

# *West Michigan Medicare Equity Coalition*

## **Testimony for the Record House Committee on Ways & Means Hearing on Expiring Medicare Provider Payment Policies**

**September 22, 2011**

Section 508 Area Wage Index (AWI) protection has corrected a flaw to the Medicare payment methodology that, if unaddressed, would have cost West Michigan hospitals hundreds of millions of dollars through inaccurate Medicare payments. The West Michigan Medicare Equity Coalition (WMMEC) represents multiple hospitals and health systems in the region that would have faced a near-catastrophic loss of Medicare funds had Section 508 not been implemented and subsequently extended. WMMEC has advocated for extension of Section 508 protection as well as implementation of an equitable long-term reform plan that will address the underlying problems with the AWI system. The coalition is pleased to provide the Ways & Means Committee Subcommittee on Health with the following testimony on the benefits of Section 508 and the need for equitable long-term AWI reform.

### **Background on AWI**

The AWI exists to compensate hospitals fairly by addressing regional variations in labor costs associated with hiring and retaining high-quality nurses, technicians, and other staff. The system recognizes variations in labor markets and modifies federal Medicare payments accordingly so providers in higher cost regions that must pay higher labor costs receive indexes – and corresponding payments – that reflect these expenses. The index of each Metropolitan Statistical Area (MSA) is a ratio of that MSA's average hourly wage compared to the national average hourly wage, and the law requires the Center for Medicare & Medicaid Services to update the wage index annually using a number of financial inputs including hospital-specific cost data.

The law permits hospitals to petition CMS to reclassify to another MSA they believe is more representative of their true costs of doing business. According to a report to CMS by Acumen, LLC in April 2009, about one-third of all hospitals paid under the Inpatient Prospective Payment System (IPPS) have reclassification status. This statistic speaks strongly to the need for an overhaul of the system while retaining its mission of compensating hospitals fairly for market variations in the cost of labor. While WMMEC strongly supports implementation of an equitable long-term reform plan, we wish to address first the need for continuation of Section 508 protection, the item addressed during this hearing.

### **The Situation in West Michigan**

In 1997, Butterworth Hospital and Blodgett Hospital in Grand Rapids merged to form Spectrum Health. As a condition of approving the merger, the United States District Court ordered the system to freeze wages for the first three years, 1997 to 1999, and to limit price increase for the four following years, 2000 to 2004. To comply with this directive, Spectrum Health froze staff

wages. During the same period, Congress enacted the Balanced Budget Amendment (BBA) that included Medicare provider cuts. The combination of the wage freeze and Medicare cuts created a "perfect storm" that sharply reduced the Grand Rapids MSA wage index from 1.0048 in Fiscal Year 2002 to .9548 in Fiscal Year 2003.

Section 508 protection provided our hospitals with a route to petition CMS and successfully reclassify to the Kalamazoo MSA, thus enabling us to receive an index that more closely reflects the region's labor costs. Since being enacted through the Medicare Modernization Act, **Section 508 has prevented the hospitals of West Michigan from losing more than \$280 million in Medicare payments.** Most importantly, Section 508 protection has enabled the hospitals of West Michigan to expand and enhance care options for area patients while holding down costs. The latter has been particularly critical given the prolonged economic recession the state of Michigan is undergoing as it has prevented a host of undesirable consequences including layoffs, service reductions, and cost shifts to individuals and businesses. But because of the way in which indexes are calculated, the decline caused by the merger and BBA cuts would have a residual impact for years going forward, meaning the underlying problem remains uncorrected to this day. As a result, were Congress to not extend Section 508 protection, the hospitals of West Michigan would be saddled with the original problem and face the loss of tens of millions of dollars in Medicare funding.

### **A culture of Value**

During this challenging financial climate, the hospitals of WMMEC wish to note the region's legacy of providing high-quality and lower-cost healthcare. According to the Dartmouth Atlas of Healthcare, Medicare reimbursements per-enrollee is nearly \$900 less than the national average. This underscores that our hospitals take value seriously and take great care to limit costs while providing high-quality care. It is this concern for efficiencies that also drives our core principles for comprehensive AWI reform, a topic WMMEC remains committed to working with this committee to address.

### **Enacting Equitable Long-Term Reform**

Twice over a little more than three years, in 2006 and in 2010, Congress has directed CMS and the Department of Health and Human Services to develop a long-term reform proposal. The first such effort resulted in no recommendation, and the second requires the Secretary of HHS to submit recommendations to Congress by the end of this year. To help shape this effort, WMMEC several years ago developed a core set of principles for reform, attached as Addendum A. Atop this list is the principle that reform must address concerns about efficiencies and not punish hospitals that hold down costs. Unfortunately, this tenet does not apply to the present system, meaning hospitals that pay higher wages are rewarded with higher indexes, creating the phenomena of "circularity" and only perpetuating the unsustainable cycle of high-costs.

A reformed AWI system must drive value-oriented reforms of our healthcare delivery system, notably the provision of efficient, high-quality, and patient-centered care. These reforms must not punish lower-cost providers by rewarding high-cost providers that overspend on labor costs. These reforms must reduce year-to-year volatility and reduce variation between neighboring

regions, particularly by reducing and eliminating "cliffs" from one region to another. And these reforms must also recognize the fundamentally unique operation that a hospital is and use transparent and auditable hospital-specific data to calculate wage indexes.

## **Conclusion**

It is abundantly clear to all members of the West Michigan Medicare Equity Coalition that the AWI system must be reformed. But until this happens and an equitable reform plan can be implemented, Congress must maintain Section 508 protection. Failure to do so will resurrect the underlying problem and unjustly reduce Medicare payments to West Michigan hospitals by tens of millions of dollars. We urge the committee to protect beneficiary access to high-quality and low-cost care by maintaining this protection, and to redouble your efforts toward implementing an equitable long-term reform system. We thank the committee for providing us with this opportunity to submit testimony, and we look forward to working with the committee on both tasks.

## Addendum A: WMMEC Principles for Long-Term AWI Reform

- **Reform should reflect growing concern about efficiencies.** With healthcare policymakers at all levels growing increasingly more concerned about achieving efficiencies within the healthcare setting, any long-term changes to this system should include this dimension. Unfortunately, under the current system, hospitals have a disincentive to be efficient because reduced cost results in lower indexes. Going forward, it is imperative that any AWI reform recognize the need to improve efficiencies and be non-punitive to those institutions which succeed in lowering costs.
- **Start with present wage indexes.** Considering the significant number of hospitals that are currently reclassified to other Metropolitan Statistical Areas (MSAs), a wholesale reversion to native AWI levels would result in significant economic harm to hospitals throughout the nation. Congress and CMS must recognize that current reclassifications have been appropriately assigned and are based on individual circumstances. As such, any AWI reform should begin by using nothing less than the area wage index assigned to each hospital as of September 30, 2007.
- **Gradual phase-in.** Any AWI reform will have a major impact on our nation's hospitals. As such, WMMEC strongly recommends that any reform package be phased in over an appropriate transition period. This phase-in period will enable all providers, especially those who will experience major changes under a reform proposal, to adjust to the changes.
- **Reduce volatility through annual "circuit breaker."** WMMEC also believes that longer-term reform is needed to produce less year-to-year volatility. As such, WMMEC recommends that any final proposal include a limit by which no hospital would see an annual reduction in its AWI of greater than 1.5 percent. This would help guard against extreme volatility and thereby diminish demand for reclassification.
- **Accurate data over a longer-time period.** Under the current system, a region that experiences an economic anomaly may end up being punished at least twice; once when the anomaly occurs and again, three years later, when the area wage index takes effect. This is simply not right, as all West Michigan hospitals can attest. We propose that any longer-term reform plan include a "rolling index" that consists of two years' worth of hospital data to help prevent such scenarios.
- **Ensure data reflects actual hospital employment challenges.** Hospitals are unique and highly specialized healthcare providers. They must provide state-of-the-art care around the clock. As such, hospitals find themselves competing against other hospitals for the qualified healthcare talent they need. To help ensure hospitals have the resources to attract and retain the best healthcare staff possible, it is critical that any longer-term reform recognize this business reality. Failure to do so, by including disparate professions and/or employers in the data set, will only make it more challenging for hospitals to fulfill their unique missions.

- **Smoothing data for more gradual changes when possible.** WMMEC supports the concept of creating a system with fewer dramatic shifts between adjoining statistical areas. This is part of the phenomenon experienced in West Michigan.
- **Maintain an appeal process.** WMMEC sympathizes with the desires of Congress and CMS to minimize the number of annual reclassification requests. Nonetheless, as MedPAC has noted, it is difficult to predict every individual scenario that may arise in crafting a new AWI model. While AWI reform may help reduce the number of appeals, it is essential that an appeal mechanism be retained in any new system. Simply put, hospitals must maintain the right to petition CMS if they believe evidence supports reclassification.
- **Integrity and Transparency of data.** Any AWI reform must allow the underlying data to be audited and verifiable as accurate. The sources and methodologies for compiling the data must be transparent. Together, these factors will help ensure the reliability of the AWI calculations.