



# SECTION 508 HOSPITAL COALITION

**Statement Submitted to the  
U.S. House of Representatives  
Ways & Means Subcommittee on Health**

by

**Section 508 Hospital Coalition**

**Regarding the Hearing on Expiring Medicare Provider Payment Policies  
Wednesday, September 21, 2011**

The Section 508 Hospital Coalition is pleased to provide this statement regarding expiring Medicare provider payment policies.

Formed in 2004, the Section 508 Hospital Coalition represents those hospitals that qualified for wage index geographic reclassification pursuant to Section 508 of the *Medicare Modernization Act* (MMA).

Under Medicare's Inpatient Prospective Payment System (IPPS), the payment system used to reimburse hospitals for inpatient services furnished to program beneficiaries, payments are adjusted to reflect the cost of labor in the area where the services are furnished. The basic premise underlying this adjustment is that hospital personnel – nurses, technicians, housekeepers, dietary staff, billing clerks, *etc.* – are more expensive to employ in New York City than in rural Iowa, and payments should be adjusted accordingly.

To adjust payments in this manner, the Centers for Medicare and Medicaid Services (CMS) uses a multiplier called the “wage index.” The wage index is calculated by collecting average hourly wage data from each hospital across the country, and developing a national average hourly wage. CMS then determines a local average hourly wage. To define local areas, CMS relies on the Metropolitan Statistical Area (MSA) scheme developed and maintained by the U.S. Office of Management and Budget. CMS develops a distinct average hourly wage for each MSA around the country, and one for the rural portion of each state (*i.e.*, areas not within an MSA). The wage index for an MSA or rural area is the quotient of the average hourly wage for that area divided by the national average hourly wage.

Recognizing that MSAs are not always an accurate reflection of labor markets, Congress in 1989 established a process whereby hospitals could reclassify to a nearby MSA, and if they meet certain criteria, receive the higher wage index of that MSA. Of the more than 3,500 hospitals in the United

States (not including Critical Access Hospitals), approximately 650 hospitals (19 percent) are reclassified each year.

Each year, dozens of hospitals complain to CMS and Congress about shortcomings of the current reclassification system. Most of the complaints center around the use of MSAs as proxies for labor markets, and how grouping hospitals into MSAs creates unjustifiable and unfair reimbursement differentials between hospitals that are physically proximate and competing for labor in the same labor market. Hospitals in these situations that cannot qualify for reclassification for one reason or another assert that the reclassification criteria and process are too rigid, and not overcoming the shortcomings of using MSAs as proxies for labor markets, as it was originally intended to do.

Despite this chorus of complaints, CMS rarely updates or improves the reclassification system. Moreover, when CMS does decide to make a change, most often the change makes it more difficult for hospitals to qualify for reclassification, and reduces the number of hospitals qualifying for reclassification.

In 2003, Congress expressed its frustration with CMS's reluctance to modernize the reclassification criteria by directing CMS to establish a process under which hospitals otherwise not eligible for wage index reclassification could apply and qualify for reclassification. Specifically, Section 508 of the *Medicare Modernization Act* directed CMS to establish a one-time appeals process whereby CMS would develop new criteria that would resolve many of the problems with the reclassification criteria historically raised by hospitals. Hospitals qualifying for reclassification under these revised criteria would be reclassified for a three-year period beginning April 1, 2004. Congress provided \$900 million for this purpose. The MMA did not specify the criteria to be used – other than to say that a hospital already eligible for reclassification could not qualify – or direct CMS which hospitals to reclassify. The legislation gave CMS complete discretion to devise the criteria that would apply.

In enacting Section 508, Congress demonstrated a determination that some hospitals suffered from inequitable wage index classifications, and needed extraordinary assistance to rectify our various situations. While not expressly stated in the MMA, we believe that Congress limited the duration of the reclassifications for two reasons: (1) to limit the overall cost of the provision; and (2) because Congress hoped CMS would use this opportunity to modernize the reclassification criteria to permanently incorporate the changes made pursuant to Section 508. Regrettably, CMS has not made any change that would enable the majority of these hospitals to reclassify on their own. As such, they continue to need Section 508 reclassification to overcome inherent labor market unfairness and to continue to effectively serve their communities.

Fortunately, Congress has recognized the ongoing need for Section 508, often paired with the Medicare physician payment formula legislation or “doc fix”, and has extended the Section 508 reclassifications five times:

- *Tax Relief and Health Care Act of 2006* – Extended through 2007;
- *Medicare, Medicaid, and SCHIP Extension Act of 2007* – Extended through FY 2008;
- *Medicare Improvements for Patients and Providers Act of 2008*– Extended through FY 2009;
- *Patient Protection and Affordable Care Act of 2010*– Extended through FY 2010; and
- *Medicare and Medicaid Extenders Act of 2010*– Extended through FY 2011.

Under the criteria promulgated by CMS, 120 hospitals qualified for reclassification for the initial 3-year period. In FY 2012, only 91 hospitals from the following states continue to need and benefit from Section 508.

Alabama - 1	Iowa - 4	Pennsylvania -13
Alaska -1	Michigan - 30	South Dakota – 1
California - 1	Mississippi - 3	Vermont -1
Colorado -1	New Jersey -7	Virginia -1
Connecticut - 14	New York - 7	Wyoming -1
Illinois - 2	North Carolina -1	
Indiana - 1	Oregon – 1	

Unless Congress acts to again extend this important provision, the hospitals that benefit from Section 508 will lose millions of dollars in Medicare reimbursements that are necessary to maintain their workforce and serve Medicare beneficiaries in their communities.

Extending Section 508 now is more critical than ever. These hospitals are often the economic engines of their communities, and many of the communities they serve are struggling economically. Hospitals benefiting from Section 508 are in some of the country's most economically hard-hit areas, like Detroit and Scranton. If Medicare payments to these hospitals are further reduced, and these hospitals are forced to reduce workforce as a result, their communities could be further set back on the road to economic recovery and job creation.

Moreover, many of these hospitals, like hospitals across the country, are working to implement and absorb the requirements and Medicare payment-related changes resulting from health reform. Some of our hospitals expect Medicare reimbursement reductions as a result of health reform. Further reimbursement reductions at this vulnerable time could be economically crippling to these facilities.

Although most of the various extensions have been for one-year periods, the qualifying hospitals have come to depend on the additional reimbursements. Hospitals have established programs, hired personnel and built infrastructure thanks to this program. Without the assistance Congress has provided over the past eight years, these hospitals will find it more difficult to recruit and retain essential staff, and to care for Medicare beneficiaries and other patients in their communities.

We recognize that the country is facing difficult economic conditions, and that reducing the deficit is imperative. Nonetheless, Congress still must distinguish programs that require ongoing federal support from those that are better positioned to sustain cutbacks. This program is fundamental to the health of Medicare beneficiaries and economic well-being of our communities.

We further recognize that Congress would prefer to find long-term solutions to some of the programs that have been annually extended. We also would prefer a solution that provides hospitals with more predictability and stability. However, to date, a long-term viable solution has been elusive. Congress has asked CMS, the Institute of Medicine and the Medicare Payment Advisory Commission to propose solutions to some of the problems associated with the wage index and reclassifications. In fact, the same provision extending Section 508 reclassifications for FY 2010 in the Affordable Care Act also required CMS to develop an action plan for

improving the wage index. To date, none of these studies have produced politically or financially viable solutions. Until such time as Congress takes action to reform the wage index and obviate the need for reclassifications, it should continue to maintain a level playing field between the hospitals that benefit from reclassification, and those that need Section 508 to reclassify.

We ask for your leadership to help us protect our hospitals and the patients they serve by extending these reclassifications.