

Congress of the United States
Washington, DC 20515

June 10, 2013

The Honorable John Boehner
Speaker
U.S. House of Representatives
U.S. Capitol, H-232
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
U.S. Capitol, H-204
Washington, DC 20515

The Honorable Dave Camp
Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
House Ways and Means Committee
1106 Longworth House Office Building
Washington, DC 20515

Dear Speaker Boehner, Leader Pelosi, Chairman Camp, and Ranking Member Levin:

We are writing to express our strong opposition to H.R. 2053, the Medicare Hospital Wage Index Equity Act of 2013, sponsored by Rep. Kevin Brady. The bill discriminates against hospitals in Massachusetts, California and several other states by subjecting them to an unfair and unequal payment system. There has been considerable misinformation regarding this bill, and we would like to set the record straight.

Medicare adjusts payments provided to hospitals on a yearly basis. These reimbursement adjustments are made for a number of reasons, one of which is to ensure adequate payments to urban hospitals. Under the rule known as the “rural floor,” Medicare cannot reimburse a state’s urban hospitals, whose operations are typically more expensive, at a lower rate than its rural hospitals. The law requires that reimbursement changes under this rule – like other payment adjustments within Medicare - must be paid for from a constant national hospital pool of funds. From its enactment in 1997 until 2008, payment changes increases due to the rural floor rule were made budget neutral on a *nationwide* basis. In other words, higher payments to a hospital in one state were offset with slightly reduced payments to hospitals across the country (rather than only lowering reimbursements to other hospitals in that state).

As a result of this policy, Massachusetts hospitals lost \$480 million from 2004-2006, funding which benefitted *all other states* in the form of higher Medicare payments. Changes in hospital criteria among rural hospitals in the state meant that Nantucket Cottage Hospital would, by 2008, form the rural wage index and floor for Massachusetts. Contrary to what some proponents of H.R. 2053 claim, Nantucket Cottage Hospital has *always* met federal guidelines of a rural hospital ever since those guidelines have existed. Claims that this hospital was somehow given special consideration in order to become classified as a rural hospital are untrue. Instead, it

meets the same long-standing eligibility requirements for a rural hospital that apply to every other rural hospital in the country.

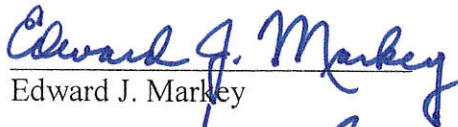
In 2009, Centers for Medicare and Medicaid Services (CMS), decided to take an unprecedented step— rather than continuing to offset rural floor adjustments on a nationwide basis, they would now be offset within the *state*. This targeted rule change would have severely reduced payments received by Massachusetts going forward and would have negatively impacted other states, as well. CMS' proposal was opposed by the American Hospital Association and the majority of hospitals across the country. Not a single hospital association supported CMS' proposal, but the agency went ahead and adopted the change to within-state budget neutrality for the rural floor.

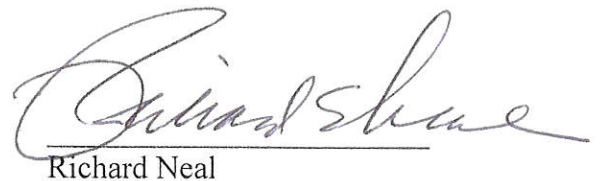
Senators Kerry and Menendez included a provision in the Affordable Care Act (ACA) that reinstated an equal playing field in Medicare's reimbursement system. Under Section 3141 of ACA, any adjustments made as a result of the rural floor would once again be offset on a nationwide basis, as are other Medicare adjustments. Contrary to claims made by proponents of H.R. 2053, this provision was included in an *open and transparent manner*. The Menendez-Kerry amendment was approved by the Senate Finance Committee in a publicly televised mark-up on the ACA held in the first week of December of 2009. It remained part of the publicly available Senate version of the ACA for the next four months until the final bill was enacted on March 23, 2010.

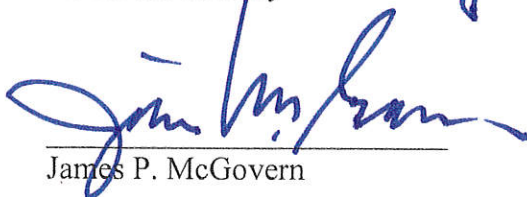
Massachusetts is not the only state that would be negatively impacted by H.R. 2053. Nine states – Massachusetts, Connecticut, California, New Jersey, Nevada, Alaska, New Hampshire, Rhode Island and Colorado – would be directly harmed if this bill succeeded in reverting to state-based neutrality for the rural floor. Furthermore, this bill would single out rural floor adjustments for unfair treatment; other Medicare payment adjustments requiring budget neutrality are offset on a nationwide basis. If other Medicare adjustments required state-based budget neutrality, as this bill proposes for the rural floor, all states would be required to offset any benefit to one hospital by cutting payments to other hospitals within their state.

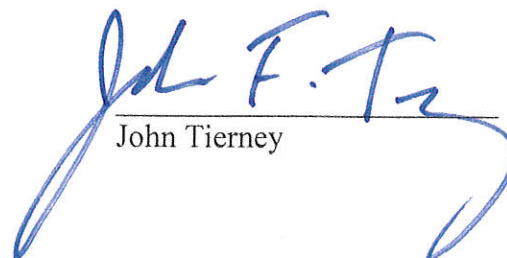
While we strongly oppose HR 2053, we do support a thoughtful and comprehensive review - and reform - of how all Medicare reimbursement changes are made. We feel it is important that the hospital community focuses on how best to reform the methodology used to calculate the Medicare area wage index to make it equitable and sustainable. H.R 2053, which singles out certain hospitals and states for unequal treatment, is simply not the solution.

Sincerely,


Edward J. Markey

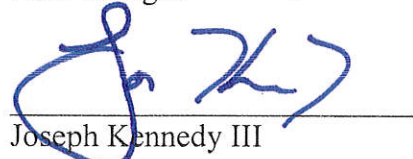

Richard Neal

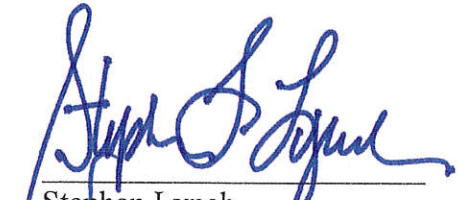

James P. McGovern


John Tierney


Michael Capuano


Niki Tsongas


Joseph Kennedy III


Stephen Lynch


William Keating

RURAL FLOOR – BACKGROUND AND TIMELINE

BRADY BILL, H.R. 2053

The Medicare Hospital Wage Index Equity Act of 2013, sponsored by Rep. Kevin Brady, would repeal Section 3141 of the Affordable Care Act, a provision that reinstated Medicare's long standing policy of nationwide budget neutrality for increases in payment due to the area wage index rural floor. Repealing this provision, as the legislation intends, would result in "*within-state*" budget neutrality rather than "*nationwide*" budget neutrality, effective October 1, 2013.

MASSACHUSETTS BACKGROUND

There has been considerable misinformation about the provision, how it was included in the ACA, and about how Massachusetts hospitals qualified under the provision.

While numerous states supported section 3141 of ACA when it was offered during Senate Finance Committee markup, Massachusetts felt particularly strong about it because for the previous eight years, CMS actions *specifically, unfairly and repeatedly targeted Massachusetts hospitals in targeted efforts to prevent them from obtaining wage index relief* that is allowed under current law and regulations. These discriminatory detrimental actions by CMS against Massachusetts hospitals started in 2004 when CMS arbitrarily lowered the Massachusetts rural wage index by nearly 8%. This resulted in Massachusetts hospitals losing hundreds of millions of dollars: \$12.2 million in 2004; \$270.7 million in 2005; and \$197 million in 2006. *Because the rural floor budget neutrality adjustment in those years applied at a national level, the lost payments for Massachusetts hospitals went back to all other states in the form of higher IPPS payments.*

The provision addressed in Section 3141 of the ACA dates to 2009 when CMS (in its latest discriminatory action) adopted a proposal to apply for the first time the rural floor budget neutrality adjustment based, *not on a national budget neutrality factor as is the case with all other Medicare budget neutrality adjustments, but on a within- state basis.* Since the 1997 enactment of the rural floor provision, the law required that the impact of all wage index rural floors has to be budget neutral to the Medicare program and, as with all other budget neutral adjustments under the Medicare program, this had been historically achieved by applying a uniform offset to payments for all hospitals across the nation. Applying budget neutrality on a within-state basis, as CMS started to do in FY2009, was therefore an unprecedented new way of applying this adjustment.

The American Hospital Association, after consultation with allied hospital association members, and the hospital associations of 26 states commented *against* the within-state rural floor budget neutrality (RFBN) proposal; with *not a single hospital association commenting in favor of within- state RFBN.* We believe that this reflected their recognition that the proposal conflicted with statutory intent, was critically flawed and inconsistent with both past and existing regulatory policy, and violated the objective of

wage index stability and equity. Despite overwhelming opposition to within-state budget neutrality, CMS went ahead with applying within-state RFBN in FY2009 and FY2010.

A coalition of states working with their Delegations worked to reverse CMS' flawed policy of within-state budget neutrality for the rural floor. Through their efforts, supported by AHA, consistent with AHA policy at that time based on consultation with the allied hospital associations, the within-state budget neutrality policy was reversed under the ACA of 2010 in which Congress directed the Centers for Medicare and Medicaid Services (CMS) to ***reinstate Medicare's policy of nationwide budget neutrality for increases in payments due to the rural floor. The ACA provision simply asked CMS to go back to the way things had always been done since the rural floor budget neutrality provision was enacted in 1997 – there was nothing specific to Massachusetts or any other state.***

The amendment addressing budget neutrality was offered by Senator Menendez of New Jersey and co-sponsored by Senator Kerry and was approved by the Senate Finance Committee in a publicly televised mark-up on the ACA held in the first week of December of 2009. It remained part of the Senate version of the ACA for the next four months until a combined Senate and House bill was enacted on March 23, 2010.

Contrary to recent press reports, the ACA provision was neither slipped into the ACA at the last moment nor was it a Massachusetts specific 'fix'. It was an action that was generally supported by the hospital industry—and it required CMS to apply the same rules to the rural floor that the agency does to all other Medicare provisions.

There have also been numerous claims about Nantucket Cottage Hospital (NCH) that somehow Massachusetts manipulated the rules to create a rural status for NCH -- also untrue. Contrary to what has been reported in the press, Nantucket Cottage Hospital ***was not reclassified to rural status; it is located in a rural area of Massachusetts. NCH has been a rural hospital for as long as CMS has defined rural hospitals.***

Regulations determining the wage index are subject to annual changes. ***Claims that the rural floor benefit to Massachusetts and other states will remain in "perpetuity" are both unrealistic and misleading.*** The Massachusetts rural floor impact has already changed significantly from the first year 2012, to 2013, and now in the proposed 2014 Inpatient Prospective Payment System rule, the impact is expected to drop again. Similarly, other states' benefits have also changed from year to year – Arizona received rural floor funding in 2013, but not in 2014 and Nevada will receive funding for the first time in 2014. And other states that benefit from rural floor funding also experience significant variation from year to year.

There are many adjustments under the AWI system, some of which are budget neutral while others are financed by new money and therefore add new Medicare costs to the system. Some of the largest ones are: Medicare Geographical Classification Review Board (MGCRB) reclassifications; Outmigration adjustments; rural floor to Frontier States; Section 508 reclassifications (terminated last year); Section 401 reclassifications; and Lugar Counties. These adjustments result in higher reimbursement for eligible

hospitals and the states that have been the loudest in opposition to Section 3141 benefit greatly from having one or more of these adjustments. In another interesting note, CMS never published a list of the winners and losers for any other budget neutral adjustments until it chose to do so for the first time for the rural floor adjustment in FY2012. ***In other words, we have no information from CMS about the magnitude of the state-by-state redistribution of Medicare funds that occurs due to any other budget neutral adjustment. CMS has chosen to be selectively transparent.*** In order to have honest dialogue, information should be made available on all wage index arrangements, including the “cost” to other states and to the federal government for these other budget neutral adjustments.

This history of the rural floor provision is a reminder that the Medicare area wage index system is extremely complex with funding changes throughout the nation depending on the year and provision. But the history on budget neutrality is simple and clear. *Nationwide* budget neutrality has always been used for Medicare area wage index changes, both increases and decreases, as a way to spread the annual adjustments among as many hospitals as possible. All hospitals (and all states) have experienced its impact over the years, sometimes as winners and sometimes as losers. ***None of these changes, neither in section 3141 nor in HR 2053, impact the federal deficit because they are, by definition, “budget neutral.”***

In an unprecedented departure from the norm of *nationwide* budget neutrality, in 2009 and 2010, CMS adopted a rule to single out for the first time the wage index rural floor change, making it subject to budget neutrality on a *within-state basis* –while still keeping all other wage index changes budget neutral on a *nationwide basis*. This discriminatory step by CMS appeared to be a tool to manipulate the rules so that a certain group of hospitals, who otherwise met the same criteria that all other hospitals had to meet, would not be treated the same. Section 3141 of the ACA reversed the CMS rule that sought to single out certain states to be treated differently on the issue of budget neutrality. There are sound reasons to maintain budget neutrality on a *nationwide* basis for all Medicare wage index changes adjustments. Foremost of those reasons is that it is a more stable and fair basis on which to fund such adjustments and spread the annual fluctuations.

While the rural floor benefit might seem limited to the nine states who are overall beneficiaries, **it is important to realize that in the absence of *nationwide* budget neutrality, all states’ would have to fund any individual hospital wage index increases due to the rural floor by redistributing payments between hospitals in their states.** This could prove to be a significant problem for additional states who current oppose the rural floor provision thinking that it only impacts Massachusetts and perhaps a few other states.

The Brady bill now in Congress pretends to reform the wage index, but in reality protects all of the area wage index adjustments but one. That is neither sound public policy nor fair.

RURAL FLOOR TIMELINE

- FY2004 – 2006: In 2004, CMS made an arbitrary and unprecedented change in the wage index calculation which lowered the Massachusetts rural wage index by 7.58% - reducing Medicare payments to Massachusetts hospitals from 2004-2006 by over \$480 million – because the budget neutrality was applied at the national level, the lost payments for Massachusetts hospitals went back to all other states in the form of higher IPPS payments.
- FY2008: Changes in hospital criteria among rural hospitals in the state meant that Nantucket Cottage Hospital **would**, by 2008, form the rural wage index and floor for Massachusetts.
- FY2009: CMS proposed and adopted rule to apply, for the first time, the rural floor budget neutrality adjustment based on a *with-in* state basis rather than *national* basis.
- December, 2009: Senators Menendez and Kerry successfully offered an amendment, with no opposition during the televised public Senate Finance mark-up of the Affordable Care Act (ACA) to repeal the CMS rule, returning the rural floor adjustment to national budget neutrality. The provision remained in the Senate version of the ACA through final passage of the ACA.
- April, 2011: CMS published the proposed rule for FY 2012, along with the wage index values for all CBSAs and rural areas – included an impact analysis of the proposed wage index changes (and the return to national budget neutrality). During the comment period, no hospital association opposed the CMS' calculation methodology for the Massachusetts rural floor.
- August, 2011: CMS published the final IPPS and for the first time, CMS published a list of the winners and losers but solely for the rural floor budget neutral adjustments, not for any other budget neutrality adjustments in the final rule. In other words, no information was published from CMS about the magnitude of the state-by-state redistribution of Medicare funds that occurs due to any other budget neutral adjustment, only the rural floor.