Madison County Health Department

August 11, 2005

AUG 16 2005

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

SUBJECT: PROVISIONS OF THE PROPOSED REGULATIONS:

Dear Sir:

Under 42 CFR Part 484, Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2006; Proposed Rule, CMS proposed to adopt the OMB designated Core-Based Statistical Area (CBSA). The CBSA designation created 565 Micropolitan Areas, including one that removed Madison County from the Lexington-Fayette County MSA and combined it with Rockcastle County. Of the 674 counties that were selected to form the Micropolitan Areas, 41 counties were removed from Metropolitan Areas. Madison County was one of those 41 counties and is the only contiguous county to Fayette that was removed from the Lexington-Fayette Metropolitan Area.

CMS states,

> The process used by OMB to develop the MSAs creates geographical areas upon characteristics that we believe also ***generally*** [emphasis added] reflect the characteristics of unified labor market areas. For example, an adjacent territory that reflects a high degree of social and economic integrations. This integration is measured by commuting ties, thus demonstrating that these areas ***may*** [emphasis added] draw workers from the same general areas. (Federal Register/Vol. 70, No.134, page 40793)

CMS proposes to re-calculate wage indices using the Metropolitan, Micropolitan and non-urban statistical areas. As before, the Metropolitan Area will have an urban wage rate and the non-urban areas will have a rural wage rate. CMS now proposes to develop the Micropolitan wage rate using a rural wage rate. Concerning this decision, CMS states, "...how these areas are treated would have significant impact on the calculation and application of the hospital wage index." The Home Health PPS in Micropolitan Areas will likewise be based on a rural rate.

We conclude that your proposed rule is flawed in how it calculates the labor wage index for Micropolitan areas. We provide four comments, recommend a change, and request an additional exception to the proposed rule if our arguments are not amenable.

COMMENT 1: CMS's general belief that the OMB-developed statistical areas reflect unified labor markets is not an accurate reflection for Micropolitan Areas. CMS must

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revisit the method proposed for calculation of wage indices in Micropolitan Areas. The proposed rule is flawed because some Micropolitan Areas or particular counties in the Micropolitan Areas form an unified labor market area with a contiguous Metropolitan Area. Previously OMB more correctly included Madison County as a significant member of the Lexington-Fayette Metropolitan Area.

Madison County was the second most populated county in the Lexington-Fayette MSA. Like Fayette, Madison has a large state university and a prominent private college. The Lexington-Fayette MSA was comprised of 7 counties: Fayette and 6 contiguous counties. Madison was the only county that was removed to form a Micropolitan Area., combining it with Rockcastle County. The City of Richmond, Kentucky Comprehensive Plan documents that 1,719 workers commute from Rockcastle County into Madison and that only 100 workers commute from Madison County into Rockcastle. More striking, the plan documents that 6,870 workers from Madison County commute to Lexington-Fayette and that 1,043 workers commute from Lexington-Fayette County into Madison. Additionally, a comparison of current unemployment rates supports the contention that Madison County is more closely linked economically with Lexington-Fayette Metropolitan Area. For June 2005, the unemployment rate for Fayette, Madison, and Rockcastle Counties were 4.7%, 5.1%, and 6.6%, respectively. If Madison were more closely linked economically to Rockcastle County and if Madison and Rockcastle were truly one unified labor market, then the unemployment rates of Madison and Rockcastle would be similar. When comparing those counties that formerly made up the Lexington-Fayette MSA, Madison has the strongest links with Fayette County. The CMS belief that Madison would be more closely linked with Rockcastle and would form a unified labor market area is clearly a poorly conceived assumption.

We would suggest one of the following remedies, in the order of preference given:

1) In any situation where a county of a Micropolitan Area is contiguous with the principal county of a Metropolitan Area, CMS must independently determine whether a unified labor market exists and allow for the use of an urban rate calculation. OR
2) OMB defined 120 Combined Statistical Areas, groupings of Micropolitan Areas with Metropolitan Areas or other Micropolitan Area because of the economic and social linkages. In our situation, OMB created the Lexington-Fayette –Frankfort – Richmond, KY Combined Statistical Area and explicitly held that there were economic and social linkages between Madison County's two cities (Richmond and Berea) and Lexington-Fayette. Madison County residents can commute to the nearest Lexington, KY hospital in as few as 15 minutes. Clearly OMB recognized the unified labor market between Madison County and Lexington-Fayette. If CMS is unwilling to independently examine the 565 different Micropolitan Areas, it should at least independently examine the Micropolitan Areas that are contained in the 120 Combined Statistical Areas. OR

3) In at least 41 situations, counties were removed from Metropolitan Areas and from unified labor market areas to form Micropolitan Areas. In at least these 41 situations CMS must adapt a different proposed rule for calculation of wage indices. CMS stated accurately "how Micropolitan Areas would be treated [urban or rural] would have significant impact on the calculation and application of the hospital wage index."

COMMENT 2: The proposal to treat Micropolitan Areas as rural labor market areas under the HH PPS was badly conceived, leaving at least our county and perhaps many others at a disadvantage that will drive medical personnel to seek employment elsewhere.

The proposed rule on maintaining an urban rate for Metropolitan Areas is consistent and sound. Metropolitan areas with urban hospitals must pay higher competitive wages to attract non-physician medical professionals, particularly registered nurses (RNs). The proposed rule on maintaining a rural rate for rural areas is consistent and sound. The truly rural areas generally have lower costs of living. Hospitals and home health agencies in these truly rural areas can be competitive with each other for the available pool of RNs.

However, the proposed rule to establish a rural wage index for Micropolitan Areas is flawed because (1) it is inconsistent with the definition for Micropolitan Areas, (2) it will lead hospitals and home health agencies into financial difficulty, and (3) it is potentially detrimental to the health care provided in these areas.

First, OMB established the Micropolitan Area as an intermediary statistical area composed of urban and non-urban areas. By definition and composition, the Micropolitan Areas contain an urban core. In numerous instances, the urban core in counties that are contiguous to Micropolitan areas have a higher degree of social and economic integration, forming a more unified labor market area with the urban core in the Metropolitan Area than with the rural areas within the Micropolitan Areas. To propose that a rural rate be established for Micropolitan Areas is to infer that these areas are rural and that these areas are more closely linked economically to rural areas. This is not the case, particularly for counties in Micropolitan Area that are contiguous to Metropolitan Areas.

Second, the proposed rule will lead hospitals and home health agencies in Micropolitan Areas, particularly those that are contiguous to Metropolitan Areas, into financial difficulty. The disparity between the urban wage index and the rural wage index is significant. This disparity will favorably impact reimbursement for those hospitals and home health agencies using an urban rate. Those hospitals and home health agencies that are in the same unified labor market area but that are located in a contiguous Micropolitan Area will be unfavorable impacted by the wage index disparity.

In our situation, Madison County Health Department (dba MEPCO Home Health) provides home health services to some of the most vulnerable homebound patients in Madison County. The CMS proposed rule would reduce our Medicare reimbursements by over 11 percent. Our actual Medicare payments for Fiscal Year 05 (Ended 6/30/05) for Madison County patients totaled $2,099,677 based on the Lexington Fayette MSA wage index of 0.9219. The CMS proposed rule will establish our Micropolitan Area wage index at 0.7844 and, for comparison purposes, would have resulted in payments of $1,863,885 for the same level of workload. This loss of revenue in the amount of $235,792 will have significant impacts and will seriously endanger MEPCO's ability to provide vital services to Madison County citizens. We are not unique.

Forty-one counties were removed from Metropolitan areas and added to Micropolitan areas. These counties will experience lower PPS payments since the proposed rule, with two exceptions, establishes the state rural rate as the wage index.

Third, the national shortage of registered nurses (RNs) is said to be a crisis. The use of a rural wage index for Micropolitan Areas will force many nurses and other medical professionals away from hospitals and home health agencies in Micropolitan areas to seek employment in higher paying positions in hospitals and home health agencies in Metropolitan Areas or out of the medical field entirely.

CMS cannot take a position that the nursing shortage is not germane to the discussion on its proposed rule on HH PPS; such a position would be shortsighted. Both Congress and Health and Human Services have made efforts to ease the nursing shortage through increased funding for a number of federal programs including the Nurse Reinvestment Act, the Nursing Education Repayment Program, and direct grants to colleges and universities. HHS and its many agencies must be consistent in its effort to improve the nursing workforce. The American Association of Colleges of Nursing (AACN) reported that many RNs leave the nursing field due to job burnout and dissatisfaction. The Journal of American Medical Association cited a study that concluded that job dissatisfaction and emotional exhaustion, from nurses having to take care of more patients than they can safely take care, was contributing to avoidable patient deaths.

The proposed rule for Micropolitan Areas will create a disparity in an otherwise consistent labor pool between the Metropolitan and Micropolitan Areas, particularly in those that are contiguous to a Metropolitan Area. Hospitals and home health agencies in Micropolitan Areas will become less competitive; nurses will migrate to higher paying positions in Metropolitan Areas. Nursing shortages in Micropolitan Areas will be exacerbated; these growing shortages will become, as described by the AACN, a catalyst for increased job burnout and dissatisfaction among those remaining RNs, many of whom will leave the field of nursing altogether. Nursing care in hospitals and home health agencies will create unsafe staffing patterns. The proposed rule will, unintentionally, be detrimental to patient care.

We would suggest one of the following remedies, in the order of preference given:

1) Establish the wage index for Micropolitan Areas as an urban rate, averaging the states urban rates. OR
2) For those Micropolitan areas that contain one of the 41 counties that were removed from a Metropolitan area, adopt the wage index of the Metropolitan Area that they were removed from. Those counties were previously part of a Metropolitan (MSA) Area because of commuting patterns, and these patterns have not changed. OMB has already proposed exemptions for two sets of Micropolitan Areas, which explicitly concludes that the Micropolitan Area wage index formula does not fit all Micropolitan Areas. CMS recognized that some situations require adjustments. OR
3) Calculate the Micropolitan area as an average of hospitals in the Micropolitan Area and the Metropolitan Area labor index in those cases where the Micropolitan area is contiguous to a Metropolitan Area. . OR
4) Calculate the Micropolitan area as CMS has proposed; however, for those counties that were part of Metropolitan (MSA) Areas continue the urban rate for a three-year phase in for Home Health PPS in the same manner as CMS proposes for Hospitals.

COMMENT 3: CMS failed to incorporate OMB's designation of Combined Statistical Areas, compositions of two or more Metropolitan Areas and/or Micropolitan Area, which according to OMB have **demonstrated** [emphasis added] economic and social linkage. OMB defined 120 such groupings.

To illustrate, OMB created the Lexington-Fayette –Frankfort – Richmond, KY Combined Statistical Area and explicitly held that there were economic and social linkages between Madison County's two cities (Richmond and Berea) and Lexington-Fayette. As stated above the commuting patterns between Fayette and Madison establish a pool of non-physician medical personnel who compete for jobs in hospitals and home health agencies in the two counties. Hospitals and home health agencies in Madison County must provide competitive salary and benefits packages with those in Lexington. The national nursing shortage that plagues the medical milieu is particularly exacerbated in situations where larger urban hospitals are able to provide lucrative sign-on bonuses and higher wages. Those hospitals in urban cities in Micropolitan Areas that are contiguous to Metropolitan Areas will find that the CMS proposed rates based on a rural wage index will further erode their competitiveness. The unfortunate result will be an adverse impact on patient care as stated in Comment 2.

The solution is for CMS to establish a separate provision in the rule for Micropolitan Areas that form a Combined Statistical Area with a Metropolitan Area. The proposed rule should allow the wage index to be calculated as an urban rate in conjunction with the other hospitals in the Combined Statistical Area.

COMMENT 4: If CMS unfavorably considers Comments 1,2 and 3 above, CMS must consider the special situation of Madison County, Kentucky and allows for an exception as seen in the uniqueness of exceptions to proposed rule for Micropolitan Areas.

CMS proposes two exceptions to the rule on Micropolitan Areas: In exemption one, two Micropolitan Areas (Puerto Rico and Massachusetts) do not have any rural hospitals that would be averaged into the statewide rural rate so they will adopt last year's wage index for rural Puerto Rico and Massachusetts. This seems to be a reasonable manner for the calculation of the wage index for Home Health Agencies that provide services in these rural areas. These agencies will not be hurt financially by this exception to the rule.

The other and more interesting exception pertains to two Micropolitan Areas (one in Hinesville, Georgia and one in Mansfield, Ohio) where there are no urban hospitals that could be averaged into the statewide rural area. In those Micropolitan Areas, a statewide urban average is being used to calculate an appropriate rate. Hinesville lies about 41 miles southwest of Savannah, Georgia and is in a truly rural area. The wage index for Hinesville will be generous since the urban area of Atlanta will be used in its calculation. In Mansfield, Ohio, MedCenter Health System consists of two 300+ bed hospitals that boast to be the area's largest employer with about 2,700 employees. The exception for Mansfield that will use the state urban average based on such urban areas as Cincinnati, Columbus and Cleveland will be generous as well. Neither Hinesville nor Mansfield should suffer from the exception to the proposed rule.

We seek an exception based on the uniqueness of our situation.

Madison County was the second most populated county in the Lexington-Fayette MSA. Like Fayette, Madison has a large state university and a prominent private college. The Lexington-Fayette MSA was comprised of 7 counties: Fayette and the 6 contiguous counties. Madison was the only county that was removed to form a Micropolitan Area., combining it with Rockcastle County. The City of Richmond, Kentucky Comprehensive Plan documents that 1,719 workers commute from Rockcastle County into Madison and that only 100 workers commute from Madison County into Rockcastle. More striking, the plan documents that 6,870 workers from Madison County commute to Lexington-Fayette and that 1,043 workers commute from Lexington-Fayette County into Madison. Additionally, a comparison of current unemployment rates supports the contention that Madison County is more closely linked economically with Lexington Fayette Metropolitan Area. For June 2005, the unemployment rate for Fayette, Madison, and Rockcastle Counties were 4.7%, 5.1%, and 6.6%, respectively. If Madison were more closely linked economically to Rockcastle County, then the unemployment rate should be much higher in Madison and significantly lower in Rockcastle County. When comparing those counties that formerly made up the Lexington-Fayette MSA, Madison has the strongest links with Fayette County.

Clearly, Madison County is more integrated with Fayette County and should never have been removed from the Lexington-Fayette County Metropolitan Area. While CMS is not responsible for the removal of Madison from the Lexington Fayette, it is responsible for the effects of its proposed rule and must fairly treat counties that are going to be adversely impacted by the proposed rule.

Because this situation appears to be unique to only 41 counties out of the total, it can be addressed without significant impact no the remaining 3,100 counties. Those that were urban will retain their urban rate. Those that were rural will retain that designation or have been integrated into Metropolitan areas in which case they will benefit. Only the 41 will be unfairly and adversely impacted.

The impact can be significant. Madison County Health Department (dba MEPCO Home Health) provides home health services to some of the most vulnerable homebound patients in Madison County. The CMS proposed rule would reduce our Medicare reimbursements by over 11 percent. Our actual Medicare payments for Fiscal Year 05 (Ended 6/30/05) for Madison County patients totaled $2,099,677 based on the Lexington Fayette MSA wage index of 0.9219. The CMS proposed rule will establish our Micropolitan Area wage index at 0.7844 and, for comparison purposes, would have resulted in payments of $1,863,885 for the same level of workload. This loss of revenue in the amount of $235,792 will have significant impacts and will seriously endanger MEPCO's ability to provide vital services to Madison County citizens.

In conclusion, CMS has stated its concern that the establishment of a wage index in some instances may create relatively unstable situations and have unfavorable impacts. We conclude that the proposed rule will have an unfavorable impact on our financial status and unfavorable impact the patients we serve. CMS must provide a final rule that uses an urban rate to more fairly calculate the wage index in Micropolitan Areas.

Very Respectively,

James L. Rousey, Jr. MHA
Public Health Director

CC: Congressman Ben Chandler

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PUBLIC HEALTH NURSING AGENCY
WARREN COUNTY HEALTH DEPARTMENT
162 East Washington Avenue
Washington, New Jersey 07882
Tel: 689-6000

AUG 18 2005

JOHN HAWK
Public Health Coordinator
Health Officer

DOROTHY HARTH, RN, BSN
Division Head

August 11, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1301-P
PO Box 8016
Baltimore, MD 21244-8016

Re: Proposed Revision to the HH PPS Labor Market Areas

Dear Dr. McClellan,

Thank you for this opportunity to comment on CMS's proposed rule: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2006.

Having had a long standing designation in the Newark MSA, Warren County, NJ's proposed designation into the Allentown- Easton CBSA represents a dramatic wage index decrease of 19%. I question how the wages of Warren County's health professionals as well as the local economy can be so substantially different from our similar, neighboring New Jersey counties who remain in the Newark MSA.

Many of the changes in the proposed rule will result in major reductions in Medicare home health payment and will have a critical impact on the ability of Warren County providers to continue the level of service they offer to Medicare patients. The ability to attract and retain qualified, competent health care professionals will most certainly be adversely affected by this designation with its inequitable wage index. Already at a premium, home health nurses can easily bypass Warren County to gets jobs in neighboring counties who are positioned to offer higher salaries. Fewer agency resources, with its deleterious effect upon staffing and agency operations, will mean Warren County providers will struggle, or simply not be able to care for the sickest and most vulnerable Medicare beneficiaries who require more costly care and services.

In the proposed rule, pre-reclassified hospital wage index will be used in the final HH PPS rule, but unlike acute care inpatient facilities, home health providers have no ability to request reclassification of their wage index/ MSA designation. In 2004, Warren County's local hospitals were reclassified from the Allentown-Easton designation to the New York MSA. This reclassification will remain in effect until 2007. As health care providers in a particular locale are essentially competing for the same employee pool, I am proposing, a designation of Warren County to the Newark CBSA notwithstanding, that the wage index of the HH PPS should parallel the current, reclassified designation/wage index of the local inpatient hospitals.

I appreciate the opportunity to offer these comments on the proposed rule and hope consideration will be given to minimize the adverse effect that it will have on Warren County's home health providers and their capacity to provide quality care to their patients.

Respectfully submitted,

Dorothy Harth

Dorothy Harth, Division Director

VNAA Visiting Nurse Associations of America®

SEP - 2 2005

the voice of home healthcare

August 22, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1301-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Dr. McClellan:

I am writing on behalf of the Visiting Nurse Associations of America (VNAA) in response to your request for public comments on the proposed rule: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2006 (CMS 1301-P). The VNAA represents over 400 non-profit, community-based visiting nurse associations across the United States.

At the outset, we would like to express our appreciation for the opportunity to comment on the proposed rule. We would like to offer our following comments.

Provisions of Proposed Regulations

Wage Index Issues

Our primary concern in this proposed rule is the serious negative impact that will be experienced by many VNAs whose costs for providing care have not gone down but that will receive reduced Medicare payments simply because of the conversion from current MSA areas to new CBSA areas. We believe that such agencies need and deserve a transition period, as has been afforded hospitals, SNFs and hospices, to adjust to the reductions in their wage index. While a 2-3 year transition period impacting only adversely affected agencies would be optimal, we believe that at a minimum, home health agencies should be afforded the 50/50 blend of MSA and CBSA-based wage indices, which were granted to hospices.

Since CMS has already acknowledged the need to offer transitional payments to other providers to mitigate the effect of CBSA conversion, it may not be necessary to justify this need at great length. But we would point out that the impact data presented by CMS that aggregates the effect of CBSA conversion across large numbers of CBSA areas masks the effect of the specific impacts experienced by individual VNAs that generally serve only one or two areas. There are many agencies that will experience significant reductions in payment only because of the redesignations of their areas compared to any reduction they would have experienced from the normal MSA to MSA annual change. For example, the VNA serving New York City will experience a 2.1 percent reduction from CBSA conversion on top of a .9% MSA to MSA reduction. The VNA serving Midland Michigan will suffer a 5.6 CBSA conversion reduction on top of a 2.9% MSA to

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MSA reduction. Our VNA serving Rochester, New Hampshire will see a 6.9% CBSA conversion loss in addition to an MSA to MSA reduction of 1.2%. The VNAs serving Essex and Middlesex counties in Massachusetts and Rockingham and Hillsboro Counties in New Hampshire will suffer up to a 7.3% reduction on top of a 1.2% MSA to MSA reduction.

We would also like to point out that this year's wage index problems prompted by CBSA conversion are not the only distortions in Medicare payments created by the wage index. As we have pointed out in meetings with the CMS Chronic Care Policy Group staff, each year several home health wage index areas experience dramatic drops that reflect changes in relative hospital wages but not changes in the labor costs of HHAs in the same geographic area. We urge CMS to use its authority to provide a transition period each year to mitigate the effect of sudden wage index reductions greater than 2%. This "circuit breaker" or "corridor" provision would preserve the overall direction of wage index adjustments but reduce large year-to-year fluctuations.

The other major distortion in home health wage index adjustments is the disparity between the wage indexes of hospitals that have benefited from wage index reclassification and the wage indexes of HHAs in the same geographic area. Hospitals then use these extra funds to draw staff away from VNAs in the same labor market that do not have the opportunity for wage index reclassification. Our position is that HHAs deserve parity with hospitals with regard to such wage index adjustments since they compete in the same labor market for the same types of labor. We believe CMS should develop a system to adjust the home health wage index of each area in which hospitals have been reclassified to eliminate or reduce the wage index differential between reclassified hospitals and home health agencies serving patients in the same labor market.

While we agree with CMS staff that no specific legislative authority was given to CMS to allow home health agencies to request individual reclassifications, we believe CMS does have the authority to adopt a home health wage index that is more equitable. CMS was given the authority under the enabling legislation for the home health PPS to adopt virtually any wage index adjustment that would "reflect the level of wages and wage-related costs applicable to the furnishing of home health services in the geographic area compared to the national average applicable level." (Section 4603(a)(4)(C) of BBA-97). While CMS chose to adopt the pre-floor, prereclassified hospital wage index for home health, it clearly has the authority, and mandate, to develop a wage index that is reflective of the wage levels experienced by home health agencies. We believe it is important that CMS undertake an effort to address the wage index differential between reclassified hospitals and home health agencies serving patients in the same labor market areas.

Outlier Issues

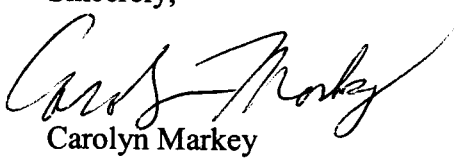
We also concerned that the proposed rule leaves as an open question whether or not the final rule will change outlier payment policy based on Medicare expenditure data. We believe that the outlier threshold should be reduced each year until such time as

expenditures equal the 5% threshold specified in legislation. When CMS determines that expenditures have actually reached the threshold, the evidence for making no further reductions in the threshold should be presented in the proposed rule and finalized only after public comment. CMS's delay in adjusting the outlier threshold until it achieves the expenditure cap amount continues to penalize those agencies serving outlier patients.

Finally, we would like to express our appreciation for the more complete and helpful tables provided as part of this proposed rule. We would urge that all future wage index notices include tables that compare the proposed wage index with the current wage index by each locality and show the year to year change in each area. This assists the public in assessing impact. We would also suggest that the tables be presented both in CBSA alphabetical order, as well as by county within state, as was done in the proposed rule. We would also suggest that a table highlight those areas experiencing the largest increases and decreases in wage index. This would help the public identify and research changes that may reflect statistical or reporting errors. If more complete tables cannot be published in the Federal Register itself, we would suggest contemporaneous publication on the CMS website.

Again, thank you for the opportunity to comment on these proposed regulations. Please direct any questions you may have to Bob Wardwell of our Washington office at 240-485-1855.

Sincerely,



Carolyn Markey
President and CEO

Nantucket Cottage Hospital

SEP - 7 2005

Lucille C. Giddings, RN, CHE
President and CEO

Founded in 1911

August 31, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1301-P
PO Box 8016
Baltimore, MD 21244-8016

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

I am writing to provide comment on the proposed rule updating the Home Health Prospective Payment System Rate published in the Federal Register on July 14, 2005. Specifically, I write to request your careful review and reconsideration of your wage index calculation for Massachusetts' rural areas, which at present consist only of the islands of Martha's Vineyard (Dukes County) and Nantucket (Nantucket County).

As the rule indicates, there are no longer any rural hospitals in Massachusetts for the purposes of calculating a rural wage index. There are, however, still two hospitals on Martha's Vineyard and Nantucket. These hospitals are now considered Critical Access Hospitals (CAH) and thus their data is not included in the Inpatient Hospital Prospective Payment System (IPPS) data upon which the home health wage index is based. The proposed rule further states that "in addressing this situation (no IPPS hospital data) we are proposing approaches that we believe serve as proxies for hospital wage data and will provide an appropriate standard that accounts for area wage differences". Unfortunately the proposed approach falls far short of approximating the wage disparity.

For many years the "Rural Massachusetts" geographic area included Franklin County in the northwest area of the state, Martha's Vineyard (Dukes County) and Nantucket County. Each of these counties had one hospital so the Rural Massachusetts wage index was calculated using the data from all three. The wage data from Franklin Medical Center has consistently been far lower than the wage index for Martha's Vineyard and Nantucket Cottage hospitals, as the following data from the CMS hospital wage index calculation published in the Federal Register on August 11, 2004 demonstrates:

	2003 Average Wage
Franklin Medical Center	$24.62
Nantucket Cottage Hospital	$31.13
Martha's Vineyard Hospital	$29.61

The wage data from the island hospitals has consistently been more similar to the wage data for the two hospitals on Cape Cod (Barnstable County) than to Franklin Medical Center as indicated by the following from the same source as above:

Falmouth Hospital	$29.68
Cape Cod Hospital	$31.10

Using wage data from all three rural hospitals, CMS calculated a Rural Massachusetts wage index in 2004 of 1.1288, or 12.88% higher than the nation average. By contrast, the 2004 wage index for Barnstable County was 1.3202. For 2005, CMS stopped using data from Critical Access Hospitals and based the Rural Massachusetts wage index on data from Franklin Hospital alone. As a result the 2005 Rural Massachusetts wage index dropped to 1.0217, almost 10% lower than the previous year.

For 2006, Franklin County has been incorporated into the Springfield Metropolitan Area, eliminating the last rural, non-Critical Access hospital in Massachusetts. CMS then "imputed" a rural wage index for Massachusetts of 1.0679. This imputed wage index was not applied to home health rates. Rather, CMS decided to maintain the 2005 rural wage index. If CMS used the wage data from the hospitals on Martha's Vineyard and Nantucket to calculate the 2006 rural wage index, it would approximate the wage index for Barnstable County (1.2527) and far more accurately reflect the true cost of providing services on these two islands.

Nantucket Cottage Hospital operates a hospital based, licensed Home Health Agency with approximately 5,000 annual visits. The Board of Trustees considers this service an important part of the hospital's mission to serve the island's 10,000+ year round residents as well as its 50,000+ seasonal residents. But the financial impact of CMS failure to use accurate wage data in calculating Home Health rates has significantly contributed to financial losses incurred in providing this service, projected to approximate $300,000 for fiscal year 2006. Nantucket has one of the highest costs of living in the United States necessitating high wages and housing subsidies in order to attract employees to work for our agency. In recruiting staff, we access the same pool of prospective employees as the agencies on Cape Cod and, therefore, must pay wages competitive with them. We currently pay nurses between $29 and $35 per hour and nurses' aides between $18 and $20 per hour at our home health agency. Since the island does not have a licensed Speech Therapist we are required to transport one from the mainland three times a week at a cost of $60 per hour in order to provide this service through our agency. Even with these higher wages, recruitment has been difficult and we have frequently been required to supplement staffing with travel nurses and other agency help at much higher per hour costs. The use of a more accurate wage index would go a long way toward ensuring the financial viability of our agency and ensure that Medicare beneficiaries residing on Nantucket as well as Martha's Vineyard continue to have access to home health services.

In response to your request for comments on the Home Health Prospective Payment System Update for 2006, we respectfully request that CMS reconsider its methodology for calculating the Rural Wage Index for Massachusetts. We propose that the hospital data from the two Critical Access Hospitals be used to establish a rural wage index for home health in 2006. The estimated costs to the Medicare Program, based on CMS' 2004 utilization data for these two counties, would be $300,000. This amount represents a relatively small outlay to CMS but would make a huge difference to the home health services on the two islands. Alternatively, we recommend that CMS apply the same wage index to home health rates for Martha's Vineyard and Nantucket as that used for Barnstable County, with whom we must compete in the recruitment and retention of staff.

I thank you for you attention to this matter and look forward to seeing your response in the final rule.

Sincerely,

Lucille C. Giddings

Lucille C. Giddings, RN, CHE

Cc: Margaretta Andrews, Chair, Board of Trustees

Via Electronic Mail

September 6, 2005

Dr. Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
mark.mcclellan@cms.hhs.gov

RE: CMS-1301-P

Dear Dr. McClellan:

The American Association for Homecare (AAHomecare) appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Home Health Prospective Payment System Rate Update for Calendar Year 2006," published in the *Federal Register* on July 14, 2005.

The American Association for Homecare is the only national association that represents every line of service within the homecare community. Our members include providers and suppliers of home health services, durable medical equipment services and supplies, infusion and respiratory care services, telehealth, and rehabilitative and assistive technologies, as well as manufacturers and state associations. With more than 700 member companies at 3,000 locations nationwide, AAHomecare and its members are committed to advancing the value and practice of quality health care services at home.

Our comments will focus on the wage index, specifically the transition to new Core Based Statistical Areas (CBSA), which include Metropolitan Statistical Areas (MSAs), and Micropolitan Statistical Areas to be deemed rural labor markets. The reconfiguration and new definitions will result in an update for urban MSAs of 2.3 percent and rural areas of 3.5 percent.

On page 40796, CMS states that "this proposed rule would have a significant positive effect upon small entities." Furthermore, although some home health agencies (HHAs) will be so-called "losers," there will be no transition period because there are many winners as well as losers. CMS does not "believe that in the aggregate HHAs would be impacted negatively by the new CBSA designations." CMS also states that a transition period is not necessary because payment is based on the wage area for the area in which patients reside, with lower wage areas being offset by areas with higher wage indexes. AAHomecare does not believe that the fact that there are "winners" justifies the severe dislocation the proposed rule constitutes for many of the "losers."

In addition, CMS states on page 40796 that "since HHAs compete for the same staff as hospitals in any geographic area, we believe the hospital wage index used by HH PPS reflects the wages that are paid by HHAs." If all things were equal, then this could be a valid statement, but hospitals in an area may be able to benefit from reclassification to a higher wage area and other wage adjustments, a benefit not available to home health agencies.

In contrast to past practice, the proposed rule does not provide a table indicating the percentage gain and loss resulting from wage index revisions from the previous year. Inclusion of such a table would provide a clearer picture of the impact of the proposed rule. In the October 24, 2004, *Federal Register* announcing PPS rates for the current calendar year, Addendum C contained a comparison of the old and new wage indexes and the percentage gain or loss for all MSA and rural areas. Addendum C in the July 14, 2005, proposed rule appears to contain (1) wage indexes as they would exist in 2006 if not for the transition to CBSAs (which is *different from the index being used for 2005 rates*), and (2) the proposed CBSA based wage indexes for urban and rural areas. There is no indication of the percentage increase or decrease from 2005 to 2006 resulting from the application of CBSAs compared to the *current* MSA designations and values.

It is our belief is that the transition to CBSAs may be hitting mid-tier metropolitan areas particularly negatively. In other cases, there appear to be inexplicable reductions for certain urban areas, including central and western New York. Several counties formerly classified in MSAs but now reclassified to rural status are particularly devastated. To follow are examples of wage index reductions for New York and for MSA counties reclassified as rural:

- Erie County, NY (Buffalo, Niagara Falls) (MSA 1280):
  2005 - .9339 to 2006 - .8889
- Cayuga County, NY (Syracuse) (MSA 8160):
  2005 - .9394 to 2006 - .8157
- Genesee County, NY (Rochester) (MSA 6840):
  2005 - .9196 to 2006 - .8157
- St. James Parish, LA (MSA 5560):
  2005 – .9130 to 2006 - .7418
- Kane County, UT (MSA 2620):
  2005 - 1.0611 to 2006 - .8126

- Culpepper County and King George County, VA (MSA 8840):
  2005 - 1.0971 to 2006 - .8012

Reimbursement reductions of this magnitude for the "losers" cannot be justified while the proposal rule simultaneously acknowledges a 3.3 percent increase in the cost of providing home health services. No home health agency is able to reduce salaries and benefits for nurses and therapists commensurate with such precipitous reimbursement reductions.

Because of the shortage of skilled nurses and therapists, and also the competitive disadvantage in areas where the local hospitals have reclassified to a higher wage area, HHAs are experiencing increasing difficulty recruiting and retaining nurses, the largest single labor component, placing upward pressure on wage and benefit levels. Growth in costs for this critical factor in home health operations must be fully accounted for in CBSA wage index values and reimbursement rates.

In addition, CMS expects home health agencies to achieve improved patient outcomes, operational efficiencies, and cost savings for the Medicare Program through adoption of health information technology, evidence-based best practices, and transformational change in corporate culture, as indicated in its quality roadmap and in the 8th Scope of Work for the Quality Improvement Organizations. HHAs have also eagerly embraced this agenda, but lack of funding will deprive many of them of the resources needed to achieve our mutual goals.

AAHomecare urges CMS to adopt the following remedies to address anomalies and ameliorate the dislocation for home health agencies that will result from adoption of CBSAs as proposed in the July 14 *Federal Register*:

- In order to address anomalies in the CBSA wage index, CMS should validate the accuracy and completeness of wage data submitted by hospitals and ensure that all hospitals in an area have reported.

- CMS should provide a mechanism for home health agencies to challenge the accuracy of wage index values for their areas, especially in cases where there are indications of an irregularity.

- CMS should provide for a transition period during which HHAs could opt for a 50-50 percent blend of the current and new wage indexes. Unlike home health agencies, hospitals benefited from a one year transition period, with a blended rate for those experiencing reductions from adoption of CBSAs. What's more, hospitals that previously were located in a MSA area but were reclassified as rural have the benefit of the wage index of the MSA to which they were previously assigned for a period of three years. Hospices have also been accorded a one year blended wage index transition period. As a matter of equity, CMS should grant negatively impacted HHAs the same consideration through a non-budget-neutral transition period based on such a blend.

- To provide parity between hospitals and home health agencies in areas where hospitals have reclassified to a higher wage index area, CMS should either administratively authorize a similar wage index adjustment for home health agencies or seek such authority from Congress, as well as authority to put a floor on wage index reductions from one year to the next.

Thank you for your consideration of our comments. Please feel free to contact me at (703) 535-1888 or kayc@aahomecare.org should you have any questions or concerns.

AAHomecare looks forward to working with CMS to address the issues posed by the July 14 proposed rule, as well as during the coming months as CMS further refines the home health Prospective Payment System.

Sincerely,

Kay Cox

Kay Cox
President and CEO

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