Excellence    Exceed Expectations

30 Locust Street • Northampton, MA 01060 • www.cooley-dickinson.org • Phone (413) 582-2000 • Fax (413) 586-9333
Lastly, we are very concerned as to the methodology and data used by the task force. We believe that the projected impact to our hospital, as well as every hospital nationwide, is significantly understated. The task force projections did not include the estimated impact on outpatient Medicare payments and Medicare Advantage payments. The AWI affects more than just the Medicare inpatient payments. All facets of Medicare payments using the AWI must be considered in any meaningful analysis of any proposed change/revision to the Medicare AWI system.

Cooley Dickinson Hospital thanks the Medicare Area Wage Index Task Force for the effort that has been put into this project, but before any meaningful proposal is forwarded to Congress the above issues need to be addressed. We all agree that the Medicare AWI system is very complex and needs reform, but it needs to be reforms based on a thorough and complete analysis and a system that is fair to all.

Sincerely,

Conrad Letourneau
Manager Budget/Financial Planning
Dear Committee Members:

Thank you for this opportunity to share our thoughts on the AHA’s principles and recommendations for reforming area wage index policy. It’s a complex issue – a controversial issue – and we respect the work that has gone into this process by the AHA Board, the AWI task force and the AHA staff. We especially appreciate the AHA’s willingness to introduce added opportunities for member education and feedback.

We have availed ourselves of those opportunities for member engagement, and it’s clear to us that there is no consensus on this issue – not only in New Jersey but also in many other states and regions. And while we certainly appreciate AHA’s efforts to achieve consensus, in its ongoing absence we urge you to avoid approving any policy direction that would further divide the field. This is a pivotal time for healthcare providers, with difficult battles ahead including Medicare and Medicaid DSH cuts, additional deficit reduction cuts, the sustainable growth rate and the ongoing rollout of ACA implementation. We question the wisdom of introducing even greater revenue volatility into a climate that already is simmering with looming revenue pressures for healthcare providers. Rather than invest energy, resources and political capital on an issue that divides us, let’s focus the collective clout of the nation’s hospital and broader healthcare community on other critical issues on which we all can agree.

Our opposition to the AWI proposal is built on several policy arguments, as well as one practical argument: the fact that New Jersey hospitals stand to lose more than $228 million in federal funds over five years if the AHA’s proposal were to be adopted as part of federal policy. For added perspective: The loss of $228 million in federal funds would come to a state where the
average statewide operating margin is 3 percent (compared with a national average of 5.5 percent) and where 11 hospitals have closed their doors in the last decade. In addition, the unknown impact on post-acute providers, which NJHA has in significant numbers as core members, is of great concern. We must oppose any action by AHA that could cause such significant harm to New Jersey’s healthcare organizations and the patients and communities that depend on them.

As for the policy points, our opposition centers on four main concerns:

- The AHA proposal is built on inherently contradictory principles. One of the key principles adopted by the AHA Task Force is that there should be no exceptions to the new system. And yet, the AHA Task Force has adopted a very significant exception called “exponentiation” to artificially raise low AWI hospitals. The “exponentiation” principal states that “all wage indices of less than 1.000 would be raised to the power of 0.6848.” The cost of exponentiation would be $1.3 billion – far more than the $950 million cost of all of the current exceptions to the AWI system. The proposal prioritizes one group of hospitals over another group – with little basis or explanation. And, the exponentiation exception would apply to 66 percent of the field, compared with just 38 percent of hospitals that currently receive an exception.

- In addition, the exponentiation provision would in essence duplicate an existing Medicare adjustment for low wage index hospitals created under the Medicare Modernization Act. The labor-related portion of Medicare payments for hospitals with a wage index less than 1.0 is only 62 percent, compared with 68.8 percent for hospitals with a wage index greater than 1.0. This adjustment drives approximately $400 million annually in additional Medicare payments to the same group of hospitals that also stand to benefit from the exponentiation exception.

- The AHA was unable to model the impact of the task force’s proposal on distinct part units and post-acute providers, nor did it quantify the impact of outpatient activity at PPS hospitals. And yet, all would have their Medicare reimbursements affected if the AHA’s proposal were adopted into federal policy. That is simply too large of an information gap – one that could affect a significant part of AHA’s membership – to proceed with this proposal.

- The AHA Board said it would “assess the political climate” before proceeding with the principles. The political climate is now worse than ever. Large Medicaid and Medicare DSH cuts loom. In addition, the issue of expanding site-neutral payments could well result in a $2 billion impact in a single year. Sequestration has begun, and healthcare is more vulnerable than ever to Congress’ hunger for more cuts to pay for deficit reduction. Floating such a redistributive set of principles to Congress will provide ample opportunity for them to skim funds for these purposes.

New Jersey is arguably the most unique market in the country, particularly for hospital labor. New Jersey has the highest population density in the nation. Those residents can commute with ease within our state and across our borders into New York City – the nation’s largest city – and Philadelphia, the nation’s fifth largest city. We must compete with those major metropolitan
areas for our employees. Across those markets, 173 acute care hospitals – along with many, many more post-acute providers – vie for limited labor resources. In addition, New Jersey’s teaching hospital density is akin to other major metro areas. Sixty-two percent of New Jersey hospitals have teaching programs, on par with cities such as Boston (63 percent) and Philadelphia (56 percent.)

Clearly, a one-size-fits-all approach to AWI fails to reflect the competitive realities of our uniquely situated state.

As AHA member organizations, there is much that we share, including the overriding goal of delivering healthcare services that are high in quality and value and accessible to all. The AHA proposal on area wage index threatens that goal for New Jersey’s healthcare providers. We urge you to abandon these divisive principles and concentrate the industry’s energy and focus on other healthcare policy challenges where industry consensus will yield successful results.

Very truly yours,

Mr. Chester B. Kaletkowski
President & CEO
Inspira Health Network

Barry H. Ostrowsky
President & CEO
Barnabas Health

Audrey Meyers
President and CEO
The Valley Hospital
Valley Health System

Martin A. Bieber
President & CEO
Kennedy Health System

Richard Miller
President & CEO
Virtua

John Lloyd
President & CEO
Meridian Health

Joseph A. Trunfio
President & CEO
Atlantic Health System

Raymond J. Fredericks
President & CEO
JFK Health System
Joseph F. Scott  
President & CEO  
LibertyHealth

Alexander J. Hatala  
President & CEO  
Lourdes Health System

David Tilton  
President & CEO  
AtlantiCare

Leslie D. Hirsch  
President & CEO  
Saint Clare’s Health System

Anthony Cimino  
President and CEO  
RWJ University Hospital - Hamilton

Al Maghazehe  
President/Chief Executive Officer  
Capital Health Regional Medical Center  
Capital Health Medical Center - Hopewell

Warren Geller  
President & CEO  
Englewood Hospital & Medical Center

Stephen K. Jones  
President & Chief Executive Officer  
Robert Wood Johnson Health System

John P. Sheridan  
President & CEO  
The Cooper Health System

Joseph P. Coyle  
President & CEO  
Southern Ocean Medical Center

Patricia Elder Ostaszewski  
Chief Executive Officer  
HEALTHSOUTH Rehabilitation Hospital of Toms River

Joseph P. Chirichella  
President & CEO  
Deborah Heart & Lung Center

John A. Fromhold  
Chief Executive Officer  
HackensackUMC Mountainside

William McDonald  
President & CEO  
St. Joseph’s Regional & Medical Center
Scott R. Wolfe
President
St. Luke's Hospital Warren Campus

Deborah K. Zastocki, Ph.D
President & CEO
Chilton Hospital

Lori Herndon
President & C.E.O.
AtlantiCare Regional Medical Center

Edward J. Condit
President & CEO
St Mary's Hospital

David A. Ricci
President & CEO
Saint Michael's Medical Center

Bruce Markowitz
President & CEO
Palisades Medical Center

Kevin Slavin
President & CEO
East Orange General Hospital

David Shulkin, MD
President - Morristown Memorial Hospital
Vice President - Atlantic Health

Steve M. Proctor
President
Matheny Medical and Educational Center

John F. Bonamo
President & CEO
Saint Barnabas Medical Center

Robert P Wise
President & CEO
Hunterdon Medical Center

Steven Littleson
President
Jersey Shore University Medical Center

Joe Hicks
President & CEO
Barnabas Health Behavioral Health Network

Gary Horan
President & CEO
Trinitas Regional Medical Center
Michael Mimoso
President & CEO
Kimball Medical Center

John A. Brennan, MD
President & CEO
Newark Beth Israel Medical Center

John Gribbin
President & CEO
CentraState Healthcare System

Alan Lieber
President
Overlook Medical Center

Kenneth Bateman
President & CEO
Somerset Medical Center

Dr. Frank Vozos
President and CEO
Monmouth Medical Center

Thomas J. Senker
President
Newton Medical Center

Michael R. D’Agnes
President & CEO
Raritan Bay Medical Center

Michael A. Maron
President & CEO
Holy Name Medical Center

Ronald Rak
President & CEO
Saint Peter’s University Hospital

Cheri Cowperthwait, RN
Chief Executive Officer
Lourdes Specialty Hospital

Roberto Muñiz
President and CE
The Francis E. Parker Memorial Home, Inc.

Douglas A. Struyk
President & CEO
Christian Health Care Center

Donald Parker
President & CEO
Carrier Clinic
Darlene Hanley, FACHE  
Chief Executive Officer  
St. Lawrence Rehabilitation Center

Linda Savino  
Chief Executive Officer  
HEALTHSOUTH Rehabilitation Hospital of Tinton Falls

Tammy Feuer  
Chief Executive Officer  
HEALTHSOUTH Rehabilitation Hospital of Vineland

Kirk C. Tice  
President & CEO  
RWJ University Hospital - Rahway

Violeta Peters  
Chief Executive Officer  
AcuteCare Health System, LLC  
Specialty Hospital at Kimball

Richard Kathrins, PT, MHA. Ph.D.  
President/CEO  
Bacharach Institute for Rehabilitation

Joseph S. Orlando  
President, Chairman of Board  
Bergen Regional Medical Center

Elizabeth A. Ryan, Esq.  
President & CEO  
New Jersey Hospital Association
June 27, 2013

Dr. Ben Chu  
Chairman, Board of Trustees &  
Members of the Area Wage Index Task Force  
American Hospital Association  
155 N. Wacker Drive  
Chicago, IL 60606

delivered via email: AWI@aha.org

Dear Dr. Chu and Members of the Task Force:

On behalf of our 39 hospitals in Arizona, California and Nevada, Dignity Health is pleased to provide input on the AHA’s Medicare Area Wage Index Taskforce. The fifth-largest hospital system in the nation, Dignity Health is proud of our commitment to our mission to provide quality, affordable care to all, especially the poor and disenfranchised. Dignity Health believes humanity is the very core of health care and advocates for policies to elevate the sacred covenant between providers and patients, to deliver the best care with the greatest compassion. Dignity Health appreciates the deliberative process and the time and effort Task Force members have contributed to the Task Force to identify concerns, develop principles and make recommendations.

One of the factors used to adjust hospital payments, the area wage index (AWI) has become complicated and cumbersome, while not completely capturing market factors that affect the cost of providing care. Dignity Health agrees with the principles put forth by the Task Force, but does not endorse the redistributive approach the Task Force is proposing. While addressing inconsistencies in the AWI is important, considering the current transformation in hospital financing, including changes in payment strategies, quality initiatives and coverage expansion, updating the AWI should not be a proactive, high advocacy priority for the AHA at this time. Instead, Dignity Health urges the AHA to use the important work developed by the Task Force to guide advocacy efforts as Congress begins to develop legislative changes in the AWI.
AWI SIMPLIFICATION

Dignity Health has long advocated for the simplification of the wage index methodology by using current, validated hospital data obtained through the annual cost report to create a hospital-specific wage index. Cost reports contain hospitals’ actual salary costs, professional fees, and occupational mix data. To smooth changes in the index, CMS should use a hospital-specific three-year rolling average. To make sure the index captures competition in the labor market, surrounding hospital wage indices within a fifty mile radius (regardless of state or MSA) could be blended into the hospital-specific rate. These proposals will also slow down year-to-year volatility.

Using already-required data that is subject to audit and validation eliminates the need for reclassifications, adds oversight in hospital business practices and – more importantly – pays hospitals based on their actual paid wages and wage related costs as originally intended.

TASK FORCE RECOMMENDATIONS

Dignity Health agrees with the concerns raised by the Task Force, but has significant concerns with some of the recommendations, outlined below:

1. To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.

Dignity Health agrees designating one FI/MAC would be an appropriate step that would promote nationwide consistency in data collection and processing. **However, we are concerned with the sheer manpower it would require to undertake this task. No existing MAC has the capacity to oversee the AWI data collection and processing, especially if the AWI is not simplified.**

2. To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, Congress should phase-in reform using a transitional period of at least 5 years.

Dignity Health agrees with creating a transitional period to mitigate fluctuations in hospital payments that may result from AWI reform and agrees a five-year transition period is appropriate. **Any changes to the AWI should have a five-year transition period, blending the old and new payment rates.**

3. To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using
the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

In principle, Dignity Health is not opposed to including all hospitals and hospital distinct-part units in the wage index data set, and agrees it gives a truer picture of health care providers across the spectrum of care. However, we share other providers’ concerns that introducing new data without understating the effects on the overall index itself may create more volatility to the index in the outset. This methodology would be more appropriate in a hospital-specific wage index approach, as recommended above. **Dignity Health recommends more study on the implications of including additional providers’ data to calculate the wage index. Alternatively, Dignity Health recommends slowly phasing in the data to mitigate dramatic shifts in the overall wage index calculation.**

4. To ensure that hospitals do not experience excessive year-to-year volatility, Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These polices should apply both during and after the five-year transitional period.

While we understand it is important to minimize single-year losses through a stop-loss policy, it is unclear why a stop-gain policy is also needed. **The transition plan recommended above, should sufficiently address volatility. Under Dignity Health’s AWI Simplification recommended above, a three year rolling average would further mitigate volatility.**

5. To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. **Puerto Rico wage indexes should be increased to the lowest pre-reclassification wage index outside Puerto Rico.**

Dignity Health is concerned this recommendation is based on the assumption that hospitals in some states purposely inflate wages in order to draw down a more favorable wage index. If this were the case, there would be data showing year-to-year inconsistencies in hospital wages. However, the exponential methodology recommended by the Task Force inappropriately penalizes hospitals that are in high wage areas and subsidizes low-wage hospitals without appropriately understanding the root cause of the problem, creating a whole new group of winners and losers. **Dignity Health opposes this recommendation as a whole.**

The report also discusses the use of Bureau of Labor Statistics (BLS) data as an alternative approach to addressing the concern of circularity. The report appropriately points out that BLS data is based on estimated wages and employment rates based on a voluntary and confidential survey conducted every
six months. It also does not include benefit information. **Dignity Health is equally opposed to using BLS data because it is not transparent and incomplete. Dignity Health appreciates the Task Force dismissing this recommendation.**

**Dignity Health recommends the Task Force hold off on addressing this concern until more complete data is available. Dignity Health encourages the Task Force to consider developing a methodology to create hospital-specific wage indices using the annual cost report, as described above. This will provide a more detailed and accurate picture of a hospital’s wages, benefits and occupational mix and, more importantly, pays hospitals based on their actual paid wages and wage related costs as originally intended.**

6. **Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10 percent smoothing adjustment; and**

7. **Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer out-commuting adjustment.**

The purpose of the AWI index is to make appropriate adjustments to hospital payments based on labor market costs. While Dignity Health agrees reclassification has created some disparities in the system, it has been a necessary tool to ensure more reasonable reimbursement of hospitals’ share of costs. If AWI Simplification is adopted as described above, reclassification will be unnecessary because a hospital’s wage index will be reflected. **Absent Dignity Health’s AWI Simplification, more study of the out-commuting recommendation is necessary using actual hospital data before any changes are made to address this concern before eliminating reclassification all together.**

**CONCLUSION**

Dignity Health appreciates the opportunity to submit comments on the Task Force recommendations and hopes our input was helpful. If you have any questions, please feel free to contact Clara Evans, Director of Public Policy & Fiscal Advocacy at 916.851.2007 or Clara.Evans@DignityHealth.org.

Sincerely,

Eric Lucas
Senior Director
Government Programs

Clara Evans
Director
Public Policy & Fiscal Advocacy
TO: American Hospital Association’s Area Wage Index Task Force Subcommittee
FROM: Eric J. Beyer
President and Chief Executive Officer
DATE: June 27, 2013
RE: Recommendations of AHA Area Wage Index Task Force Subcommittee – Tufts Medical Center Hospital’s Comments

Tufts Medical Center Hospital appreciates the opportunity to provide comments and feedback on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is an extraordinarily complex system that has very significant impact on hospital reimbursement. We support a comprehensive review and reform of the wage index system. However, because of the importance, complexity, and impact of the wage index, every effort should be made to ensure that the hospital community’s concerns are addressed in order to reach consensus on the nature, timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

In Massachusetts, the impacts of changes to the Medicare inpatient wage index system extend beyond Medicare reimbursement: these changes impact not only Medicare inpatient operating, inpatient capital; outpatient and post-acute facilities reimbursement as well as Medicare Advantage payments, but would also impact Medicaid reimbursement since MassHealth uses the geographic reclassifications approved by CMS to adjust MassHealth payments to hospitals.

We are one of 64 acute care hospitals in Massachusetts. Tufts Medical Center Hospital has a combined Medicare and Medicaid payor mix of 52% and growing (based upon gross charges), and in FY 2012 we had an operating margin of 0.6%. We are very dependent upon a fair, equitable and predictable Medicare Area Wage Index for the necessary treatment of our population at an urban major teaching hospital.

We have reviewed the Task Force’s report and offer the following comments. We request that the AHA Area Wage Index Task Force Subcommittee to give serious consideration to our comments.

1. Of the seven recommendations of the Task Force, we **support four recommendations without reservation**: these are as follows

- **Recommendation #1**: To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.
• **Recommendation #2:** To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.

• **Recommendation #4:** To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period.

• **Recommendation #7:** The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment.

2. We have reservations about two of the recommendations: these are:

• **Recommendation #3:** To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

We support the position and analysis provided to the Task Force by the Massachusetts Hospital Association on this Recommendation. We refer you to their comment letter.

• **Recommendation #6:** The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

We commend the Task Force for correctly recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. We support the inclusion of outmigration and smoothing adjustments in the AWI reform recommendations. However, we note that these adjustments, in particular the smoothing adjustment, are difficult to replicate and hospitals would therefore have trouble verifying the accuracy of the wage index that is assigned to them. It contradicts the task force’s principle that the wage index data and methodology should be as consistent, easy to administer, transparent and understandable as possible. It is also unclear what the size of the budget neutrality offset to fund the outmigration and smoothing adjustments would be. Additional information and data about these adjustments should be provided to AHA members.

We disagree with the Task Force on preserving non-budget neutral exceptions—this is contradictory to the Task Force principle that having so many exceptions is an issue in the current AWI system. It would also, we fear, lead to a race among hospitals to secure their own “special deals” in Congress which will increase complexity, add administrative burden and decrease the integrity of the wage index system.

3. *We strongly object to one recommendation. It remains the single most important concern we have with the Task Force’s recommendations.*
Recommendation #5: To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to the lowest pre reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- One of the Task Force’s principles is that the current system of exceptions is “unacceptable”, and recommendation #6 specifically seeks to eliminate all budget-neutral exceptions. Yet, at the same time, recommendation #5 would put in place a new budget neutral “exception”-the exponential floor- which would increase the AWI for 67% of all hospitals. Hospitals with AWI less than 1 would get an arbitrary increase in their AWI every year, which would continue in perpetuity without any application process or oversight.

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, “the extent to which is exists cannot be quantified” (June 4, 2013 conference call); and that the exponential floor adjustment was “arbitrary but appealing” (June 4, 2013 conf call). We are very troubled that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has neither been adequately studied nor quantified.

- The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for providers with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This is neither fair nor logical, and strikes us as an arbitrary adjustment.

- Hospitals with AWI less than 1 have had other available protections in place for years, such as a lower labor share (62% versus 69.6%) and the Frontier wage index. There is no evidence that these protections have helped low-AWI hospitals increase their AHW at a higher rate than the national average. If this is the case, the Task Force should not expect that the exponential floor adjustment will achieve a different result.

- Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications. For our state, the Massachusetts Hospital Association has computed the cost of the exponential floor budget neutrality adjustment by applying a 1.2% reduction to all PPS payments for providers that use the IPPS wage index. The statewide impact was negative $66.3m a year.
It remains unclear to us why we, as a struggling urban teaching hospital in Massachusetts, should have to sustain deep Medicare payment cuts which would be devastating, in order to subsidize an arbitrary adjustment for hospitals in other states in perpetuity.

Hospital leaders have pointed out that other factors, not the Medicare AWI (which has a four year lag), determine the wages that they pay their employees. Hospitals in high wage areas offer higher wages because of competitive forces—they not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

The exponential floor adjustment would raise the AWI of low wage hospitals, but could very well have no impact on the rate at which their AHW changes—thereby resulting in no improvement in their baseline AWI. Since the exponentiation formula works in a manner that as the AWI approaches 1.000, the percentage by which the exponentiation increases the baseline AWI declines. But if there is no link between the wage index and wages paid by a hospital, we could end up with an AWI death spiral where the high wage hospitals have to keep funding the exponential floor in perpetuity.

There is no evidence, according to the AHA (June 4, 2013 conference call) that there is a correlation between the wage index that a hospital receives and its margins—high AWI hospitals can have low margins and vice versa. We therefore question the very premise implementing this adjustment for low-AWI hospitals given the lack of evidence that such an action would improve their bottom lines.

In our view, the exponential adjustment is a very expensive redistributive experiment—one we cannot afford. We request that the AHA Task Force not move forward with this recommendation.

Again, we appreciate the opportunity to provide comments to the AHA Area Wage Index Task Force to reform the Medicare Area Wage Index system.

Eric J. Beyer  
President & Chief Executive Officer  
Tufts Medical Center  
800 Washington Street  
Boston, MA  02111  
617-636-8335
June 28, 2013

Mr. Richard J. Pollack
Executive Vice President
American Hospital Association
Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802

Dear Rick:

On behalf of our member hospitals and health systems, the Louisiana Hospital Association appreciates the opportunity to comment on the work of the AHA Medicare Area Wage Index Task Force and the recommendations of that body.

Overall, the LHA is supportive of the work of the Task Force and of its recommendations related to the issues plaguing the Medicare Area Wage Index (AWI) and its effect on hospital payment. The current system is flawed in many areas and has grown into a maze of mathematical convolution that often requires specialized outside technical assistance in navigating. We agree with the task force and that the five major issues in the current methodology of the AWI that need to be addressed are: accuracy and consistency; volatility; circularity; reclassifications and exceptions; and labor markets.

Accuracy and consistency: In its work, the Task Force noted that an inconsistent application of definitions, methodologies, and rules/interpretations exists across the various Medicare Administrative Contractors (MACs) and Fiscal Intermediaries (FIs). To address this issue, the Task Force has recommended that the Centers for Medicare & Medicaid Services (CMS) should designate one MAC/FI to complete all wage index data collection and processing. By centralizing the wage index work, differences in the collection and/or processing of the data, as well as inconsistent application of rules and interpretations, would be eliminated, thus improving accuracy and consistency. The LHA is supportive of the Task Force recommendation.

Volatility: As the Task Force noted, volatility across the AWI can be problematic for hospitals. A fundamental value of the Prospective Payment System (PPS) is the ability of providers to reasonably estimate payments in advance and enable that provider to make key management decisions such as budgeting and staffing in advance. However, data analyzed by the Task Force showed rather significant swings in wage index impact, to the degree in some cases of completely offsetting the market basket update. To ensure that any changes to the AWI do not cause sudden and extreme fluctuations in hospital payments, the Task Force recommended that wage index reform (a) should be transitional over a period of five years; (b) include all hospitals and distinct-part units paid using the PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set; (c) include a budget neutral 3-percent stop-loss policy that would limit the amount by which a hospital’s wage index could decrease in a single year. The LHA is supportive of the Task Force recommendation.

Circularity: During its analysis of the complex issue of circularity, the Task Force acknowledged the difficulties that low wage index hospitals may face in the being able to increase wages over time. For example, hospitals whose hourly wages increase at a lower rate than the national average will see a decrease in their wage index. The Task
Force went on to note that their payments will then not increase at the same rate as other parts of the country, which may create pressure to exert even tighter control over costs. To address this issue, the recommendation supported by most Task Force members was that Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Raising all wage indices of less than 1.0 to the power of 0.6848 would, in effect, compress wage index values up towards 1.0 and help combat the problem of circularity. The LHA is supportive of the Task Force recommendation.

Reclassifications, exceptions, and labor markets: In its final report, the Task Force noted that developing a single wage index to accurately capture the differences in labor costs across hospitals is a complex task. While there are certainly situations where hospitals in different markets compete for the same labor pool and adjustments are needed, the Task Force recognized that the current system of reclassifications is flawed and should be eliminated, except when reclassifications are done in a budget-neutral manner. The recommendation of the Task Force went on to suggest replacing it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment. Additionally, it was recommended that Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment, thus bringing more current data to the process. Also, such data could be refined to help ensure that they are defined broadly enough to encompass all hospitals competing for the same workers, but narrowly enough to avoid encompassing hospitals with wage costs that vary widely. The LHA is supportive of the Task Force recommendations.

The LHA would like to thank the AHA for convening this Task Force and attempting to address a very complex, and potentially divisive, issue. We certainly agree with the Task Force’s acknowledgement that there is no single solution to completely fix the AWI. However, the approach taken by the AHA and the Task Force has been thoughtful, deliberate, and considerate of the various perspectives across the industry.

If you have any questions or need additional information, please contact me at (225) 928-0026 or jmatessino@lhaonline.org.

Sincerely,

John A. Matessino
President & CEO
To: The AHA Area Wage Index Task Force Subcommittee

Lahey Clinic Hospital, Inc. (Massachusetts) appreciates this opportunity to provide comments and feedback on the recommendations of the AHA Area Wage Index (AWI) Task Force to reform the Medicare Area Wage Index system.

The Medicare AWI is an extraordinarily complex system that has very significant impact on hospital reimbursement in every state. We support a comprehensive review and reform of the wage index system. However, because of the importance, complexity, and impact of the wage index, every effort should be made to ensure that the hospital community's concerns are addressed in order to reach consensus on the nature, timeline and process of AWI reform. We believe that if the current wage index system is to be replaced, the replacement system should first be thoroughly tested by assessing the completeness and accuracy of the underlying data followed by a comprehensive modeling of the impact.

In Massachusetts, the impacts of changes to the Medicare inpatient wage index system extend beyond Medicare reimbursement. These changes impact not only Medicare inpatient operating, inpatient capital; outpatient and post-acute facilities reimbursement as well as Medicare Advantage payments, but would also impact Medicaid reimbursement since MassHealth uses the geographic reclassifications approved by CMS to adjust payments to hospitals.

There are 64 acute care hospitals in Massachusetts; of these hospitals, 70% have a public payer mix (i.e. Medicare and Medicaid charges) of more than 50%. And 28% of acute care hospitals had a negative margin in 2012.

According to the 2013 AHA Hospital Statistics publication 29% of all Massachusetts hospitals are post-acute providers (defined here as Rehab hospitals, Psych hospitals and Acute LTC hospitals). Massachusetts therefore has a disproportionately high percentage, nearly double, of post-acute providers as a percent of total hospitals-- the national average is 16%.

<table>
<thead>
<tr>
<th>Description</th>
<th>MA</th>
<th>US*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>15</td>
<td>424</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>8</td>
<td>198</td>
</tr>
<tr>
<td>Children’s rehabilitation</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Acute long-term Care</td>
<td>8</td>
<td>263</td>
</tr>
<tr>
<td><strong>Total Post Acute</strong></td>
<td>32</td>
<td>885</td>
</tr>
<tr>
<td><strong>Total Hospitals</strong></td>
<td>109</td>
<td>5724</td>
</tr>
<tr>
<td>Community</td>
<td>4973</td>
<td></td>
</tr>
<tr>
<td><strong>Percent Post Acute</strong></td>
<td>29.4%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>
Post-acute providers in Massachusetts have an even higher public payer mix: LCTHs have an 80% public payer mix; IRFs have a public payer mix of 59% and Psych hospitals 53%.

We have reviewed the Task Force’s report and studied the recommendations. We outline below the seven Task Force recommendations, our position and, where applicable, the specific reasons behind our concerns. We urge the AHA Area Wage Index Task Force Subcommittee to give serious consideration to our comments.

Of the seven recommendations of the Task Force, Lahey Clinic Hospital, Inc. support four recommendations without reservation. These are as follows:

- **Recommendation #1:** To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.

- **Recommendation #2:** To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, the Congress should phase-in reform using a transitional period of at least 5 years.

- **Recommendation #4:** To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital’s wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period.

- **Recommendation #7:** The Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment

We have reservations about two of the recommendations. These are:

- **Recommendation #3:** To help limit year-to-year volatility in individual hospitals’ wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Post-acute providers tend to have lower average hourly wages than acute care providers and since post-acute providers currently have their Medicare reimbursement adjusted for labor costs using the IPPS AWI (without applying any exceptions). If adopted, this recommendation would lower the AWI for both post-acute and acute providers.
A key finding from a wage survey conducted by our hospital association is that the average hourly wages for registered nurses at acute care facilities are 27% higher than at post-acute facilities. The weighted average hourly wage at post-acute hospitals in Massachusetts was $25.89/hr compared with $33.19/hr at acute hospitals. Because 7% of all provider wages were paid at post-acute facilities versus 93% at acute care hospitals, this results in a combined weighted average hourly wage that is 1.6% lower than that using acute care provider data alone.

If this decline of 1.6% is applied to payments projected for 2013, it is estimated that it would result in a $58m decline in payments to both acute and post-acute providers in Massachusetts. Although the final methodology used to quantify this impact may differ from what CMS would use, in states such as Massachusetts which have a disproportionately higher number of post-acute hospitals, the fact that the national average hourly wage (the denominator in the AWI calculation) would also decline is unlikely to mitigate the negative impact of diluting the numerator (the combined AHW of both acute and post-acute facilities).

Recommendation #3 was not modeled by the Task Force because the data required to do so is either not available or incomplete. Because the potential negative unintended consequences of recommendation #3 are unknown at this point, we strongly recommend further study. As we strive to provide more coordinated care in an integrated delivery system, we cannot afford to jeopardize the financial stability of our hospital on a completely untested methodology.

Since the Task Force report states that recommendation #3 is intended to mitigate the impact of small sample size and volatility, an option to consider might be a hold harmless provision which would limit the application of this recommendation only in labor market areas that meet specific criteria and would be helped by the inclusion of post-acute providers’ wage data.

- **Recommendation #6:** The Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10-percent smoothing adjustment.

The Lahey Clinic Hospital, Inc. commends the Task Force for correctly recognizing that labor area boundaries are not rigid and wage index cliffs should be avoided in any wage index system. We support the inclusion of outmigration and smoothing adjustments in the AWI reform recommendations. However, we note that these adjustments, in particular the smoothing adjustment, are difficult to replicate and hospitals would therefore have trouble verifying the accuracy of the wage index that is assigned to them. It contradicts the task force’s principle that the wage index data and methodology should be as consistent, easy to administer, transparent and understandable.

The size of the budget neutrality adjustment needed to offset the outmigration and smoothing adjustments is unclear. Before moving forward, additional data about these adjustments should be provided to AHA members.
We disagree with the Task Force’s recommendation to preserve non-budget neutral exceptions. This is contradictory to the Task Force principle that having so many exceptions is an issue in the current AWI system. It would likely lead to a race among hospitals to secure their own “special deals” in Congress which will only increase complexity, add administrative burden and decrease the integrity of the wage index system.

Lahey Clinic Hospital, Inc. strongly objects to one recommendation, and it remains the single most important concern we have with the Task Force’s recommendations.

- **Recommendation #5:** To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments. Puerto Rico wage indexes should be increased to the lowest pre-reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797).

There are several reasons for our opposition to recommendation #5 and these are outlined below:

- One of the Task Force’s principles is that the current system of exceptions is “unacceptable”, and recommendation #6 specifically seeks to eliminate all budget-neutral exceptions. Yet, at the same time, recommendation #5 would put in place a new budget neutral ‘exception’ - the exponential floor - which would increase the AWI for 67% of all hospitals. Hospitals with AWI less than 1 would get an arbitrary increase in their AWI every year, which would continue in perpetuity without any application process or oversight.

- According to the Task Force’s report, the exponential floor is meant to address the issue of wage index circularity. However, the AHA admits that while there is evidence that circularity exists, the extent to which it exists cannot be quantified. We are very troubled that the Task Force would recommend a questionable and massively redistributive “fix” for a problem that has not been adequately studied and quantified.

- The wage index is based on the average hourly wage (AHW) in a given labor market area compared to the national average hourly wage. Applying the exponential floor adjustment would artificially increase the wage index for providers with AWI less than 1, potentially to a level much higher than the prevailing wage levels in their market area; and this increase would be achieved by removing very significant Medicare funding from hospitals with high AWI whose wage index reflects the market conditions in the area where they are located. This is neither fair nor logical.

- Hospitals with AWI less than 1 have had other “protections” in place for years such as their lower labor share (62% versus 69.6%) and the frontier wage index. There is no evidence that these protections have helped low-AWI hospitals increase their AHW at a higher rate than the national average. If this is the case, the Task Force should not expect that the exponential floor adjustment will achieve a different result.
Per the Task Force report, the exponential floor would redistribute 1.2% of all PPS payments. This is double the 0.6% of PPS payments that are redistributed in the current system because of the budget neutrality requirement for the rural floor and geographic reclassifications. For Massachusetts, the impact of the exponential floor budget neutrality adjustment is over $66m a year.

It’s unclear to us why a struggling community hospital in Massachusetts should have to sustain deep Medicare payment cuts, which could be devastating for some of our hospitals, in order to subsidize an arbitrary adjustment for hospitals in other states in perpetuity.

Hospital leaders have pointed out that other factors, not the Medicare AWI (which has a four year lag); determine the wages that they pay their employees. Hospitals in high wage areas offer higher wages because of competitive forces—they not only compete with other hospitals but with other industries—high tech, research, biotechnology etc.

The exponential floor adjustment would raise the AWI of low wage hospitals, but could very well have no impact on the rate at which their AHW changes—thereby resulting in no improvement in their baseline AWI. Since the exponentiation formula works in a manner that as the AWI approaches 1.000, the percentage by which the exponentiation increases the baseline AWI declines. If there is no link between the wage index and wages paid by a hospital, we could end up with an AWI death spiral where the high wage hospitals have to keep funding the exponential floor with no end in sight.

Further, there is no evidence, according to the AHA (June 4, 2013 conference call) that there is a correlation between the wage index that a hospital receives and its margins—high AWI hospitals can have low margins and vice versa. We therefore question the very premise implementing this adjustment for low-AWI hospitals given the lack of evidence that such an action would improve their bottom lines.

In our view, the exponential adjustment is a very expensive redistributive experiment, one we cannot afford. We request that the AHA Task Force refrain from moving forward with this recommendation.

**Comments on the Impact Analysis:**

The AHA made available a hospital specific and statewide impact analysis of the recommendations to members. Lahey Clinic Hospital Inc. has concerns about the methodology, data and gaps in the AHA analysis—and we believe that the AHA analysis may be significantly understating the impact of the recommendations. We note that the AHA statewide impacts did not include the impact of the recommendations on post-acute providers, IPPS capital payments, Medicare Advantage payments and OPPS payments, all of which are impacted by changes in the IPPS wage index.
In its impact modeling, AHA also did not account for compounding: in other words, the AHA impact shows a first year impact for Massachusetts (at 20% implementation) of -$50m; but the second year impact is also shown to be -$50m (at 40%); and in years 3, 4 and 5, the annual impact remains at about -$50m a year, despite the fact that the transition stages in those years are 60%, 80% and 100% respectively. If we assume that the -50m impact in year 1 is correct (though it reflects only IPPS operating payments, as stated above), the total 5 year impact should be a loss of $750m in inpatient operating payments alone (when compared to today), and not of negative $246m as AHA has stated.

According to our hospital association, their preliminary analysis indicates that the negative impact on Massachusetts would be negative $457m annually (in contrast to the AHA’s estimate of negative $246m) and even without the effect of losing the Massachusetts rural floor, the state would still be impacted by over -$191 million per year. It’s imperative that AHA provide additional information, so all hospitals fully comprehend the implications of these recommendations. To date, no additional data has been received.

In April, the AHA informed the hospital community that outside consultants would be asked to review the methodology and to confirm the validity of its results. According to the AHA, the charge to these consultants was to “check if the modeling does what it is supposed to do”—which in our view addresses only part of the problem. There are significant gaps in the AHA analysis—other payment systems impacted by AWI changes are not modeled, the impact of including post-acute data in the IPPS AWI is not included, etc. Our current understanding is that these gaps will remain, and the review process will simply reaffirm that the gaps exist, and not actually attempt to fill them in.

In addition, there is an unprecedented degree of opacity in the methodology and the impact of individual recommendations—for example, how is the 10% smoothing called for in recommendation #6 actually being applied? Can wage indices be either increased or reduced to achieve the smoothing, or just increased? If the modeling only allows wage indices to be increased to achieve smoothing, what is the budget neutrality adjustment required for this? Similarly, for the out commuting adjustment, what data is being used (can the AHA make available the data underlying this adjustment at a CBSA level)? Can the AHA share the out-commuting budget neutrality adjustment for this?

In our opinion, to endorse and advocate for the recommended changes in the wage index system without a complete understanding of the potential impact would be wrong. We realize that trying to establish a national consensus on such a complex matter as the Area Wage Index is a major challenge and we commend AHA for taking that challenge. At the state level, we also have challenges in crafting a consensus on complex and controversial issues. And, we realize that building a consensus around proposals that will significantly harm a significant number of members is neither wise nor sustainable. Based on that philosophy and after listening to the comments of other states that share our concerns, we respectfully urge the AHA Board of
Trustees to address all the concerns that we have outlined above and in particular, to firmly reject Recommendation 5 dealing with “circularity.”

We hope you will give serious consideration to our concerns. Please contact me at 781 744 2816 if you have any questions about our comments. Thank you.

Sincerely,

Michael Gill

Vice President of Revenue Finance
July 3, 2013

VIA EMAIL: AWI@aha.org

Richard Umbdenstock  
President and Chief Executive Officer  
American Hospital Association  
325 7th Street, N.W.  
Washington, DC  20004-2802

Dear Mr. Umbdenstock:

On behalf of Allegiance Health of Jackson Michigan, I am pleased to provide these comments on the AHA’s Medicare Area Wage Index Task Force recommendations to reform the Medicare Area Wage Index.

Allegiance is a 411-bed community-owned and locally-governed health system with a full range of inpatient and outpatient services. We are proudly in our 10th decade of serving the people of south central Michigan with local, high-quality health care. We staff our facilities with exceptional, caring professionals who are dedicated to the health and well-being of the communities we serve. As you no doubt will recall, Allegiance was recently awarded the prestigious Foster G. McGraw award, an honor we cherish and strive to fulfill every day.

Allegiance commends the AHA for its vision in assembling the Task Force, and applauds the many volunteer leaders and staff who dedicated so much time and effort toward this important and challenging endeavor. As a hospital that for years has struggled mightily against and complained loudly about the inequities inherent in Medicare’s wage index, we have a special appreciation for the work of this group, and for the manner in which the AHA is attempting to advance reform. We likewise appreciate the AHA’s solicitation of input from its members on this very important matter.

Allegiance supports many of the changes recommended by the Task Force, including the following:

- We concur that processing wage data through a single contractor would improve accuracy and minimize inconsistencies in determining the wage index.

- We likewise enthusiastically agree that any reform must be phased in using an extended transition period, and concur that the five years proposed by the Task Force are appropriate.

We lead our community to better health and well being at every stage of life.
We lead our community to better health and well being at every stage of life.

Force would strike the right balance between achieving change and providing hospitals with adequate planning and preparation opportunity.

- We also agree that limiting significant fluctuations from year-to-year is an important goal. Hospitals struggle to absorb wild wage index fluctuations, especially when they are unrelated to the hospital’s own actions, and are therefore not foreseeable. For this reason, we support the 3-percent stop-loss/stop-gain governor recommended by the Task Force. We believe that 3-percent is the right parameter, that as a matter of fairness it should apply to gains as well as losses, and that it should be implemented in a budget neutral manner.

Nonetheless, there are some recommendations that we cannot support. First and foremost, we strongly disagree with the Task Force’s recommendation to eliminate the current system of reclassifications and exceptions, except when done in a non-budget neutral manner. While we agree that some reclassification and exception opportunities strain credibility – e.g., Section 508, the Rural Floor and the Frontier State floor – some are reasonable responses to shortcomings of the current system, and must remain so long as those shortcomings remain. Most importantly, so long as Medicare continues to use Metropolitan Statistical Areas (MSAs) and county boundaries to define labor markets, the system must maintain a process to look beyond those boundaries when the MSA is not a reasonable proxy for a labor market.

Allegiance is keenly sensitive to this issue because we reside in a single county MSA. While we also are the only hospital in that MSA, and therefore arguably control our wage index, that does not mean that we are fairly compensated vis-à-vis competing hospitals in surrounding nearby labor markets.

Jackson County is surrounded on three sides by other MSAs, including Lansing and Ann Arbor. Hospitals in those MSAs receive a substantially higher wage index, even though those closest to us have an average hourly wage lower than ours. Allegiance’s FY 2013 wage index (0.8555) with the out-migration adjustment (0.0205) is 0.8760. Chelsea Community Hospital, which is located 22 miles away, but in the Ann Arbor MSA, receives a wage index of 1.0030. Yet, Allegiance’s average hourly wage ($32.3277) is considerably higher than Chelsea’s ($28.9128). This dynamic highlights the inequity of using MSAs as the building blocks on which to develop and assign the wage index. This dynamic also highlights the importance of having a reclassification process. After years of fighting a senseless obstacle to reclassification, Allegiance now qualifies for reclassification to both the Ann Arbor and Lansing MSAs. As a result, in FY 2013, Allegiance gets a higher wage index, 0.9426. While our wage index still is considerably lower than the wage index bestowed on Chelsea by virtue of nothing more than its location on the other side of a county line, reclassification at least goes a long way toward reducing the differential.

While the Task Force’s recommendations include many helpful improvements, eliminating the reclassification opportunity would not only perpetuate, but greatly exacerbate this inequity. Under the AHA’s recommended changes, Allegiance’s wage index would eventually fall 0.0286 percentage points to 0.9140, while Chelsea’s would fall only 0.0116 to 0.9914, leaving an inexplicable and indefensible differential of 0.0774! To be clear, our
comments are not about a disparity with Chelsea Community Hospital. We are in no way trying to disparage Chelsea or undermine them or their wage index. They are merely an example. If we were to look at the other hospitals near to Allegiance and with which we compete for labor – Eaton Rapids, St. Joseph’s – similar dynamics and disparities would show. As such, while out-migration adjustments and smoothing factors are reasonable and even helpful policies, they clearly are not doing the job of addressing the problem associated with using MSAs to define labor markets. More is needed.

Needless to say, Allegiance is not unique. There are many instances across the country where the problems with using MSAs to define labor markets are apparent, and where a reclassification process is necessary to overcome or minimize those problems. AHA should not support a recommendation that maintains the arbitrary nature of building labor markets using MSAs while not permitting a subjective process for overcoming the inevitable and inherent flaws in that approach. All rules need exceptions, and reclassification is a necessary exception if Medicare is to continue using MSAs as building blocks to define labor markets.

For these reasons, we urge the AHA to either revise its position on reclassifications, and specifically to maintain a reclassification opportunity, perhaps with some improvements to the qualification criteria, or embrace a change that resolves the inequities of establishing wage index values based on MSAs.

Additionally, we question the Task Force’s recommendation to use an adjustment for wage index values of less than 1.0 to decrease the problem of circularity. While we agree that circularity is a problem worthy of attention, and we stand to benefit from this proposed change, we are dubious of the merits of the proposed solution, and worry that it undermines the credibility AHA needs to maintain to be an effective voice in this debate. We appreciate the opportunity to comment on these recommendations, and thank you for your efforts and consideration.

Sincerely,

Georgia Fojtasek
President & CEO
Allegiance Health

cc:  Kim Byas, Sr., MPH, Regional Executive, American Hospital Association
    Scott Malaney, President & CEO, Blanchard Valley Health System