MEDICARE'S GEOGRAPHIC COST ADJUSTORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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MEDICARE'S GEOGRAPHIC COST ADJUSTORS

TUESDAY, JULY 23, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:12 p.m., in room B–318 Rayburn House Office Building, Hon. Nancy L. Johnson [Chairman of the Subcommittee] presiding.

[The advisory and the revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 16, 2002
No. HL–16

CONTACT: (202) 225–3943

Johnson Announces Hearing on Medicare's Geographic Cost Adjustors

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on assessing Medicare's geographic cost adjustors used for Medicare payment. In addition, the Subcommittee will assess the adequacy of the definition of labor market areas. **The hearing will take place on Tuesday, July 23, 2002, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from the U.S. General Accounting Office, the Medicare Payment Advisory Commission (MedPAC), academia and interested Members of Congress. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Hospitals, skilled nursing facilities, and home health agencies are paid by Medicare under prospective payment systems. These payments are adjusted to reflect the cost of buying labor and other services across areas, as measured by the wage index. The wage index is one of the most important determinants of Medicare facilities' payment. Thus, its adequacy in accurately capturing geographic differentials in labor costs is critically important. Data on salaries and fringe benefits (including bonuses) from each hospital in the country are the only information used in calculating the wage index.

The wage index is estimated by calculating an average hospital wage for each labor market area, and the average for that area is compared to the national average hospital wage. The labor market areas are Metropolitan Statistical Areas (MSAs), which are defined by the Office of Management and Budget. Counties not in MSAs are grouped into a single rural area in each State.

Research by the Prospective Payment Assessment Commission (the predecessor to MedPAC) showed that the current labor market areas are frequently too large. The MSAs may contain an inner-city core labor market with higher wage costs than those in the surrounding suburban areas. More recent research (Dalton, et al 2000) suggests that the statewide rural areas typically contain three distinct markets based on the population size in the county. Consequently, the wage index redistributes payments within labor market areas from the inner city to suburban hospitals and to outlying hospitals in rural pockets within MSAs. Similarly, isolated rural hospitals benefit financially as the wage index is dominated by the higher wages of rural hospitals in large towns.

However, the historical political county boundaries that define current labor market areas often arbitrarily separate facilities that participate in the same labor market. To address this problem, the Omnibus Budget Reconciliation Act 1989 (P.L. 101–239) established a process enabling hospitals to reclassify into another labor market if the hospital is close to the area, disadvantaged due to much higher costs than their actual labor market location (8 percent higher for urban hospitals and 6 percent higher for rural hospitals), and if it had wage costs no more than 18 percent lower for urban hospitals and 16 percent lower for rural hospitals to those in the nearby area. Under the reclassification provision, 568 hospitals will receive a different and higher wage index in fiscal year 2003. Geographic reclassification is

budget neutral (neither increases or decreases overall expenditures) so that the Centers for Medicare and Medicaid Services estimates that payments for urban hospitals will be reduced 0.5 percent and payments to rural hospitals increased 2.5 percent in fiscal year 2003.

Although hospitals utilize the reclassification process, a number of hospitals that do not meet the criteria in the law have pursued congressional action to legislatively reclassify hospitals or arbitrarily raise the wage index. These bills often lack empirical evidence or support from the MedPAC for such changes.

The geographic practice cost indices used to compute physician payments are conceptually quite different than hospitals. Separate geographic adjusters apply to three components: work, practice expense, and professional liability insurance. The geographic adjuster for work is based on a sample of median hourly earnings of workers in six professional specialty occupation categories and conceptually is intended to measure differences in the cost of living. The geographic adjuster for practice expense is based on employee wages, office rents, medical equipment and supplies, and other miscellaneous expenses. The geographic adjuster for professional liability insurance reflects the cost of this insurance.

In addition, the geographic adjustment areas used to calculate physician payments are larger than those used to compute the wage index, and in a number of instances statewide. The physician geographic adjusters are reviewed, and revised as necessary, every 3 years, compared to the annual update of the hospital wage data.

In announcing the hearing, Chairman Johnson stated, "The operation of the wage index is extremely complex. Not only does it consume an inordinate amount of time to adjudicate changes on a case-by-case basis, we have heard a number of complaints about the huge disparities across regions and apparent inequities between providers who are situated just miles apart. This hearing will shed some much-needed light on this complex area."

FOCUS OF THE HEARING:

Tuesday's hearing will focus on assessing the current Medicare payment geographic adjustor and highlighting suggestions for improvement of the formula and appeals process.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, by the close of business, Tuesday, August 6, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call (202) 225–1721 or (202) 226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

* * *NOTICE—CHANGE IN LOCATION* * *

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Subcommittee on Health

FOR IMMEDIATE RELEASE
July 22, 2002
No. HL–16–Revised

CONTACT: (202) 225–3943

Change in Location for Subcommittee Hearing on Medicare's Geographic Cost Adjustors Tuesday, July 23, 2002

Congresswoman Nancy L. Johnson, Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on Medicare's Geographic Cost Adjustors, scheduled for Tuesday, July 23, 2002, at 2:00 p.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held in room B–318 Rayburn House Office Building.**

All other details for the hearing remain the same. (See Subcommittee advisory No. HL–16 dated July 16, 2002.)

Chairman JOHNSON. The hearing will come to order. My apologies to my colleagues for having to start a little bit behind.

Good morning. Today's hearing will focus on the important subject of how Medicare payments account for differences in the costs of providing services across regions of the country.

Our goal is to ensure that providers are compensated fairly for costs over which they have no control. Medicare funding is critical to the Nation's hospitals, nursing homes, home health agencies, and physicians. It is our obligation to make sure that payments are fair and the system works.

In my own district, the limitations of the hospital geographic classification process are vividly exposed. The western edge of my district borders New York State and the southern edge borders the New York City Metropolitan Statistical Area (MSA). The hospital wage index in that portion of my district is 1.2294. The wage index for the area just across the State line is 1.4427, a 17-percent differential. Wage indexes are assigned by location, generally along county lines.

As a result, a hospital in Danbury would be classified in New Haven MSA of 1.22 while one in Putnam County New York, only a few miles away, would be classified in the New York MSA wage index of 1.44. The result is that Putnam County receives Medicare payments 17 percent higher than even the Danbury hospital, even

though they share a labor pool and draw patients from the same geographic area.

Further adding to the inequity, the average hospital wage in Danbury is higher than the average hospital wage in Putnam County. One of the results is that the hospitals in the New York MSA have an inpatient margin of 28 percent compared to hospitals in the New Haven MSA with a negative margin of 10.3 percent.

In my own hometown of New Britain, the New Britain General Hospital would have an increase of $5 million a year if they could reclassify to New York City MSA and $.25 million a year if they could reclassify to the New Haven MSA and so on and so forth.

Only five hospitals in all of Connecticut qualified for a reclassification in 2003, so I appreciate the importance of this hearing.

I welcome my colleagues to testify because only through evaluating your experiences and the information you bring us about geographic adjustments in your communities and for your hospitals and doctors will we be able to determine if we can improve our payment system and its sensitivity to regional variations in costs.

While this is a very complicated area of the law, it is an important one. If we focus on the facts, I believe we will be able to assure sound policy.

That much said, the witness today from the U.S. General Accounting Office (GAO), the Medicare Payment Advisory Commission (MedPAC) and the Urban Institute will provide information that we simply must recognize, though for many of us the Medicare Payment Advisory Commission and the Urban Institute will provide information that we simply must recognize, though for many of us, some of their information contradicts what many have come to consider conventional wisdom.

For example, the hard fact is that rural hospitals are helped by the wage index and large teaching hospitals in the inner cities are hurt by the wage index. This is because the wage adjustment process starts with actual hospital wage data and computes both a national average and a MSA regional average wage from reported hospital wages.

This process of averaging inherently disadvantages the high-wage institutions in the MSA and inherently advantages the low-wage institutions and the MSA. While this is the underlying foundation of our system, other aspects of our system, the definition of the wage areas, the reclassification and all its parts must be scrutinized to determine if the system can be made to function more fairly.

Congress has improved and modified the geographic adjustment process several times since 1983. Over 1989 an appeals process was established so that a hospital could increase its wage index by proving that it should be assigned to a different labor market.

The bar for reclassification to a higher wage area is set low. The hospital's wage can be up to 16 percent lower than the wages in the area it seeks to join. In addition, the hospital must prove it is disadvantaged by its actual location. While experts conclude that the appeals process has made the system work a little better, it may need adjustments as the environment in which health care delivery has changed.

Our experts will also tell us that the geographic adjustors for physician payments favor rural areas. The physician fee schedule includes three components: physician work, practice expense, and professional liability insurance. Each component has its own geographic adjustor.

When Congress enacted the physician fee schedule in 1989, it limited geographic adjustment of the work component of physician payments. Instead of accounting for all cost of living differences, Congress decided to adjust only one quarter of the payment for physician work.

This last of full accounting for cost of living differences means that physicians in lower cost of living rural areas are paid relatively more. Physicians in higher cost of living urban areas are paid relatively less than they would be paid if the full geographic adjustment had been made to the work component.

In fact, more than half, 55 percent of the average Medicare physician fee is a national fee with no geographic adjustment. Three-quarters of physician work and all medical equipment and supplies are paid on a nationwide basis.

In addition, Medicare is a program to deal with physician shortages which provides a 10-percent incentive bonus to physicians who previous care in any rural or rural health professional shortage area.

In the Medicare Modernization and Prescription Drug Act of 2002, I call for a GAO study of geographic differences and payments for physician services. This study would assess the validity of the adjustors and evaluate how they are constructed and used.

Once we have this GAO report, we will return to this issue. I am committed to maintaining access to quantity care for all our seniors in all communities across America. As payments policies in both the public and private sectors have changed and each payer is focused more narrowly on the costs of its own patients, resources to cover uncompensated and under-compensated care have diminished and payments based on averages may be having new impacts on access and quality.

As we study the issues raised in the hearing, we will be looking for solutions that will treat providers more equitably in this era of bargained down reimbursements and rising costs. The answers will not be easy, but the signs of serious strains cannot be ignored.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, a Representative in Congress from the State of Connecticut, and Chairman, Subcommittee on Health

Good morning. Today's hearing will focus on the important subject of how Medicare payments account for differences in the cost of providing services across regions of the country. Our goal is to ensure that providers are compensated fairly for costs over which they have no control. Medicare funding is critical to the Nation's hospitals, nursing homes, home health agencies and physicians, and it is our obligation to make sure the payments are fair and the system works.

I am pleased to see so many Members here today to talk about how geographic adjustments affect their communities. It is through evaluating the experiences of your hospitals and doctors that we will be able to determine if we can improve our payment system and its sensitivity to regional variations in cost. While this is a very complicated area of the law, it is an important one and if we all focus on the facts, we will be able to assure sound policy.

That much said, the witnesses today from the General Accounting Office, the Medicare Payment Advisory Commission, and the Urban Institute will provide infor-

mation that we must recognize, though for many of you some of their conclusions contradict what you have come to consider conventional wisdom.

For example, the hard fact is that small rural hospitals are helped by the wage index and large teaching hospitals in the inner cities are disadvantaged. This is because the wage adjustment process starts with actual hospital wage data and computes both a national average wage and an MSA regional average wage from reported hospital wages. This process of averaging inherently disadvantages the high-wage institutions of an MSA—giving the low-wage providers more than their costs and high-wage providers less than their costs for labor.

While this is the underlying foundation of our system, other aspects of the formula, the definition of wage areas, and the reclassification system must all be scrutinized to determine if the system can be made to function more fairly.

Congress has improved and modified the geographic adjustment process several times since 1983. In OBRA 1989, an appeals process was established so that a hospital could increase its wage index by proving that it should be assigned to a different labor market. The bar for reclassification to a higher wage area is set low: the hospital's wage can be up to 16% lower than the wages in the area it seeks to join. In addition, the hospital must prove it is disadvantaged by its actual location. While experts conclude that the appeals process has made the system work a little better, it may need adjustment as the environment in which health care is delivered changes.

Our experts will also tell us that geographic adjusters for physician payments favor rural areas. The physician fee schedule includes three components: physician work, practice expense, and professional liability insurance. Each component has its own geographic adjuster.

When Congress enacted the physician fee schedule in 1989, it limited geographic adjustment of the work component of physician payments: Instead of accounting for all cost-of-living differences, Congress decided to adjust only one-quarter of the payment for physician work. This lack of full accounting for cost-of-living differences means that physicians in lower cost-of-living rural areas are paid relatively more, and physicians in higher cost-of-living urban areas are paid relatively less than they would be paid if full geographic adjustment were made to the work component.

In fact, more than half—55 percent—of the average Medicare physician fee is a national fee for which no geographic adjustment is made. Three-quarters of physician work, and all of medical equipment and supplies are paid on a nationwide basis.

In addition, Medicare has a program to deal with physician shortages. Medicare provides a 10 percent incentive bonus to physicians who provide care in any rural or urban health professional shortage area.

In the Medicare Modernization and Prescription Drug Act of 2002, I call for a GAO study of geographic differences in payments for physicians' services. This study would assess the validity of the adjusters, and evaluate how they are constructed and used. Once we have this GAO report, we will be better able to evaluate the need for reform.

I am committed to maintaining access to quality care for all seniors in Medicare in all communities. As payment policies in both the public and private sectors have changed and each payor has focused more narrowly on the costs of only its own patients, resources to cover uncompensated and under-compensated care have diminished and payments based on averages are having new impacts on care access and quality.

As we study the issues raised in the hearing, we will be looking for solutions that will treat providers more equitably in this era of bargained-down reimbursements and rising costs. The answers will not be easy but the signs of serious strain cannot be ignored.

Mr. Stark, would you like to comment?

Mr. STARK. Madam Chair, thank you. I am often troubled by our process in that we dance around with a variety of formulas in an effort to be fair We have built into the system or the system has built into it an appeals process for those hospitals that I suspect we are mostly talking about today, who feel they have been unfairly treated, or for some reason or another, their MSA is just across the river and that is closer than the adjoining MSA that is across the mountains.

Unless hospitals who have been turned down for an adjustment, which means that they not only don't qualify for a MSA labor payment, but they have appealed through the process and then been turned down again. I'm uncomfortable creating what I would refer to as rifle shots to start adjusting this on individual hospital bases unless we are willing to do it for all hospitals individually, which I would support.

I certainly am uncomfortable doing it in the absence of hospital-specific financial data, which the hospitals don't like to provide. Now, we have that available to us, and I would ask each witness, both at the table and my colleagues to come, if we can't provide it and we would try in some cases to look, because what we often find is that the Medicare margins of the hospitals that you are concerned about are quite positive and the overall margins of the hospitals are negative. What does that tell you?

Basically, it tells you that they have taken deep discounts from managed care plans or other and on this they are making money on Medicare, but they are losing money on other services. This happens probably in two-thirds of the hospitals across the country that have negative margins, they are making money on Medicare.

So, the question then comes, should we increase the Medicare payments to bail out hospitals that either have poor management or have to take deep discounts to buy into managed care plans to generate volume or not. In some cases that may be a valid objective, but it is very hard.

You know, we are going to end up with one MSA running from New York to Los Angeles, pretty soon, and then there will be basically no adjustment. I don't know what that gets anybody. I am happy to work with the Chair and our staff to remember instances where a strong case can be made that there is inadequate service available, there are no competing hospitals, for example, that the margins are low and that the hospital has a plan to correct its financial shortfall rather than trouble you all with having to come back here every couple of years and say, "Good old Saint Somebody didn't make it this year again because they are just counting on our adding a subsidy," which, by the way, is unfair to the hospitals in your district, to our neighboring districts that are doing a good job, or doing a better job financially, I should say.

So, to the extent that each of you can provide us more specific data, it will be helpful, I think, to come to judgment because there is a whole lot of requests in here for that. I for one would like to see the process become a little bit more empirical so that the hospitals that had to submit data, perhaps it could be in a uniform format to make the case that it would be a lot easier for us then, because it is a zero-sum gain; whatever money that you all are able to get for your hospitals comes out of the hide of other hospitals. So, we have to take that into account.

I look forward to your testimony. I hope that you will recognize the problem that the Chair and the staff will have in coming to a fair decision in this case as to whether or not we have money to solve each of these problems.

Thank you, Madam Chair.

Mr. KLECZKA. Madam Chair.

Chairman JOHNSON. Yes.

Mr. KLECZKA. Madam Chair, our colleague from the Committee on Ways and Means, Mr. Cardin, was scheduled to be on the fist panel and had to leave. I would ask unanimous consent that his testimony be made part of the official record.

Chairman JOHNSON. Yes, I was going to do that after introducing the panel. I do regret that Mr. Cardin had to leave. We will submit his testimony for the record.

[The statement of Mr. Cardin follows:]

Statement of the Hon. Benjamin L. Cardin, a Representative in Congress from the State of Maryland

Thank you, Madam Chairman, for the opportunity to submit testimony to the Subcommittee on Medicare's Geographic Cost Adjustments. My testimony addresses an often overlooked aspect in the wage index debate-the negative effects of the existing system on providers other than hospitals, specifically nursing homes.

First, unlike hospitals, nursing facilities are unable to petition for geographic reclassification to benefit from the higher wage index of the area from which they draw labor because no SNF-specific wage index exists. This means that a free-standing SNF across the street from a hospital that has received a geographic reclassification cannot receive the same reclassification. Furthermore a hospital-based SNF based at that very same hospital cannot receive it either.

Yet, the hospital, the freestanding SNF, and the hospital-based SNF are all facing the same labor market. The result is an economic disadvantage facing both SNFs in trying to recruit and retain the best available care-givers.

Second, the use of hospital wage and fringe benefit data to set payment for nursing homes has created an imprecise measure that may result in lower than appropriate reimbursements to these facilities. Currently, the wage index portion of the nursing home reimbursement formula is determined by the same cost reports that hospitals submit for their payment. Often the two sets of data vary. Even when they are very similar, for this approach to work, hospitals must provide accurate wage and benefit data. If hospitals fail to report their own data accurately, and as a consequence, the wage index for a particular MSA is lowered, nursing home PPS rates will be reduced accordingly.

Seemingly minor errors can produce wide variations in payment. Often payments are lower than merited because incomplete reports are submitted. In some cases, the Centers for Medicare and Medicaid Services (CMS) will assume the lowest amount in lieu of unreported data. The vast majority of the nation's hospitals have an incentive to ensure accuracy because their payments will be adversely affected by incorrect reporting.

But nursing home operators in my home state of Maryland face a unique situation. Hospital data errors can reduce the wage index and the PPS rates for nursing homes but not for hospitals, because our hospital rates are governed by the Health Services Cost Review Commission. Historically, these hospitals have had less incentive to verify the accuracy of the reports they file. For this reason, I strongly support the timely development of a SNF-specific wage index that will accurately measure labor cost fluctuations in nursing homes.

Recent experience in the Baltimore MSA illustrates this very problem. In May 2001, when CMS released the 1999 wage index data that would be used to calculate rates for FY2002, nursing home administrators noticed a suspiciously low indicator of 0.9365, down from the previous year's wage index of 0.9891. A consultant subsequently determined that several large Baltimore hospitals had failed to include fringe benefit data in their reports. That 5% drop in the Baltimore MSA wage index resulted in a $15 per patient day reimbursement loss for 111 nursing homes, for a total reduction of $4 million in FY 2002.

The current regulatory process provides facilities an opportunity to repair errors resulting from defective cost reports in the following manner: CMS publishes wage index data in the *Federal Register* as part of the May PPS proposed rule; this gives hospitals 60 days to comment and make corrections before the final rule establishing payment is published in August. The May proposed rule shows the new wage index numbers, but it does not indicate whether the rate will result in an increase or decrease from the previous year's payment unless the change is greater than 10%. In addition there is a mid-year corrections process for wage index data, but mid-year corrections are made *only* when the fiscal intermediary or CMS has miscalculated the data provided, not when incorrect data was supplied.

In this case, the local nursing home association contacted the hospitals involved, which then submitted revised data to CMS. Effective October 1, 2001, the wage

index was corrected, and the FY2002 rates were increased to reflect the adjusted wage index of 0.9856. The consultants' analysis also determined that the Maryland wage index was erroneous for FY2001-it was based on 1998 data. That year's error cost Maryland nursing homes approximately $3 million in FY2001. CMS has concurred with this estimate, but because the period for hospitals to submit cost report corrections had elapsed, CMS lacked the authority to adjust the nursing homes' payments.

Recommendations

The Maryland experience demonstrates clearly the need for changes to the geographic classification system. I have several recommendations that I would encourage the Subcommittee to consider. First, Congress should urge CMS to develop a SNF-specific wage index as soon as possible. My Senate colleague, Russ Feingold, has introduced legislation, S. 1955, which I support. It requires the area wage adjustment for SNFs to be based on the wages of their employees.

Second, CMS should be provided the flexibility to make mid-year corrections when errors are made by providers, as well as when they are made by CMS or the fiscal intermediary. Third, as a short-term remedy, CMS should be granted the authority to increase Baltimore nursing home rates in fiscal year 2003 by the amount that these facilities lost in FY2001 because of the hospitals' error.

Madam Chairman and Members of the Subcommittee, I very much appreciate the chance to present this matter to you for your consideration, and I would welcome the opportunity to work with you on this issue.

Mrs. THURMAN. Also, there is a request from Representative Stupak and Senator Crapo that would also like to have their testimony inserted into the record.

Chairman JOHNSON. We will certainly accept that for the record.

[The joint statement of Mr. Stupak and Mr. Crapo follow:]

Joint Statement of the Hon. Bart Stupak, a Representative in Congress from the State of Michigan, and the Hon. Mike Crapo, a United States Senator from the State of Idaho

We applaud the Ways and Means Subcommittee on Health for addressing Medicare geographic cost adjusters, particularly Medicare geographic reclassification. The Medicare geographic reclassification process is a good and important opportunity for hospitals, particularly those in rural areas, to compete effectively for highly skilled clinical personnel. This highly skilled work force allows these hospitals to offer sophisticated health services in rural communities. It is our understanding that hundreds of rural hospitals across our Nation depend on the geographic reclassification process in order to recruit health professionals to their communities. However, it is not a perfect system. We join together to correct one particular flaw. Specifically, we recommend Congress immediately enact the Medicare Geographic Adjustment Fairness Act.

(S. 659/H.R. 1375), legislation that would deem hospitals that have been geographically reclassified for purposes of their inpatient wage index to be reclassified for all provider based services. Congress has required the Centers for Medicare and Medicaid Services CMS to reimburse hospitals for most services provided to program beneficiaries using prospective payment systems (PPS). Hospital services that are reimbursed using PPS schemes include hospital inpatient, outpatient, skilled nursing, inpatient rehabilitation, long-term care, and home health services. In addition, we are informed CMS is also developing a PPS for inpatient psychiatric services. As you may know, under PPS, payment rates are geographically adjusted by a factor known as the "wage index," which is intended to reflect the cost of labor in the area in which the hospital is located.

In order to improve the system to more accurately reflect the actual labor rates of certain rural hospitals, Congress approved within the Omnibus Budget Reconciliation Act of 1989 provisions creating the geographic reclassification process and the Medicare Geographic Reclassification Review Board (MGCRB). The MGCRB is charged with considering requests from hospitals that wish to reclassify from the area in which they are physically located to receive a wage index adjustment equal to that of a nearby area that experiences the same labor costs.

However, when Congress established the reclassification opportunity in 1989, hospital inpatient services were the only services reimbursed under a PPS and the only

services where payments were geographically adjusted using a wage index. Therefore, the wage index geographic reclassification opportunity applies only to hospital inpatient services even though, today, most hospital-based services are reimbursed under some form of a PPS and geographically adjusted using a wage index. CMS exercised discretion to extend a hospital's reclassified wage index to hospital outpatient services, but has not done so to reclassify wage indices for other hospital-based services. As such, a hospital that qualifies for wage index geographic reclassification from a rural area to an urban area will have the urban wage index used to adjust payments for hospital inpatient and outpatient services, but the rural wage index for other provider-based services, such as skilled nursing and inpatient rehabilitation services, even if these services are all provided in the same physical location.

This has created a complicated and confusing system for rural hospitals in which, for example, Medicare pays one wage rate on one floor of a hospital and another wage rate on another floor. Since hospitals most often provide inpatient, outpatient, skilled nursing, inpatient rehabilitation, and other services in the same building, or on the same campus, it is logical to apply the same wage index to each of these services.

To correct this disparity, we have introduced the Medicare Geographic Adjustment Fairness Act, which would require CMS to deem hospitals that have been geographically reclassified for purposes of their inpatient wage index to be considered reclassified for purposes of all other services that are provider-based and for which payments are geographically adjusted using a wage index. We are pleased to be joined in seeking this change by 15 of our colleagues in the Senate and 19 of our colleagues in the House of Representatives. We thank the Subcommittee for the opportunity to submit this testimony and urge it to support and advance these changes. Thank you, Mr. Chairman

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Chairman JOHNSON. I do think that the goal of this hearing is to determine whether this is about individual hospitals and individual problems or whether this is about a system that is no longer operating effectively and fairly as it should.

From your testimony and the testimony of our experts, and it will take considerable work thereafter, we hope to determine whether there are systems changes that are appropriate at this time. Mr. English.

Mr. ENGLISH. One more? I apologize for interrupting. I ask unanimous consent to insert into the record Congresswoman Wilson's testimony. She will not be able to make it on the panel.

Chairman JOHNSON. We are happy to do that. We are sorry that she cannot stay.

[The statement of Ms. Wilson follows:]

Statement of the Hon. Heather Wilson, a Representative in Congress from the State of New Mexico

I want to thank the Chairwoman for holding this hearing on equity in the Medicare system. Addressing the disparity of physician payments is one of my top priorities to improve health care in my state. I appreciate the Committee's willingness to examine this important issue.

The current physician fee schedule for Medicare has several components, one of which is a geographic index supposedly to adjust for cost differences in different areas. While this makes sense for a physician's expenses for office rent and other costs to vary by region, the time spent evaluating and treating a patient should not depend on where a senior lives.

I believe we should make the physician work component of the Medicare physician fee schedule fair. The physician work component measures the physician time, skill and intensity in providing a service. Two additional components account for practice expense and malpractice expense. While practice and malpractice reimbursement should reflect differences in geographic costs, significant differences in physician fees in a national market for health care providers directly creates shortages in some communities like New Mexico, and excesses in other communities because they pay more.

The physician work geographic practice cost index (GPCI) for New Mexico is 0.973. Bringing New Mexico and other communities closer to a 1.00 geographic ad-

juster whether through a floor or making all physician fees equal would translate into about a $2,592,203 annual increase in Medicare payments to New Mexico physicians. I worked to include a provision in the recently passed Medicare prescription drug bill to bring up lower paying states without hurting higher paid areas. Closing the gap between pay rates for this component will help New Mexico keep our physicians.

More and more seniors are learning that their physician has moved to a neighboring state because salaries are dramatically higher. New Mexicans don't pay into Medicare based on where we live, and we should not be denied access to health care because of where we live. Seniors in rural areas or "low cost areas" have seen increasing numbers of doctors leave for higher paying areas. Keeping doctors in rural states is extremely difficult because of the pay gap driven by discriminatory Medicare reimbursement. The disparities are very large. In 2000, average Medicare payments per beneficiary in New Mexico were $3,726, while in Texas average payments were $6,539—70% more.

The New Mexico medical community continues to be very concerned about geographic adjustments to the Medicare fee schedule which result in higher Medicare payments to the physicians in other states than in New Mexico. Our lower Medicare fees (32nd in the nation) contribute to other physician reimbursement problems and pose unique challenges for New Mexico in the national marketplace of medicine.

New Mexico is especially affected by these payment disparities—58.3% of our population is either uninsured, covered by Medicaid (18%) or Medicare (13%). Compare this to the rest of the country at 42.2%. Medicaid in New Mexico is paid at 95% of Medicare, and because most health plans establish their payments from Medicare levels, New Mexico falls lower for payments in the commercial area. These numbers all add up to low physician reimbursements in New Mexico. Data this year indicate the situation worsening with family practice doctors' income decreased from $125,000 to $110,000. Because reimbursements are lower, physician medical specialists like general surgeons, neurosurgeons, psychiatrists, endocrinologists and anesthesiologists are almost impossible to recruit. Physicians coming out of medical school and residency programs with high student loans cannot even consider New Mexico. We simply can't compete with other areas with much lower numbers of uninsured and where Medicare pays more.

It isn't surprising that we often face physician shortages, especially in rural areas. But even in cities, patients often have a difficult time finding primary care physicians who can take new patients. Recently, Mike Stanford, president of First State Bank, called the New Mexico Medical Society in desperation after being unable to find a primary physician for himself and his family. Patients needing specialty services are delayed often by several months. I know of a emergency room physician who could not find neurosurgeon for his own mother. A top pediatric surgeon left New Mexico because he could not find an anesthesiologist on a regular basis.

New Mexico Department of Health Secretary Alex Valdez is working with the New Mexico Medical Society to address what can be done on the state level to keep the doctors we have and get more here. But the medical profession is a national marketplace and New Mexico is not on a level playingfield. National intervention is needed.

I urge my colleagues, especially those in rural states to carefully consider the implication of this discrimination on low paid areas and help me bring equity and access to the outdated Medicare system.

Mr. STARK. Madam Chair, I assume that all Subcommittee Members will be able to submit statements for the record.

Chairman JOHNSON. Of course, and also Subcommittee Members will be able to be part of the discussions about this. We certainly do want Subcommittee Members. That is why I inserted some of my own concerns to demonstrate that this is a concern for me as well as being Chairman.

I am interested in how many Subcommittee Members have popped right up. So, we are going to hear from those off the Committee, but those on the Committee are going to have plenty of chance.

Thank you all for being here. Thank you for your patience. Mr. Nussle?

STATEMENT OF THE HON. JIM NUSSLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. NUSSLE. Thank you, Madam Chairwoman and my colleagues from the Committee on Ways and Means. You are correct that those of us on the Committee on Ways and Means will have an opportunity to be heard on this subject for quite some time, and you will hear from us, particularly if the attitude is going to be that small adjustments to a flawed system is all we are going to be able to do, because I think that the phrase that comes to mind to me in listening to the opening statements is that "If you always do what you always did you will always get what you always got."

That is the problem we have with Medicare right now, that we are continuing to make small minor adjustments to a system that was created in 1965. We wonder why GAO, within that context, comes back with data that suggests that within that context the system, which is flawed, may show that rural areas in particular are doing just fine.

If that's the case, I mean I have very respectful testimony here that I would like to put into the record, but I can't believe that the opening statement is that rural areas are just doing fine, according to GAO. I don't know who GAO is talking to.

We can't retain physicians. We have hospitals that are below the margin. I don't know what you are talking about, and I don't know what GAO is talking about. I came in here ready to give some very respectful testimony on what we need to do to adjust it, but if the testimony here today is that GAO is operating with 2-year-old data, which is what this is, is coming in here and say, oh, don't worry about it; rural areas are doing just fine.

Tell that to the doctors that are leaving and that we can't retain. Tell that to the new graduates that aren't willing to look in rural areas to work. They are going to the urban areas. They are not going to the rural areas.

So, if the word out of GAO is that your reimbursement must just be fine, the market is operating with their feet. People are voting with their feet and telling us very clearly that something is wrong.

So, okay, if GAO says rural areas are doing just fine, I guess that is GAO's opinion based on 2-year-old flawed data. I think the marketplace is demonstrating this. Let me be clear, especially to Mr. Stark, we will take your deal, one MSA.

We pay the same taxes out in Iowa as you do in California, but you have a better reimbursement. We will take your deal. Your hospitals seem to be doing just fine. Saint Somebody's, by the way, isn't just serving some no-name town out there. We are talking about people's lives.

If the hospital closes, the town closes, because there is only one service provider in many instances for as far as 30 or 40 miles. So, if the hospital in my town of Manchester decides because of its geographic hospital wage index it can't make it and pay its bills, that means not only is Medicare disadvantaged because it can't provide services to those folks, but it means the next obstetrician case, the next baby that needs to be delivered in that town, has the same disadvantage.

I will go back to my testimony, but I have to say that when you say, "We will take it out of the hide of other hospitals, that is the

reason we are here." When you say, "We will take it out of the hide of other hospitals and that is the only way you can fix it," that is really the crux of the whole debate here. Since 1965 this has been a zero-sum game and that the only way for me to have fairness in my systems is for me to take it from your system, that therein, I think, lies the problem. We have to figure out a way to get away from it.

I understand because you have shown me then, 2-year-old data saying some hospital in my district is making ends meet. Okay, that is really nice. I have to tell you, that is not the way it is in the reality of the world that we operate in.

So, you can quote statistics to me, but when we have, well, you can laugh, but this is a problem we are going to deal with, Mr. Stark, we are going to deal with it, because damn it, we pay the same taxes as your folks pay in California. We are not getting the same services and our doctors are not staying and our hospitals are not making margins.

As long as you think that is okay, we have a problem.

Mr. STARK. There is a 20 margin on Medicare in Manchester.

Mr. NUSSLE. Where?

Mr. STARK. In Manchester. Delaware Country Memorial Hospital, Manchester.

Mr. NUSSLE. What year?

Mr. STARK. In 1999.

Mr. NUSSLE. Oh, well how many years ago has that been? That is 3-year-old data. So, I will take back my time, and I would be glad to submit my testimony for the record on both hospitals and doctors. We have a problem so long as you think we are living back in 1965. It is old data. It is an old formula.

If you always do what you always did, you will always get what you always got, and we will have a tax rebellion about this at some point if we don't figure out a way to fix it.

Now, I am willing to be part of the solution, but as long as you think this is about Saint Somebody's in some town that doesn't matter—which is the crux of this debate—there are people who think there are too many hospitals open in this country. I never hear that about California. I hear it about Iowa, and I hear it about other rural areas.

As long as that is the attitude of some Members of this Committee, we are going to have a continuing debate and disagreement about how we are going to get our arms around this.

Mr. STARK. I look forward to that. You will lose.

Mr. NUSSLE. Hey, trust me, we have been losing now for 35 years, so in an urban House of Representatives written by an urban body at that time, I have no doubt we are going to continue to lose. We will be heard.

I appreciate the gentlelady holding this first ever hearing on this topic.

Mr. STARK. Under the Republicans.

Mr. NUSSLE. It was never held under your watch, I will tell you that much.

Mr. STARK. Oh, it was indeed.

[The prepared statement of Mr. Nussle follows:]

Statement of the Hon. Jim Nussle, a Representative in Congress from the State of Iowa

Chairwoman Johnson, Ranking member Stark, I'm pleased to have been invited to testify before the Health Subcommittee about the impact of Medicare's Geographic Cost Adjustors on my home state of Iowa. Maintaining a high quality of health care in rural communities such as my hometown of Manchester has been one of my top priorities since being elected to Congress. In fact, just last year, I had the pleasure of hosting the Chairwoman of the Health Subcommittee, Mrs. Johnson, at several meetings with hospital administrators, physicians, and other health care providers in Dubuque.

The erroneous assumption that providing quality health care in rural states costs less than those in urban areas has persisted since the Medicare program was initiated in 1965. As you probably know, Iowa ranks 8th in overall quality of health care delivery while it remains 50th in overall Medicare reimbursement. The stability of our healthcare system across the state is threatened.

While I applaud the steps the House has taken to improve these inequities in the Medicare Modernization and Prescription Drug Act by including both a separate title with a number of rural health care improvements as well as an amendment I offered providing relief to those states with hospitals most in need, clearly more action is needed to keep health care providers from leaving small, rural communities. Among the biggest contributors to these inequities faced by rural health care providers are the geographic adjusters on both hospital and physician wages.

While the geographic adjusters for both physicians and hospitals are in essence supposed to provide an accurate reflection of area wages for particular markets and communities, in reality they have hampered the urgent efforts of small communities to retain and recruit health care personnel to serve in rural communities. The most pronounced examples of the inequities in geographic adjusters are the hospital wage index and the geographic practice cost index (GPCI).

Hospital Wage Index

The area wage index is a scale used to adjust Medicare inpatient and outpatient payments to account for varying wage rates paid by hospitals for workers in difference market areas across the country. Hospitals in areas with a higher wage index receive higher Medicare payments than those with a lower wage index for the same services.

The hospital wage index is the single greatest factor promoting geographic Medicare payment differences between urban areas and rural areas such as Iowa because it makes inaccurate assumptions about cost of living differences. I believe the current index itself is flawed because the inpatient wage index often contains wage and salary data relating to "overhead" for non-patient related healthcare personnel. The effect of this flaw dilutes the facility's average hourly wage because of the portion of total salaries attributed to lower paid employees. This phenomenon is particularly true in Iowa and other rural states where it is fairly common for a rural hospital to operate additional facilities such as nursing homes.

Also, there is an assumption that Iowa hospitals can and do pay workers less. But in reality, Iowa hospitals are handicapped by the Medicare wage index adjustment because they must compete in a regional, interstate market for labor in what is a growing work force crisis. In my district, for example, hospitals in Osage, Cresco, and Decorah with a Medicare wage index of.8147 compete in the same labor market as Rochester, Minnesota, which has a wage index well above the national average of 1.1462. Hospitals in these rural areas simply do not have the resources to compete with larger urban areas in surrounding areas and states.

It is critical that the hospital wage index be addressed to bring equity to Iowa and other poorly reimbursed states. Currently, the Iowa Hospital Association reports that the percentage of Iowa's hospitals with negative Medicare margins is growing every year. One promising idea proposed in H.R. 1609, of which I am a cosponsor, is the establishment of a wage index "floor" of.925. By establishing such a floor, significant relief could be provided to Iowa's under-compensated hospitals.

Physician Work Component of the Physician Fee Schedule

In a recent news article, Ed O'Neill, a surgeon in Dubuque, Iowa, stated correctly that, "Recruitment and Retention of quality physicians is made that much harder by sub-par reimbursement." I wholeheartedly agree.

The implementation of the Resource Based Relative Value Scale (RBRVS) was the first major change to Medicare Part B since the program's inception. This new payment system was based on three geographic practice cost indexes (GPCI's) meant to narrow the geographic differences among localities: physician work, practice ex-

pense, and professional liability insurance costs. In reality, the GPCI's have had the opposite effect. A particular troubling component is the Centers for Medicare and Medicaid Services definition of physician work as the amount of time, intensity, and skill, a physician provides in a patient visit. Clearly, physicians in Iowa provide the same time, intensity, and skill of those in all areas of the country, but yet Iowa ranks 81st out of 89 payment localities based on physician work component of the geographic practice cost index (Iowa-.959). Why should there be any difference among localities for physician's work at all? Iowa physicians provide high quality health care delivery and this inequity must be fixed.

Similar to the wage index floor for hospitals, an idea that has emerged in the House is establishing a floor for the physician work component of this system. I have cosponsored H.R. 3569, the REPAIR Act, which would phase in a floor of 1.000 over five years so that rural states like Iowa can continue to recruit and retain physicians and so that they can continue to serve Medicare patients.

Summary

I appreciate the opportunity to testify before the Subcommittee today and again applaud the efforts of the Committee and the House in passage of the Medicare Modernization and Prescription Drug Act (H.R. 4954). This bill provides significant measures to eliminate the inequities that currently exist, but clearly more must be done. I look forward to working with the Chairwoman and the committee to eliminate the current discrimination that rural states face under the geographic adjustment systems for hospitals and physicians.

Chairman JOHNSON. Mrs. Roukema. Hon. Marge Roukema of New Jersey.

STATEMENT OF THE HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mrs. ROUKEMA. Thank you. Thank you very much, Madam Chair. I would like to say I recognize a lot of what you said. You know, Connecticut and New Jersey have a similar, if not identical, problem with respect to the Medicare wage index adjustment.

I want to associate myself with many of your remarks. This is a well-timed hearing. I certainly hope we are going to move to make a correction as soon as possible. I might note that the Supplemental Appropriations Conference Report that we are going to be voting on today includes, as a result of what happened with a couple of Members of the New York delegation, language expressing in the strongest terms a request that the authorizing Committee of jurisdiction, the House Committee on Ways and Means, develop legislation as soon as possible to address the geographic inequities in Medicare payments.

This issue affects not only my district, in Northern New Jersey and the districts in Southern New Jersey that relate to Philadelphia, but also Connecticut and some of Pennsylvania.

Chairman JOHNSON. As we are going to see in these hearings, it is across the country.

Mrs. ROUKEMA. Yes, but on a regional basis—I am really speaking for, that whole New York-Philadelphia region, as you, Madam Chair have already discussed. I want to point out to you that my district, which is in Northern New Jersey, is a stone's throw from the New York City financial markets. Whether it is the securities industry or the banking industry, we are only a stone's throw, and we have an enormous number of people who are commuters to that area.

It is really a work force region where our hospitals are competing with the New York City area for employees. New York City hospitals are literally across the river, a stone's throw, from our own

hospitals and the personnel are going to the New York City hospitals. This continued dislocation of workers will exacerbate New Jersey's nursing shortage problems and our vacancy rate of registered nurses, which is now 10 percent, will easily be estimated to increase to 18 percent within the next 5 years.

We really have a crisis with respect to getting healthcare employees to New Jersey and getting patients the right kind of high quality care. The New Jersey hospital workforce shortage is directly attributable to the Medicare wage index. I would like to point out that the New Jersey delegation is, on a bipartisan basis, strongly supportive of my testimony here today and the need to fix Medicare adjustments and payments to hospitals. I would like to note that the New Jersey wage index is lower than the neighboring areas, even though it must compete with the hospitals in nearby localities for labor. This results in a Catch-22 for our hospitals.

Going back to the Chair's reference to the GAO study and the report that they are going to be hopefully accelerating, I don't know how far into the future that will go. I believe the evidence is very much there now to deal with the MSA problem on a regional basis. I would think evidence is also there for the rural hospitals. So, I don't know that I want to be put in the position of having to wait into the indefinite future for the GAO report when I think that the evidence is there now and that we can act upon it now.

What the Chairwoman has said pretty much makes the case. We have to address this issue immediately. It is not just about people's wages, but it is about the quality of care in our hospitals. We must get workers to stay in New Jersey hospitals by addressing the nursing shortage and other personnel shortages. The problem is accelerating and it is getting far, far worse and really destroying the quality of care.

[The prepared statement of Mrs. Roukema follows:]

Statement of the Hon. Marge Roukema, a Representative in Congress from the State of New Jersey

Thank you for the opportunity to speak today about an issue that has a tremendous impact on healthcare in New Jersey—the Medicare wage index adjustment. I commend you for convening a hearing on this important subject consistent with the request made by conferees in the Supplemental Appropriations Conference Report that we will be voting on today. The report reads: "the conferees express in the strongest terms their request that the authorizing committees of jurisdiction, the Senate Finance Committee and House Ways and Means Committee, develop legislation as soon as possible to address the geographic inequities that exist nationwide in Medicare reimbursements because of the wage indices used."

We must find ways to provide fiscal relief to our hospitals. New Jersey hospitals are in a terrible financial condition and it threatens access to care for the state's 8 million residents.

I represent the fifth district of New Jersey, which consists of Bergen, Passaic, Sussex, and Warren counties in northern New Jersey. My district has become known as a bedroom community for thousands of men and women who work every day in the most important financial district on the planet—in New York City. Indeed, my district is literally a stone's throw away from New York City, the largest city in the United States.

Northern New Jersey and New York City constitute one large, integrated labor market. In 1998, 300,000 New Jersey residents paid almost $1.3 billion in New York income taxes. Commuting patterns between the two areas illustrate the high level of integration. Everyday, the George Washington Bridge carries 155,000 cars eastbound into New York City. The PATH train averages 180,000 daily riders on weekdays.

In total, over 300,000 commuters enter New York City every day from New Jersey. The bottom line is that the only thing separating New Jersey from Manhattan

is a river. There is perhaps no clearer illustration of the integration of New York City and northern New Jersey than the response to the Sept. 11 attacks. Nearly 5,000 patients crossed the Hudson River that day for treatment at New Jersey hospitals.

Although the entire nation is facing a health care workforce shortage, New Jersey's proximity to New York City has caused its problems to be particularly severe. Industry analysts say that a 10 percent vacancy rate of registered nurses constitutes a severe shortage. It is projected that New Jersey will have a vacancy rate of 18 percent by 2006. This is a crisis and can be directly attributed to the inequitable Medicare wage index. New Jersey hospitals receive lower levels of reimbursement from Medicare than New York City hospitals. New Jersey hospitals simply cannot continue to compete with the nation's largest city while facing the strains of an unprecedented workforce shortage. More than 40 percent of New Jersey hospitals ended 2000 in the red, and with $21 billion looming budget cuts already set into law, the financial condition of hospitals will only become bleaker.

As you are well aware, Medicare adjusts its payments to hospitals using an adjustment factor, called a wage index, to account for labor costs. New Jersey's wage index is lower than neighboring areas, even though it must compete with hospitals in these nearby localities for labor.

Caught in a catch-22, New Jersey hospitals cannot afford to pay its employees more money to get a higher wage adjustment. Hospitals are losing their ability to attract physicians and nurses and other caregivers since they can work in higher paying hospitals in New York City.

The New Jersey delegation has fought long and hard for increased, fair Medicare reimbursement levels. We have been working with the Office of Management and Budget since the 1980s to recognize the similar labor costs between the New York City MSA and the MSAs in the northern part of New Jersey.

I would like to call the Committee's attention to the findings of the Metropolitan Area Standards Review Committee (MASRC), which was chartered in the fall of 1998 by the Office of Management and Budget (OMB) to examine the current metropolitan area standards and alternative approaches to defining those areas. The group recognized, in findings that were published in the October 1999 Federal Register, that the settlement patterns of the mid-Atlantic region constitute larger entities, suggesting that a larger "megapolitan" area for New York and New Jersey exists.

We were pleased that H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002 (passed the House on June 28, 2002), included the establishment of a GAO study on improvements that can be made in the measurement of regional differences in hospital wages.

The study would specifically examine the use of metropolitan statistical areas for purposes of computing and applying the wage index and whether the boundaries of such areas accurately reflect local labor markets. The study would also examine whether regional inequities are created as a result of infrequent updates of such boundaries. This is a step in the right direction and I commend the leadership for working with us to pursue this issue that is so critical for New Jersey hospitals. However, I believe that current evidence leaves no question that the current metropolitan area standards distort local labor markets and result in gross inequities in Medicare reimbursements.

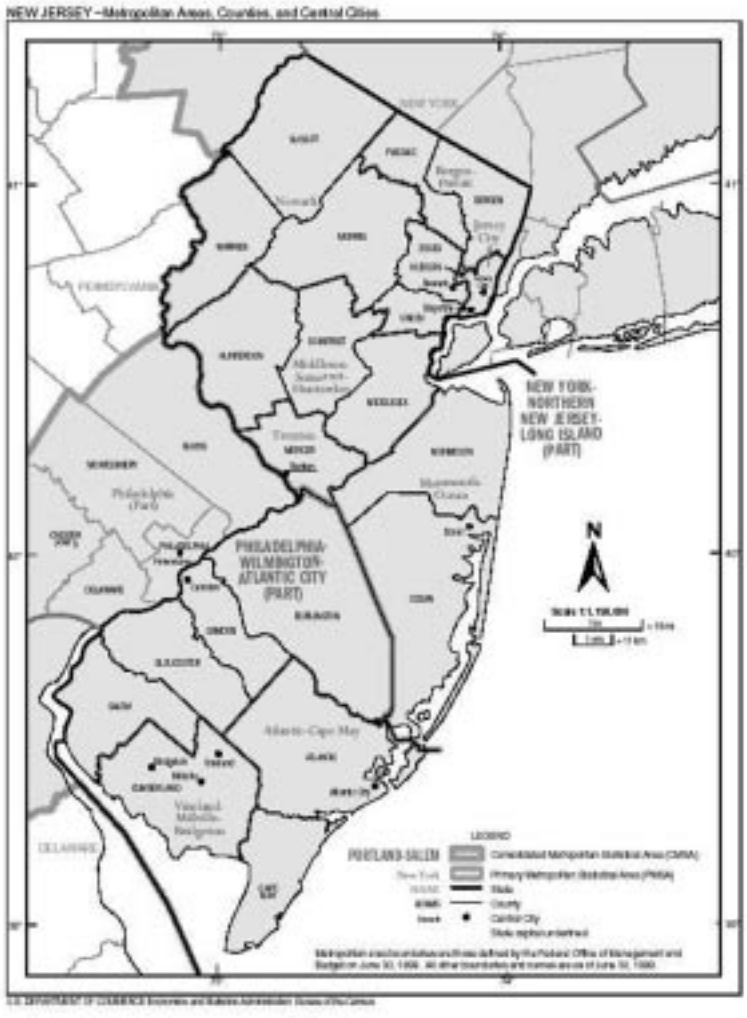
New Jersey hospitals deserve a wage index equitable to New York City. According to statistics provided by the New Jersey Hospital Association, the most recent Medicare data shows that the hospitals in my district have, on average, the lowest Medicare inpatient margins in the state. Let me offer you one example from a hospital located in my district. The Valley Hospital is a 474-bed acute care facility in Ridgewood, New Jersey. Over 50 percent of Valley's volume is Medicare. Like the other hospitals in my district, Valley only receives a 16 to 18 cent add-on to each labor related Medicare dollar as a wage index adjustment. Neighboring hospitals located in the New York City Metropolitan Statistical Area (MSA), some of which are located just a few miles away, receive a 44-cent add-on. This disparity makes no sense!

Hospitals in New Jersey are in their worst financial condition in over a decade. Because of the Medicare wage index add-on that is over two times higher than that of northern New Jersey hospitals, nearby hospitals located in New York City can afford to pay their health care professionals more. New Jersey cannot.

Let me remind you that behind this entire debate about "wage indexes" and "geographic classifications" is one simple fact. This is about patients. It is about the millions of New Jerseyans who are threatened by a struggling hospital system. Patient care will be compromised if we don't address this crisis immediately.

Additionally, our country is facing a situation today that we are totally unfamiliar with. We are battling terrorists who can strike against our country at any time and in any manner. Now more than ever, it is essential that our hospitals are capable of fully staffing their facilities. Future terrorist attacks would be even more devastating if our hospitals are not equipped with qualified staff to care for patients. This is a situation that must be addressed immediately. The safety of the residents of New Jersey is at stake.

I urge you to keep New Jersey patients in mind when examining the inequity in Medicare payment add-ons between New York City and northern New Jersey.



Chairman JOHNSON. I thank the gentle lady. Congressman Kanjorski.

STATEMENT OF THE HON. PAUL E. KANJORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. KANJORSKI. I believe that I may have an exceptional case, I doubt it, but those areas of the country which have an inordinate amount of senior citizens such as northeastern Pennsylvania, when they get stuck between MSAs, whether it is New York, Philadelphia, Harrisburg, Baltimore, and that area, which is the area that I represent, it can be catastrophic.

Now, I believe it goes back to the fundamental idea of how you set this whole system up originally. It may have worked, but it certainly didn't have attention and repairs over the years because what we really did when we set the system up is we penalized frugality and efficiency. We rewarded inefficiency and extravagance.

You can see that up and down the Medicare system. As Mr. Stark pointed out, some hospitals make a profit on Medicare payments, and that is very true. I have watched across the country areas like Philadelphia, New York, Miami, they actually show a profit on the Medicare payment. Twelve hospitals of the fifteen that were in the fix of the supplemental appropriation are in my district. Two of the twelve face immediate bankruptcy. They have exhausted their endowment programs over the last 3 or 4 years.

When you go to the appropriate executive departments they say, oh, well, we have a formula, and we analyze this, and we have an appeal. That is great. Three years from now they will change the rate. Three years from now at least 2 of these 12 hospitals will be gone and closed down. We are talking about billion dollar institutions.

I am still working on what we do with a $1-billion hospital to close it down. We probably could turn it into a chicken coop or something, but I'm not sure what else we could use it for. Certainly when it closes down for 2 or 3 years it can't be reactivated. It is a dead piece of capital sitting out there.

So, we are in dire need in northeastern Pennsylvania of a fix, I don't care whether it is an appropriation bill. I don't know if it is overall too complex for this Committee to adjust the whole country. All I am saying is if we don't rush funds to these hospitals in an immediate period, they can't meet their bottom line.

The major hospital that I represent loses $2,000 for every senior citizen that comes in the door. As the administrator tells me, they should issue a check and a taxi ride to Philadelphia to each senior citizen who seeks care because that is the only way they could survive. Unfortunately, it is very difficult for families to visit people 100 miles away who are getting this type of treatment. Where there would be a profit in Philadelphia treating them; there is a $2,000 loss in Wilkes Barre or Scranton.

Now, any system or any government that supports this type of inadequacy and inequity deserves to be censured and the Congress deserves to be censured in turning it around. We exacerbate the problem because every year when we feel a little guilty, we up the reimbursement payment by a percentage. I think it was 3 percent last year and everybody was gloriously happy.

All you did was spread the differential between the lower paid hospitals and the higher paid hospitals, 3 percent greater because the 3 percent is on the base. When we were losing money on the

base and we get 3 percent, other hospitals in other areas are making money on the base and they get 3 percent. They are making much more profit at an extended rate.

Now, we have to go back and literally look at this problem of what kind of delivery system we want for health care for this country, how close by we want it, how far do people have to travel?

Now, quite frankly, if I could convince all my constituents to be willing to travel 60 miles we can close the 12 hospitals and really work out very well. Unfortunately, those people with strokes, heart attacks, and other severe illnesses won't live that long. That has a salvation to it, because just think, we may help cure some of the Social Security payment problems. We won't really have to fix Social Security if we kill them off fast enough by not treating them. That may be the humorous response to the thing.

I think the response to the problem is being honest. In my hospitals the nurses and the doctors can travel 16 more miles and double their incomes, and they are doing that. I tend to agree with my friend Mr. Nussle, and I don't often agree with my friend from Iowa, but he is absolutely right. Mr. Stark is right. Mr. Stark, maybe you and the Chairman should come to our districts and see the problem first hand rather than listening to the GAO and the department down here and thinking everything is rosy, because I'm telling you that I have 12 hospitals that are facing bankruptcy. The other exacerbated problem that I want to bring to the attention of the Committee, you know this works well if you are in the average county and your patient rate is only 30 percent on Medicare, but how about when your patient rate is 76 percent Medicare and you are losing $2,000 per person? You are going broke very quickly. Where do we make it up? Oh, don't worry, we make it up on the private side, the 24 percent. So, our rates of medical coverage for private industry are excessive in the State of Pennsylvania and as a result if industry is smart they are not going to move to northeastern Pennsylvania. They are going to move to Philadelphia where the insurance rate is much lower on the private side because so much money is coming into Philadelphia that they make a profit on Medicare.

That is exacerbating a problem of stupidity in my view. Now, I know that this Committee pays attention to this and I know that we always say well, it is a zero-sum game, so we are stealing from Paul to pay Peter. That may be true, but I do have at least a better part than half of the Committee. You know, there was a way we could fix this. We could put more money into Medicare. We could put back the money we stole in the 1997 Act.

I say to Mr. Nussle in fairness and in defense of my side of the Committee there, maybe we should re-examine the income tax cut, if we don't have the money that we made. We are not going to squeeze any money out of stones. We are jerking our constituents and the American people around.

You know what, I want to tell you something, people from California, people from Connecticut, people from New York and people from all over this country travel through my district. I have four interstate highway systems. You had better hope you don't have a heart attack or a stroke when you are coming across northeastern Pennsylvania, because you may not be able to last long enough to

get to that higher reimbursement MSA that can give you the type of services you need.

So, it is a question of fairness and there is no reason in the world why my constituents have to have a lesser delivery system of Medicare, hospitalization, and treatment than any other area of this country. They, too, like Mr. Nussle's constituents pay the same amount of taxes for this.

So, let's not start getting this war between the urban areas and the rural areas. Incidentally, what I may say, my area is neither urban or rural; it is ex-urban. It is just small enough to be a densely populated area, but it is not rural. Our hospitals are not 100 bed hospitals. They are 500 and 1,000 bed hospitals, but they are not in New York, and they are not in Philadelphia. They are in a limited area of limited concentration of population on the east coast.

Mr. Stark, it is your idea, if you want to make an MSA, let all of Pennsylvania be in one MSA, New York in one MSA. Do you want to do it from New York to Los Angeles? I am for that. It is the only way under the present system that people who live in northeastern Pennsylvania are going to get adequate and fair care and treatment from the Federal Government.

We can go back and play formulas. They will never be equitable. That is what formulas are, a way of telling people they are equitable when in fact we all know they are not equitable.

One thing, we are short of money. We don't have a sufficient amount. We can't argue over the same pie. There isn't anybody in this world, and if they doubt me, talk to Mr. English. He knows what Pennsylvania and northeastern Pennsylvania and northwestern Pennsylvania are like.

We tried to work that fix in the supplemental appropriation with Mr. English and Mr. Sherwood's help. We failed. It is humorous to a lot of people that they thought it was a big fix, and I think it even came down that it was a political fix.

It wasn't any political fix. As many of my constituents were in that fix as any other Member of Congress's constituents. The fact of the matter is that more of the hospitals were in my district because I represented the populated portion of that district and they are not going to survive in the future.

So, Madam Chairman, thank you for having me here. Mr. Stark, I know you are an expert scholar in this area, but I think you need additional input. Don't rely on everything you read in the GAO. You have an open invitation of mine to take you to northeastern Pennsylvania to see first hand what it is like to have an underserved Medicare area in the country. Thank you.

[The prepared statement of Mr. Kanjorski follows:]

Statement of the Hon. Paul E. Kanjorski, a Representative in Congress from the State of Pennsylvania

Madame Chair, Ranking Member Stark and Members of the Committee, I appreciate the opportunity to come before you today to testify about geographic cost adjustors used for Medicare payments and the need for payment revision in the current system. These issues are of great concern and importance to the people of my Congressional district in Northeastern and Central Pennsylvania.

While almost no hospital in the nation has been left unaffected by the cost pressures brought about by the passage of the Balanced Budget Act of 1997, hospitals in my district face a unique set of problems because of the demographic composition of the area and its geographic location. First, the Metropolitan Statistical Area, or

MSA, that makes up most of my district has an extremely high number of senior citizens. Of nearly 600,000 residents in the Scranton/Wilkes-Barre/Hazleton MSA, more than 18% are over the age of 65. The population of my district is old, relatively low-income and located close enough to areas in which Medicare reimbursement rates are much higher that skilled personnel are recruited away for higher salaries. Because we have such a high concentration of senior citizens, our hospitals are therefore much more dependent on Medicare reimbursements than most hospitals in other parts of the country. The Medicare patient utilization rate is well over 50% for most hospitals and as high as 76% in one hospital. Unfortunately, hospital officials have told me that the current reimbursement rate falls far short of covering the cost of treating senior citizens, so that hospitals in our region lose money caring for seniors.

Medicare reimbursements to hospitals are based largely on the wage index for each MSA. The Scranton/Wilkes-Barre/Hazleton MSA has a wage index so low that hospitals are reimbursed at the rural wage index. This classification sets in motion a vicious cycle, however: Medicare reimbursements are lower for rural areas than for urban areas, meaning that hospitals in my district get less money back from Medicare and must consequently pay their employees less than those in urban areas. Because employee wages are lower, these hospitals continue to be classified under a lower paying rural wage index. Even as hospitals are forced to raise wages to keep qualified nurses and other personnel, the three-year lag in adjusting the reimbursement rate costs them hundreds of thousands of dollars. The hospitals are caught in this vicious cycle and cannot catch up. Meanwhile, hospitals in parts of the state that are just adjacent to my district continue to be classified under the higher paying wage index, and are consequently able to offer higher wages to their employees. A nurse working at a hospital in Hazleton, for example, has to drive just sixteen miles to work instead at a hospital in the Allentown MSA, which has a reimbursement rate 13% higher than that in my district.

This introduces the second problem caused by inadequate reimbursement rates. The health care industry is currently experiencing a nursing shortage. There are shortages in other areas of skilled health care labor as well. These deficiencies combine to create a highly competitive market among health care employers. In this environment, it has become increasingly difficult for hospitals in Northeastern and Central Pennsylvania to recruit and retain skilled health care professionals. Because these hospitals are receiving significantly lower revenues in the form of Medicare reimbursement payments than hospitals in surrounding counties, they have experienced serious labor disputes and poor morale.

Finally, this problem of proximity to areas under the higher wage index illustrates another concern. Although hospitals in my district receive Medicare payments under the lower rural wage index and thus take in less revenue than neighboring hospitals, their costs remain virtually the same as those of hospitals that are classified under the higher urban wage index. Therefore, these hospitals in my district experience an even greater financial burden than hospitals in general are experiencing.

Working with Ways and Means Committee staff two years ago, I developed legislation that would have specifically addressed the problems of economically distressed hospitals, which serve a disproportionately high number of senior citizens and receive a relatively low reimbursement rate from Medicare. Under my Essential Hospital Preservation Act (HR 4622 in the 106th Congress), hospitals which met a number of criteria, including a greater than 40% Medicare patient load, would be eligible for special funds as determined by the Department of Health and Human Services in order to develop an economic recovery plan. While I realize that this approach may not be everyone's ideal, I submit my bill as a starting point for a discussion on finding a way to address the unique problems of a small number of areas of the country which have a high proportion of senior citizens, a low reimbursement rate and a proximity to MSAs with more generously reimbursed hospitals.

I recognize that this is a highly complex and politically treacherous issue and I commend the subcommittee for addressing it. I look forward to working with you to find equity in a system that has for too long been greatly inequitable. Thank you again, Madame Chair, Ranking Member Stark and Members of the committee, for giving me the opportunity to present these facts to you today.

Chairman JOHNSON. Thank you, Mr. Kanjorski. Mr. Visclosky?

STATEMENT OF THE HON. PETER J. VISCLOSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. VISCLOSKY. Madam Chairman, thank you very much for holding this hearing. I would like to use my time to talk about three concepts.

The first is the concept of urgency. I really appreciate the fact that you and Mr. Stark and the Members of the Subcommittee are holding this hearing today. I would urge you to come to a judicious resolution of this issue and act this year.

The problem came to my attention in 1999 because of the vagaries of the formulas that has been put in place. Subsequent to that, twice using Mr. Stark's term of a "rifle shot," in conjunction with Senators Lugar and Bayh of the State of Indiana, we were able to help eight hospitals in Lake County, Indiana, as far as maintaining a classification.

We have never been successful since 1999 in having Porter Memorial Hospital, which is in an adjoining country, classified at all. This is a process that has been going for 3½ years.

Those nine institutions in those two counties are in one MSA, but they are treated differently within that one unit, which then is contiguous to the City of Chicago.

So, my second point would be formula, that is today being used despite people's best of intentions and best work product has become incredibly arbitrary. When you look at all of the standards that need to be met, I am struck that in the case of Porter Memorial they meet the cost factor as far as the rate because you cannot tell where from downtown Loop Chicago and you leave, to where the suburbs end by the time you get to Valparaiso, Indiana, and you will have also gone past those eight other hospitals in Lake County. The same holds true for the eight hospitals in Lake County, as far as their wage rate and comparability.

Yet there are now today under that formula, problems. I think when you have a formula where that is so arbitrary, it does need to be fixed.

Mrs. Roukema talked about the language that is in the supplemental that is being debated as we talk, at this moment. I was a conferee last Thursday on the Committee on Appropriations. The fact is, as I think most people know, in the rule for the Supplemental in the House you had six counties in the State of Pennsylvania, a county in New York, and a county in the State of Ohio that were going to be dealt with in a rifle-shot formula, and I am not necessarily opposed to that because I have used it myself twice.

During the debate, Mr. Harkin from Iowa said, "If you are going to fix the problem for Pennsylvania, we need to fix it for Iowa."

A Member from the State of Washington said, "Well, we have institutions in Washington."

I piped up about my nine hospitals. I believe the Committee did the right thing and said, "This isn't a question of money or the appropriators; this is a systematic failure that needs to be corrected by those who have control over the authorization process."

So, I finally would suggest that the third concept I want to talk about is we do have to approach this in a fair fashion. I don't think the time is to blame anyone, to point and turn anyone against each

other, or talk about zero-sum gains. We have people whose life and death is on the line and a system that is arbitrary.

We are all sent here, collectively and in a bipartisan fashion, to make the world a little bit better. If by the end of this year all of you join together and make this formula more fair and help these institutions financially so they could treat people and save their lives, you would in fact be doing God's work, and that is what I ask you to do.

[The prepared statement of Mr. Visclosky follows:]

Statement of the Hon. Peter J. Visclosky, a Representative in Congress from the State of Indiana

Ms. Chairwoman, Mr. Stark, members of the Subcommittee, I thank you for providing me the opportunity to testify before you today, and I thank the Subcommittee for its previous help in reclassifying Lake County, Indiana under the Chicago Metropolitan Statistical Area for Medicare reimbursement purposes.

As you may know, I have been working with two of the counties in my district to deal with the burdens they face because of the inequities set up under the Omnibus Budget Reconciliation Act of 1989. Both Lake and Porter Counties need to be reclassified under the current Medicare reimbursement system or the system needs to be changed.

These counties are significant because of their size and their current economic turmoil. Lake County is a metropolis with over 485,000 residents. It is comprised of a racially and ethnically diverse community, with over a quarter of the population being African-American. It also includes three steel mills. Porter County, in turn, has close to 150,000 residents and two steel mills, one of which, Bethlehem Steel, recently filed for bankruptcy.

It is not surprising that Lake and Porter Counties produce more steel than any other congressional district in the United States; making steel is the economic backbone of Northwest Indiana. However, the steel industry has been threatened by the surge of illegally dumped foreign steel, and has been fighting to stay viable for the past four years. As jobs in traditional manufacturing industries in the State of Indiana continue to be threatened, the local tax burden has increased along with the need for Medicare services for the maturing populations of these two industrial counties. Now more than ever these counties need to be reclassified.

In 1999, Senator Bayh, Senator Lugar and I successfully reclassified Lake County into the Chicago Metropolitan Statistical Area for Medicare reimbursement purposes via the Balanced Budget Adjustment Act of 1999. The bill was officially included in the Consolidated Appropriations Act of 1999, which reclassified Lake County for Fiscal Year (FY) 2000 and FY 2001. At the end of 2000, the county was also reclassified for another three years. Thus, hospitals in Lake County continue to receive these funds through FY 2004.

The case for Lake County is quite sound. Eight hospitals in Lake County, Indiana are contiguous to the Chicago Metropolitan Statistical Area ("MSA") and are a part of the Chicago-Gary-Kenosha Consolidated Metropolitan Statistical Area ("CMSA"). They are St. Catherine's Hospital, St. Margaret Mercy Hospital of Hammond, Community Hospital of Munster, St. Margaret Mercy Hospital of Dyer, St. Mary's Medical Center, Methodist Hospital of Merrilville, Methodist Hospital of Gary, and St. Anthony's Medical Center of Crown Point. These hospitals have been reclassified in FY 1995, 1996, 1997, 1998 and 1999. Since that year, they have been unable to obtain regulatory reclassification.

All eight hospitals, as well as all other businesses and services in the area, are fully a part of the Chicago metropolitan area. They are in the same labor pool, purchase supplies from many of the same vendors, and pay parallel costs for utilities and other necessities.

Since 1999 we have been assisting these eight hospitals in their efforts to continue to receive fair and reasonable Medicare payments comparable to those paid to hospitals located in the Chicago MSA. However, unless Congress acts, the Lake County hospitals will lose $29 million per year in Medicare payments, effective October 1, 2003.

The Lake County hospitals are completely integrated within the greater Chicago metropolitan area. In fact, one Lake County hospital, St. Margaret Hospital located in Hammond, Indiana, is only about 15 feet from the dividing line between Chicago and Lake County. In addition, the costs incurred by Lake County hospitals for the same services is virtually the same. The only difference between the Chicago and

Lake County hospitals is a county line dividing Cook County, Illinois and Lake County, Indiana.

In 1999, Lake County hospitals had Medicare costs of $4,266.00 per standardized case. Chicago hospitals per case cost was $4,481.00, a difference of only 4.8 percent. Lake County costs are clearly comparable to Chicago. In addition, the Lake County hospitals case mix index, which measures the type and severity of care needed, was 1.4343, while that of Chicago hospitals is 1.4277. This shows that for similar services, Lake County patients are actually in need of more acute care than their counterparts in Chicago.

Our second county facing hardship is Porter County, located less than 30 miles from the Chicago city limits. Though Porter County has never been reclassified, continuing hardships and new developments make them an excellent candidate for higher reimbursement.

Porter County has a single hospital, Porter Memorial Hospital. Due to the inequities between it and Chicago MSA, Porter Memorial Hospital has been forced to discontinue two services, lay off 32 employees and freeze over 100 other positions.

The main contention of Porter Memorial Hospital is that it is currently unable to compete for skilled labor because of the demands placed on it due to the vicinity to Chicago. Currently, Porter County hospitals are facing employee shortages, especially in the fields of skilled nurses. Due to the concentration of hospitals in the region, all health care providers share the same employment pool with Chicago. Porter Memorial finds it difficult to compete with the compensation offered by the Chicago hospitals for qualified employees. It continually attempts to match the trends of salary increases and large sign-on bonuses offered by the Chicago hospitals, but this is becoming increasingly difficult to do with a different reimbursement rate. Porter's wage index value is approximately 86 percent of Chicago MSA. The requirement for inclusion in Chicago MSA is 84 percent.

In terms of costs, Porter County hospitals had Medicare costs per standardized case of $4,424.00 for 1999. As mentioned previously, Chicago hospitals per case cost was $4,481.00. This is a difference of less than 1.2%. Porter County's costs are, once again, clearly comparable to Chicago.

Many other costs are comparable as well. In a recent operating performance report comparing Porter Memorial with Chicago hospitals, the supply, capital and total costs per discharge were higher at Porter Memorial than two-thirds of the Chicago hospitals studied.

In conclusion, we are seeking a further legislative extension for the existing reclassification for the Lake County hospitals and the inclusion of Porter Memorial hospital into the Chicago MSA. These hospitals are deserving of such support. They need fair and reasonable Medicare payments. They need permanent attachment to the Chicago MSA or successor entity, or they need a formula devised by CMS that fairly measures comparable costs.

I appreciate your time and hope this body can find a solution to this dilemma. I would be pleased to provide any additional information you might need. Thank you for your attention.

LAKE COUNTY, IN

Calculation of adjustment data for margin to remove
Chicago wage index and large urban standardized amount for 1999 year

	FFY 1999	FFY 2000
Per July 31, 1998 and July 30, 1999 Federal Registers		
Chicago reclassified wage index	1.0469	1.0872
Gary MSA average hourly wage	$19.6025	19.8884
National average hourly wage	÷20.7325	÷21.1800
Computed Gary Wage Index	.9455	.9390
Increase in wage index	.1014	.1482
Decrease in wage index if Gary rates were used (.1014/1.0469)	.09686	.1363
% Labor related standardized amount of total	x.711	x.711
% Decrease in standardized amount	06886	0969
Add effect of large urban standardized amount	.01600	.0160

LAKE COUNTY, IN—Continued

Calculation of adjustment data for margin to remove
Chicago wage index and large urban standardized amount for 1999 year

	FFY 1999	FFY 2000
Percent decrease in standardized amount	.08486	.1129
	Decrease in Revenue	
For December 31 hospitals (75% 1999) + (25% 2000)	.0918	
For period 3/1/99 to 12/31/99 (70% 1999) + (30% 2000)	.0933	
For June 30, 2000 hospitals (25% 1999) + (75% 2000)	.1059	

The adjusted Medicare margin for Lake County is a negative 10.72 percent in total. Six of the eight hospitals had negative margins. Porter Memorial had a 20.24 percent negative margin.

Medicare Margin

Hospital	Provider Number	Fiscal Period	Medicare Inpatient Operating Revenue CMS Data	Decrease %	Decrease in Medicare Payments (Gary Rates)	Revised Medicare Revenue Gary Rates	Medicare Margin Per CMS Data	Subtract Decrease in Payment	Medicare Margin Gary Rates	Adjusted Margin %
Methodist—Gary	15–0002	FYE 12/31/99.	27,873,101	0.0918	2,558,751	25,314,350	266,644	2,558,751	(2,292,107)	−0.0905
St. Margaret Mercy—North	15–0004	FYE 12/31/99.	41,641,303	0.0918	3,822,672	37,818,631	6,396,283	3,822,672	2,573,611	0.0681
St. Catherine	15–0008	FYE 12/31/99.	18,706,176	0.0918	1,717,227	16,988,949	874,851	1,717,227	(842,376)	−0.0496
St. Mary	15–0034	FYE 12/31/99.	22,472,891	0.0918	2,063,011	20,409,880	(1,333,555)	2,063,011	(3,396,566)	−0.1664
St. Margaret Mercy—South	15–0090	FYE 12/31/99.	11,044,174	0.0918	1,013,855	10,030,319	(508,472)	1,013,855	(1,522,327)	−0.1518
Community Hospital	15–0125	FYE 6/30/2000.	46,168,771	0.0989	4,566,091	41,602,680	(2,237,686)	4,566,091	(6,803,777)	−0.1635
St. Anthony—Crown Point	15–0126	3/1/99–12/31/99.	16,500,315	0.0933	1,539,479	14,960,836	(4,192,774)	1,539,479	(5,732,253)	−0.3832
Methodist—Broadway	15–0132	FYE 12/31/99.	27,959,117	0.1059	2,960,870	24,998,247	383,051	2,960,870	(2,577,819)	−0.1031
Total			212,365,848		20,241,957	192,123,891	(351,658)	20,241,957	(20,593,615)	−0.1072

The above computations exclude the change in inpatient capital payments resulting from the adjustment of the Geographic Adjustment Factor (GAF) which is a derivative of the wage index. This adjustment is not considered to be material.

Hospital	Operating Margin			Total Margin		
	Net Patient Revenue Gary Rates	Operating Marginwith Gary Rates	Adjusted Operating Margin %	Total RevenueGary Rates	Net Income with Gary Rates	Total Margin Percentage
Lake County						
Methodist—Gary	106,757,602	(15,140,510)	−0.1418	126,899,705	6,121,460	0.0482
St. Margaret Mercy—North	136,664,308	(346,365)	−0.0025	151,942,147	14,931,474	0.0983
St. Catherine	70,583,623	(6,298,559)	−0.0892	75,424,834	(2,057,348)	−0.0273
St. Mary	71,742,752	(2,304,366)	−0.0321	76,194,447	2,147,329	0.0282
St. Margaret Mercy—South	69,346,327	(2,911,241)	−0.0420	71,179,202	(1,078,366)	−0.0152
Community Hospital	168,139,821	1,442,533	0.0086	173,669,532	1,791,437	0.0103
St. Anthony—Crown Point	68,372,527	(8,796,563)	−0.1287	75,892,576	(1,276,514)	−0.0168
Methodist—Broadway	106,903,908	(3,254,283)	−0.0304	120,763,466	11,087,560	0.0918
Total Lake County	798,510,867	(37,609,355)	−0.0471	871,965,908	31,667,031	0.0363
Porter Memorial Hospital (Per CMS Data at Gary Rates)	140,077,043	−2,492,229	−0.0178	145,332,785	1,980,636	0.0136

The above computations exclude the change in inpatient capital payments resulting from the adjustment of the Geographic Adjustment Factor (GAF) which is a derivitive of the wage index. This adjustment is not considered to be material.

The operating margin (which include all patient income and expense) is a negative 4.71 percent for Lake County, IN hospitals and a negative 1.78 percent for Porter Memorial Hospital. This indicates that these hospitals (in total) cost shifted a portion of the Medicare loss to non-Medicare patients, but still ended up in a loss position. Seven of the eight Lake County hospitals had losses from operations.

STATEMENT OF REVENUE AND EXPENSES—FACILITY

SOURCE: HCFA FORM 2552–96, WORKSHEET G–3

Provider#		MSA/County #		150002	150004	150008	150034	150090	150125	150126	150132
Provider Name		MSA/County Name	Lake County	THE METHODIST HOSPITALS, INC-GARY	ST. MARGARET MERCY HLTHCARE-NORTH	ST. CATHERINE'S HOSPT.-EA. CHICAGO	ST. MARY MEDICAL CENTER, INC.	ST. MARGARET MERCY HLTHCARE-SOUTH	COMMUNITY HOSPITAL	ST. ANTHONY MEDICAL CENTER OF CROWN	THE METHODIST HOSPITALS, INC-BROADWAY
Fiscal Year Beginning				1/1/99	1/1/99	1/1/99	1/1/99	1/1/99	7/1/99	3/1/99	1/1/99
Fiscal Year Ending				12/31/99	12/31/99	12/31/99	12/31/99	12/31/99	6/30/00	12/31/99	12/31/99
LINE(S)	COL(S)		Group Totals								
		Revenue									
3	1	Net Patient Revenues	$819,352,824	$109,316,353	$140,486,980	$72,900,850	$73,805,763	$70,360,182	$172,705,912	$69,912,006	$109,864,778
25	1	Total Other Income	$72,855,041	$20,142,103	$15,277,839	$4,241,211	$4,451,695	$1,832,875	$5,529,711	$7,520,049	$13,859,558
		Total Revenue	$892,207,865	$129,458,456	$155,764,819	$77,142,061	$78,257,458	$72,193,057	$178,235,623	$77,432,055	$123,724,336
		Expenses									
4	1	Total Operating Expenses	$836,720,222	$121,898,112	$137,010,673	$77,482,182	$74,047,118	$72,257,568	$166,697,288	$77,169,090	$110,158,191
30	1	Total Other Expenses	$3,578,655	($1,119,867)	$0	$0	$0	$0	$5,180,807	$0	($482,285)
		Total Expenses	$840,298,877	$120,778,245	$137,010,673	$77,482,182	$74,047,118	$72,257,568	$171,878,095	$77,169,090	$109,675,906
		Net Income	$51,908,988	$8,680,211	$18,754,146	($340,121)	$4,210,340	($64,511)	$6,357,528	$262,965	$14,048,430
		Net Income/Total Revenue	5.82%	6.71%	12.04%	−0.44%	5.38%	−0.09%	3.57%	0.34%	11.35%
		Total Operating Margin									
3	1	Net Patient Revenues	$819,352,824	$109,316,353	$140,486,980	$72,900,850	$73,805,763	$70,360,182	$172,705,912	$69,912,006	$109,864,778
4	1	Total Operating Expenses	$836,720,222	$121,898,112	$137,010,673	$77,482,182	$74,047,118	$72,257,568	$166,697,288	$77,169,090	$110,158,191
		Operating Margin	($17,367,398)	($12,581,759)	$3,476,307	($4,581,332)	($241,355)	($1,897,386)	$6,008,624	($7,257,084)	($293,413)
			−2.12%	−11.51%	2.47%	−6.28%	−0.33%	−2.70%	3.48%	−10.38%	−0.27%

MEDPAC's Formula for Calculation of Inpatient Margin

PPS Inpatient Payments = PPS Operating Payments + PPS Capital Payments

PPS Inpatient Costs = PPS Operating costs + PPS Capital Costs

PPS Inpatient Margin = (PPS Inpatient Payments—PPS Inpatient Costs)/PPS IP Payments

			Total	Provider #							
PPS 16–FY99		MSA/County#	0	150002	150004	150008	150034	150090	150125	150126	150132
Line (s)	Col (s)	MSA/County Name	Lake County	THE METHODIST HOSPITALS, INC-GARY	ST. MARGARET MERCY NORTH	ST. CATHERINE'S HOSPT.-EA. CHICAGO	ST. MARY MEDICAL CENTER, INC.	ST. MARGARET MERCY HLTHCARE-SOUTH	COMMUNITY HOSPITAL	ST. ANTHONY CENTER OF CROWN	THE METHODIST HOSPITALS, INC BROADWAY
SOURCE: HCFA FORM 2552–96, WORKSHEET E, PART A PPS Operating Payments											
8	1	Total Payment for Inpatient Operating Costs +	$212,365,848	$27,873,101	$41,641,303	$18,706,176	$22,472,891	$11,044,174	$46,168,771	$16,500,315	$27,959,117
14	1	Part A Inpatient Routine Service Other Pass Through Costs +	$39,393	$0	$0	$0	$0	$0	$0	$39,393	$0
15	1	Part A Inpatient Ancillary Service Other Pass Through Costs +	$196,033	$0	$166,942	$0	$0	$0	$0	$29,091	$0
12	1	Net Organ Acquisition Costs +	$0	$0	$0	$0	$0	$0	$0	$0	$0
13	1	Cost of Teaching Physicians +	$0	$0	$0	$0	$0	$0	$0	$0	$0
21	1	Inpatient Bad Debt Payments-	$1,379,669	$64,903	$642,262	$200,874	$220,351	$98,521	$59,231	$54,485	$39,042
21.01	1	Inpatient Bad Debt Adjustment	$827,802	$38,942	$385,357	$120,524	$132,211	$59,113	$35,539	$32,691	$23,425
			$214,808,745	$27,976,946	$42,835,864	$19,027,574	$22,825,453	$11,201,808	$46,263,541	$16,655,975	$28,021,584
PPS Capital Payments											
9	1	Payment for Inpatient Program Capital +	$20,358,051	$2,094,245	$3,798,208	$1,777,287	$2,269,492	$1,359,745	$4,408,249	$1,934,157	$2,716,668
10	1	Exception Payment for Inpatient Program Capital	$0	$0	$0	$0	$0	$0	$0	$0	$0
			$20,358,051	$2,094,245	$3,798,208	$1,777,287	$2,269,492	$1,359,745	$4,408,249	$1,934,157	$2,716,668
		Total Payments	$235,166,796	$30,071,191	$46,634,072	$20,804,861	$25,094,945	$12,561,553	$50,671,790	$18,590,132	$30,738,252
SOURCE: HCFA FORM 2552–96, WORKSHEET D–1 PPS Operating & Capital Costs											
49	1	Total Program Inpatient Operating Costs Including Pass Through Costs +	$235,518,454	$29,804,547	$40,237,789	$19,930,010	$26,428,500	$13,070,025	$52,909,476	$22,782,906	$30,355,201
12	1	Net Organ Acquisition Costs +	$0	$0	$0	$0	$0	$0	$0	$0	$0
			$235,518,454	$29,804,547	$40,237,789	$19,930,010	$26,428,500	$13,070,025	$52,909,476	$22,782,906	$30,355,201
		Inpatient Margin	(−$351,658)	$266,644	$6,396,283	$874,851	(−$1,333,555)	(−$508,472)	(−$2,237,686)	(−$4,192,774)	$383,051
		Margin %	−0.1495%	0.8867%	13.7159%	4.2050%	−5.3140%	−4.0478%	−4.4160%	−22.5538%	1.2462%
Adjusted Inpatient Margin Calculation PPS Operating Payment Add-ons											
		Indirect Medical Education Adjustment	$1,412,127	$486,348	$474,947	$0	$182,181	$268,651	$0	$0	$0

MEDPAC's Formula for Calculation of Inpatient Margin—Continued

PPS Inpatient Payments = PPS Operating Payments + PPS Capital Payments

PPS Inpatient Costs = PPS Operating costs + PPS Capital Costs

PPS Inpatient Margin = (PPS Inpatient Payments—PPS Inpatient Costs)/PPS IP Payments

			Total	Provider #							
PPS 16–FY99		MSA/County#	0	150002	150004	150008	150034	150090	150125	150126	150132
Line (s)	Col (s)	MSA/County Name	Lake County	THE METHODIST HOSPITALS, INC-GARY	ST. MARGARET MERCY NORTH	ST. CATHERINE'S HOSPT.-EA. CHICAGO	ST. MARY MEDICAL CENTER, INC.	ST. MARGARET MERCY HLTHCARE-SOUTH	COMMUNITY HOSPITAL	ST. ANTHONY CENTER OF CROWN	THE METHODIST HOSPITALS, INC BROADWAY
		Disproportionate Share Adjustment ...	$10,146,105	$5,940,589	$1,916,308	$2,289,208	$0	$0	$0	$0	$0
		Additional Payment—									
		High Percentage ESRD	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Total Add-ons	$11,558,232	$6,426,937	$2,391,255	$2,289,208	$182,181	$268,651	$0	$0	$0
		PPS Operating Payments	$214,808,745	$27,976,946	$42,835,864	$19,027,574	$22,825,453	$11,201,808	$46,263,541	$16,655,975	$28,021,584
		PPS Capital Payments	$20,358,051	$2,094,245	$3,798,208	$1,777,287	$2,269,492	$1,359,745	$4,408,249	$1,934,157	$2,716,668
		PPS Operating Payment Add-ons	(−$11,558,232)	(−$6,426,937)	(−$2,391,255)	(−$2,289,208)	(−$182,181)	(−$268,651)	$0	$0	$0
		Total Adjusted PPS Payments	$223,608,564	$23,644,254	$44,242,817	$18,515,653	$24,912,764	$12,292,902	$50,671,790	$18,590,132	$30,738,252
		PPS Operating & Capital Costs	$235,518,454	$29,804,547	$40,237,789	$19,930,010	$26,428,500	$13,070,025	$52,909,476	$22,782,906	$30,355,201
		Adjusted Inpatient Margin	(−$11,909,890)	(−$6,160,293)	$4,005,028	(−$1,414,357)	(−$1,515,736)	(−$777,123)	(−$2,237,686)	(−$4,192,774)	$383,051
		Margin%	−5.3262%	−26.0541%	9.0524%	−7.6387%	−6.0842%	−6.3217%	−4.4160%	−22.5538%	1.2462%

STATEMENT OF REVENUE AND EXPENSES—FACILITY

Provider#			**150035**
Provider Name		**PORTER MEMORIAL HOSPITAL**	
Fiscal Year Beginning			1/1/99
Fiscal Year Ending			12/31/99
LINE(S)	**COL(S)**	**Total Margin Calculation**	**PPS 16–FY99**
SOURCE: HCFA FORM 2552–96, WORKSHEET G–3			
		Revenue	
3	1	Net Patient Revenues	$140,077,043
25	1	Total Other Income	$5,255,742
		Total Revenue	$145,332,785
		Expenses	
4	1	Total Operating Expenses	$142,569,272
30	1	Total Other Expenses	$782,877
		Total Expenses	$143,352,149
		Net Income	$1,980,636
		Net Income/Total Revenue	1.36%
		Total Operating Margin	
3	1	Net Patient Revenues	$140,077,043
4	1	Total Operating Expenses	$142,569,272
		Operating Margin	(−$2,492,229)
			−1.78%
MEDPAC's Formula for Calculation of Medicare Inpatient Margin PPS Inpatient Payments = PPS Operating Payments + PPS Capital Payments PPS Inpatient Costs = PPS Operating costs + PPS Capital Costs PPS Inpatient Margin = (PPS Inpatient Payments—PPS Inpatient Costs) / PPS Inpatient Payments			
SOURCE: HCFA FORM 2552–96, WORKSHEET E, PART A			
		PPS Operating Payments	
8	1	Total Payment for Inpatient Operating Costs +	$29,679,899
14	1	Part A Inpatient Routine Service Other Pass Through Costs +	$0
15	1	Part A Inpatient Ancillary Service Other Pass Through Costs +	$51,566
12	1	Net Organ Acquisition Costs +	$0
13	1	Cost of Teaching Physicians +	$0
21	1	Inpatient Bad Debt Payments-	$129,578
21.01	1	Inpatient Bad Debt Adjustment	(−$77,747)
			$29,783,296
		PPS Capital Payments	
9	1	Payment for Inpatient Program Capital +	$2,877,461
10	1	Exception Payment for Inpatient Program Capital	$0
			$2,877,461
		Total Payments	$32,660,757
SOURCE: HCFA FORM 2552–96, WORKSHEET D–1			
		PPS Operating & Capital Costs	
49	1	Total Program Inpatient Operating Costs Including Pass Through Costs +	$39,272,474
12	1	Net Organ Acquisition Costs +	$0
			$39,272,474
		Inpatient Margin	(−$6,611,717)
		Margin %	−20.2436%

STATEMENT OF REVENUE AND EXPENSES—FACILITY—Continued

Adjusted Inpatient Margin Calculation			
Operating Payment Add-ons			
3.03 + 3.24	1+1.01	Indirect Medical Education Adjustment	$0
4.04	1+1.01	Disproportionate Share Adjustment	$0
5.06	1+1.01	Additional Payment—High Percentage ESRD	$0
		Total Add-ons	$0
		PPS Operating Payments	$29,783,296
		PPS Capital Payments	$2,877,461
		PPS Operating Payment Add-ons	$0
		Total Adjusted PPS Payments	$32,660,757
		PPS Operating & Capital Costs	$39,272,474
		Adjusted Inpatient Margin	(−$6,611,717)
		Margin%	−20.2436%

Chairman JOHNSON. Thank you very much. Mr. Shays, it is a pleasure to welcome you.

STATEMENT OF THE HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. SHAYS. Thank you, Madam Chairman. I would like to submit my statement for the record and just make a few points.

I am here to request that you reclassify Connecticut's six Fairfield County hospitals into the New York City Metropolitan statistical area. This county is basically contiguous to New York, touches it, and is 30 miles from the center of Manhattan.

One of those five hospitals is outside the 4th Congressional District in Danbury. The rest are in the 4th Congressional District.

Back in 1997, I am aware of what the Balanced Budget Act did in the reclassification systems and had worked on that. I was grateful to the Committee in 2000 in working with them, that they lengthened the reclassification for 3 years.

Despite paying wage of about 10 percent less than hospitals pay in New York, the Fairfield County index is 17 percent less than the New York MSA. That has become a problem for our hospitals.

The U.S. Census Bureau counts Fairfield County in the same consolidated metropolitan statistical area. This is determined based on population figures, commuting patterns, employment data, and overall economic and social integration of the surrounding areas.

The Federal Reserve Bank, the U.S. Department of Labor, the Bureau of Transportation Statistics all include Fairfield Certify within New York City for statistical purposes.

I have a letter from the Federal Reserve Bank of New York which I have included in my testimony which states a significant portion of the county's income is earned. Fifty National Association of Realtors NAR groups have Fairfield County housing prices with New York Metropolitan areas as well. We are focused that way. We commute that way. Everyone else, except Medicare, treats us as part of the New York MSA.

We are just asking that you consider that true for Medicare as well.

What can I do to get Mr. McCrery to smile? This is a very interesting subject, Mr. McCrery.

[The prepared statement of Mr. Shays follows:]

Statement of the Hon. Christopher Shays, a Representative in Congress from the State of Connecticut

Chairwoman Johnson, Ranking Member Stark and Members of the Subcommittee, thank you for the opportunity to testify in favor of reclassification of the hospitals in Connecticut's Fairfield County into the New York City Metropolitan Statistical Area (MSA).

Fairfield County borders the New York state line and is only 30 miles from Manhattan. There are six hospitals in the county, four of which have been periodically reclassified on a temporary basis into the New York MSA. The hospitals included would be Greenwich Hospital, Stamford Hospital, Norwalk Hospital, Bridgeport Hospital and St. Vincent's Hospital from my congressional district. Danbury Hospital, which resides in Connecticut's new fifth congressional district, would also be reclassified.

I am very aware of what hospitals Congress was trying to help when it created the system were the hospitals found in my district. Back in 1997, I helped write the Balanced Budget Act. In that bill, we created the current geographic reclassification system. In 2000, I worked with the Ways and Means Committee to make the length of one reclassification three years, which gave hospitals greater long-term financial security.

Despite paying wages which are only 10 percent less than the wages paid by hospitals in the New York MSA, Fairfield County's wage index is 17 percent less than the New York MSA. The Fairfield County hospitals need to be on a level playing field with the New York hospitals to be able to attract and retain highly-skilled clinical staff.

Fairfield County is widely recognized as being part of the New York Metropolitan Area geographically, economically and socially. In fact, the Census Bureau counts Fairfield County in the same Consolidated Metropolitan Statistical Area (CMSA) as New York City. This determination is based on population figures, commuting patterns, employment data, and the overall economic and social integration of the surrounding areas with the City. In fact, fully 11 percent of Stamford Hospital's labor pool resides in New York.

In addition, the Federal Reserve Bank, the Department of Labor, and the Bureau of Transportation Statistics all include Fairfield County with New York City for statistical purposes. A letter, from Rae Rosen of the Federal Reserve Bank of New York, which I have included in my testimony, states, "A significant portion of Fairfield County commutes to New York City where a significant portion of the county's income is earned."

The National Association of Realtors groups Fairfield County housing prices with other New York metropolitan area housing prices because the markets are similar in many ways and provide the housing for the greater New York metropolitan area labor market.

By not reclassifying these hospitals, they are being penalized for efficiency. They have gone to great lengths to control costs, especially personnel costs by revamping their labor skill mix. However, rather than be rewarded for these cost-containment measures, Stamford, Norwalk and Bridgeport are penalized by the Medicare reclassification thresholds.

H.R. 4954, the Medicare Modernization and Prescription Drug Act, helps in the reclassification battle. Currently, to be reclassified, hospitals have to qualify under the standardized amount and the wage index. The standardized amount is a fixed dollar amount which is divided into two classifications: the urban area standardized amount and the "other area" standardized amount.

Section 303 eliminates the "other area" standardized amount, leaving only the urban area standardized amount. If H.R. 4954 is enacted into law, hospitals should no longer have to qualify under standardized amount provisions, which should bring some relief to many hospitals, particularly those in my district.

In this matter, I would only request that the subcommittee work with the Department of Health and Human Services to ensure that hospitals no longer have to qualify for reclassification under the standardized amount. I would be more than willing to help in any way I can.

In closing, I'd like to thank you for allowing me to testify in support of the reclassification needed for these six hospitals in Fairfield County are the type of hospital

that Congress intended to help when it created the geographic reclassification process.

Chairman JOHNSON. Well, we thank you all for your comments. I do, feel the urgency of this. Frankly, as far as I am concerned, budget neutrality is not my problem. My problem is how to define the problem, what will go with this.

Don't underestimate the difficulty of defining the problem. The reason in my statement, and my staff did not include it, the reason I included that this whole process starts with an averaging of data from hospitals about their wages is that in the very process of averaging, in a sense you do violence to the ability of hospitals to survive.

The violence of averaging helps low-wage areas and hurts high-wage areas and does affect, in an environment in which now people are paying differently for their patients than they were 20 years ago.

It was in the old days the private sector had some cushion in it and you could cost shift. You can't do that any more. So, we have a much different environment in which we are paying for health care. Therefore, every aspect of our payment system needs to be reviewed to see whether or not that technology, no matter how commonly accepted it has been, can still support our hospitals in a reasonable fashion.

Now, what is driving my friend, Pete, here nuts is that in many, many hospitals across the country, and this may be true in your own hospitals and you should quietly ask, what is the profit margin on their in-patient Medicare patients?

Now, of course, you might also ask what is the profit margin in their outpatient Medicare patients where we are having a much harder time getting an accurate payment.

Then the major teaching hospitals, 22-percent profit on inpatient, but their total margins are low, like 2.4 percent. So, there are serious problems in this payment system. Some of the assumptions that we have always relied on, like averaging, are assumptions we need to understand the implications of.

Beyond that are four or five other factors in each of these formula. One is that this data for the wage index is 4 years old; not 2 years old.

So, we will look at each component, but even the 4-year-old is only a matter of relative paymency. So, it can't take account of spikes, but it may not be inaccurate according to the relativeness to the norm of 1 percent across the country. So, that is the national average of wages.

So, I just tell you to be patient. We will try to figure out what vital information you need to get from your hospitals, to help us so you understand better, and we understand better. I personally am convinced that this not about badly managed hospitals looking for us to save them. We are way beyond that. Those guys are already out of business.

I personally believe this is a very important problem that if we don't fix, we will affect access and quality both, first quality and then access. So, I just urge you to follow the discussion.

I tried to have the Member panels after the experts. I was told that was unacceptable. I ask you to read the testimony of MedPAC and of GAO, those people who have been in the system a long time, know the technologies and complexities of the formula because in the end we do have to deal with that. We are going to have to deal with that in a way that is as rational as possible, because whatever system you have, it will have little problems.

If those little problems aren't backed by at least some logic and some consistent policy that is on the whole fair, we will be in terrible trouble. We will continue to see the effort to make legislative fixes, and those are really the most destructive to both the concept of fairness and the concept of a nationally capable health care system.

So, thank you very much for your testimony. We will go on to the next panel.

Mr. STARK. Are we going to get to say anything?

Chairman JOHNSON. Mr. Stark would like to comment.

Mr. STARK. First of all, I think we will hear from MedPAC.

Chairman JOHNSON. Yes, we will.

Mr. STARK. To the effect that there is not a whole lot of correlation between profit margins and the wage index. Make out of that what you will.

Then, for those of you who are somewhat less emotionally involved in your hospitals, how did you take Bloomsburg Hospital with 97 beds and a 25-percent occupancy, who has a 16-percent Medicare profit margin, but loses 5 percent, I just don't know the answer to that either.

Then you go to Wilkes Barre and they have a Medicare margin of 13 percent. They have 100 beds and they are 52-percent occupied. I don't know what that means. I am just trying to tell you.

Mr. KANJORSKI. One hundred beds?

Mr. STARK. There are 109 beds. They have a 52-percent occupancy, St. Joseph's. I don't know how big Wilkes Barre is. They lose 9.5 percent on Medicare, and they lose 3.5 percent over all.

Then we go to Mr. Visclosky's district with a 300-bed hospital, and they lose 20 percent on Medicare, not as these others. Yet, they are making an overall profit of 1.4. That doesn't sound like a lot.

Mr. VISCLOSKY. Indiana ingenuity.

Mr. STARK. That may be. Now, all I am trying to suggest to you is that in the same town, for instance, we were talking about Wilkes Barre, Mercy Hospital in Wilkes Barre and St. Joseph's in Hazeltine. They are in the same county, right?

Mr. KANJORSKI. Same county.

Mr. STARK. They have a major difference. One is losing money and one is making money. I don't know how big the Wilkes Barre Hospital is. I could dig it out, but I am just trying to match.

Mr. KANJORSKI. There are three hospitals in Wilkes Barre.

Mr. STARK. It doesn't make a lot of sense to us, unless—and quite frankly the hospitals are not willing to do this, and that is okay—to get hospital-specific information and then you could say, hey, this makes some sense. They have a problem for which we ought to adjust.

If you have a rural hospital of 20 beds that is 30 miles away from a major city, not a lot of people are going to go there for specialized care. Perhaps that hospital should change its mission. Politically that is tough to say, but those are all options that have to be considered.

Again, in the zero-sum gain, you have to remember even in your own districts, if we raise one hospital substantially, others will take less. This is not a question of California versus Indiana.

Mr. KANJORSKI. May I respond?

Chairman JOHNSON. Briefly, Pete, please.

Mr. KANJORSKI. Yes. They are not sophisticated areas. It took everything I could do to get them to analyze. They didn't even know why they were losing money, quite frankly, until 2 years ago. They were just losing money. We had a person come in. They are not sophisticated.

Two, I made the point in my testimony to say you are punishing us for efficiency and frugality. The wage level in these hospitals has always been extremely low. Transportation systems weren't always built in this country that you could jump from one MSA to another and the growth between those MSAs haven't been accomplished until recently.

Now, you can transport yourself 16, 20, 30 miles and easily go. We have in the Wilkes Barre area, in that entire MSA, the wage level is below the rural wage level, so we actually get a kick-up in formula because our wage is below it.

So, in order for them to start using the wage level to be competitive with other hospitals, they would have to jump the pay of the professional people to such an extent they would go bankrupt and would be incapable of doing that.

So, they will always be caught in that Catch-22. They can never move the formula up because they don't have the money to pay the wages and if they don't pay the wages, they have a drain of professional personnel and all what the penalty was because over the years they were very frugal in their delivery system and they weren't extravagant in their expenses and that punishes them in the formulas.

Chairman JOHNSON. We are going to have to continue these discussions.

Mr. STARK. This doesn't limit the wages they can pay. This just sets the reimbursement level for the hospital.

Mr. KANJORSKI. No, if you don't get the money, Mr. Stark, if 70 percent of your income is coming out of Medicare, where are you going to get your money to pay wages?

Chairman JOHNSON. This is a bigger discussion that I am sure we will be continuing.

Mr. MCDERMOTT. Madam Chair?

Chairman JOHNSON. Yes. We have two more panels of Members before the day is over, but I started it.

Mr. MCDERMOTT. I just want to say that I think that this discussion is one that raises the whole question of why we need a national health plan because we are going to put Band-Aids on various ones of these people here. I had a conversation a number of years ago with the woman who ran the Canadian Hospital Association.

She said, "We are tired of you people beating up on us because we have a system that we can change. You don't."

She said, "When I want to close a hospital or when I want to make an adjustment, I can do it. You have, whatever it is numbers, thousands of hospitals each doing it a different way. You can't even compare them."

This issue of data that Pete and you struggle with comes down to data; why does it happen that way, why is it different across the country, and how are you going to adjust it? You have no way. Medicare doesn't have any way. Medicare changes what they do, but not the rest of what goes on in health.

We spent $1.2 trillion, $4,300 per person in this country. The next highest average in the world is Switzerland with $2,300 per person.

Chairman JOHNSON. Okay, let me call the next panel.

Mr. MCCRERY. Would the gentlewoman yield for just a brief comment?

Chairman JOHNSON. I would be happy to, but briefly.

Mr. MCCRERY. I just want to know if the gentleman doesn't agree that the Medicare system is a national health care system for the elderly.

Mr. MCDERMOTT. No, it isn't a national health care system.

Mr. MCCRERY. What you are proposing is that they give Medicare to everybody?

Mr. MCDERMOTT. The problem is that it is a piece. Every county in Iowa has lost population except one. People are leaving.

Chairman JOHNSON. If you had a national health care system, you would still have to figure out how to pay the hospitals across the country and whether you adjusted for local costs would still be an issue. So, it would just be for everybody.

If you read Congressman Ryan's "Dear Colleague" about what is happening in Canada, you might not be so quick to offer it as an example. Thank you very much for your testimony.

I will call the next panel of Members to testify. While this is, in my estimation, very good for our experts who are going to follow to hear, so while it takes a long time, it is very important for Members to have a chance to contribute to this is discussion. The next panel is Mr. Collin Peterson, Mr. Hinchey, Mr. Smith, Mr. Watt, and Mrs. Kelly.

Congresswoman Kelly is long overdue for a speech. I am going to let her proceed. Your remarks will be submitted for the record in full and we are observing the 5-minute rule.

STATEMENT OF THE HON. SUE W. KELLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mrs. KELLY. Thank you very much. I thank you, Chairman Johnson, Congressman Stark, and the Members of the Health Subcommittee for giving me this opportunity to testify today.

Geographic cost adjustment in Medicare is an important issue for hospitals across the country. I am very pleased this Subcommittee is focusing on this situation.

I have been acquainted with this situation for many years due to the unique situation of the hospitals in my district, all of which are located in a commutable distance to New York City. Since hos-

pitals in the New York City MSA receive a higher Medicare payment, hospitals in my district are forced to complete for labor with larger facilities in the city that can offer more attractive salaries and benefit packages.

Nurses and other health care workers can easily take positions in New York City hospitals in order to earn more money, leaving hospitals in my district with a diminished hiring poor of health professionals.

Lately, we have all heard about the deteriorating financial situation of our hospitals. It is certainly disturbing to hear about hospitals operating in the red and having to cut services and regional variance in the Medicare reimbursements only compounds this problem. Not only does it affect hospitals budgets, but more importantly it has an impact on patient care.

I believe it is very important to level the playingfield so that hospitals in similar labor markets are reimbursed at the same level. I think this will help ensure that all hospitals are equally staffed and can accommodate patients.

Not all hospitals belong in an MSA, but many should be included and they are not. Although Medicare has an administrative reclassification process supposedly designed to provide geographic payment parity, often one hospital will qualify while others narrowly miss.

This can create yet another payment discrepancy between hospitals that are just a few miles apart and further disadvantage nearby facilities that do not meet standards for reclassification.

A large-scale solution may be necessary to remedy existing disparity, however, in the meantime we cannot ignore the problems that loom for hospitals today. Congress must address the problem in places where it is particularly acute, where it has the potential to close community hospitals.

That is why I am fighting to get the hospitals in Orange County, New York, Dutchess County, New York, and if possible those in the neighboring counties of Sullivan and Ulster Counties reclassified into the New York City MSA. There is an urgent need to ensure the hospitals in these areas can continue to provide quality care to the residents of Hudson Valley.

Already I have seen one hospital close, leave an entire county that I represent with a New York City suburban population with only one place to go and a 40- to 60-minute drive to get there. Consider what emergency care is in that county.

Hudson Valley residents depend on local hospitals for quality health care. The financial health of area hospitals is critical to their long-term ability to serve residents. For too long my hospitals have been left at a disadvantage competing with other nearby hospitals that were already receiving higher New York City rates.

I thank you very much for holding this hearing. I think it is a very important issue. I apologize for needing to leave, but I am late to make a speech.

Chairman JOHNSON. Thank you very much.

Mrs. KELLY. I will be glad to answer any questions that you have right now though, if you want to do that.

[The prepared statement of Mrs. Kelly follows:]

Statement of the Hon. Sue W. Kelly, a Representative in Congress from the State of New York

Good morning. Thank you Chairman Johnson, Congressman Stark and members of the Health Subcommittee for providing me this opportunity to testify today. Geographic cost adjustment in Medicare is an important issue for hospitals across the country and I am pleased the Subcommittee is focusing on this situation.

I have been acquainted with the issue for many years due the unique situation of hospitals in my district which are located in commutable distance to New York City. Since hospitals in the New York City Metropolitan Statistical Area (MSA) receive higher Medicare payments, hospitals in my district are forced to compete for labor with larger facilities that can offer more attractive salaries and benefit packages. Nurses and other health care workers can easily take positions at New York City hospitals in order to earn more money, leaving hospitals in my district with a diminished hiring pool of health professionals.

Lately, we have all heard about the deteriorating financial situation of our nation's hospitals. It is certainly disturbing to hear about hospitals operating in the red and having to cut services, and regional variance in Medicare reimbursement only compounds this problem. Not only does it effect hospitals' budgets, more importantly, it impacts patient care. I believe it is very important to level the playing field so that hospitals in similar labor market areas are reimbursed at the same level. This will help ensure that all hospitals are adequately staffed and can accommodate patients.

Although Medicare has an administrative reclassification process designed to provide geographic payment parity, often one hospital will qualify while others nearby narrowly miss. This can create yet another payment discrepancy between hospitals that are just a few miles apart and further disadvantage nearby facilities that do not meet the standards for reclassification.

Issues surrounding Medicare geographic cost adjustment certainly warrant further discussion. A large-scale solution may be necessary to remedy existing disparity. However, in the meantime, we can not ignore the problems that loom large for hospitals today. Congress must address this problem in places where it is particularly acute, where it has the potential to close community hospitals. That is why I am fighting to get hospitals in Orange County and Dutchess County, NY and those in the neighboring counties of Sullivan and Ulster, reclassified into the New York City MSA. There is an urgent need to ensure that hospitals in these areas can continue to provide quality care to residents of the Hudson Valley.

I thank the Subcommittee for providing a discussion forum for this important issue. I look forward to working with this panel to maintain the viability of hospitals in my district and nationwide.

Chairman JOHNSON. I think we don't have questions now. We will be taking the body of testimony from all the Members to see how we will proceed, and we will be back in touch with you. Mr. Peterson.

STATEMENT OF THE HON. COLLIN C. PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. COLLIN PETERSON. Thank you, Madam Chair. I appreciate your doing this. As you are aware, I have been talking to you and Chairman Thomas and others about a couple of my situations for some time. I think it is good that we are having this hearing.

I know you have been trying to deal with this. It seems like it is getting worse all the time. Out in my district I was having problems with these hospitals that were close to the metropolitan area.

Now, you know, I am getting complaints from everybody out there. As somebody said on the previous panel, the transportation system has just moved this thing further and further. Even some of the remote rural hospitals are saying they are having to pay the same amount of money to get doctors and maybe more than they

are paying in the Twin Cities, even though they are out in the middle of nowhere.

So, it is a big problem, and I would like to talk to you today specifically about two situations, one you have heard about before, probably, the St. Cloud Hospital, which is in the St. Cloud MSA. St. Cloud is about 60 miles northwest of Minneapolis. The area has been filling in. It has basically become a suburban area. They provide all the same kind of services that all the hospitals in the Twin Cities provide. They have an MSA there in St. Cloud.

This requirement that was put in, I guess in 1992 or whenever it was, where you had to use this 108 percent of the average-wage situation, St. Cloud actually has 90 percent of the wages in the MSA. So, they are in a Catch-22, and they can't qualify to get out of this.

They have been surviving, but now the last 2 or 3 years they are running operating losses. You know, it is just a situation that is becoming very critical so I don't know exactly how we can solve this, but we have been trying to get them reclassified so we can get them on the same basis as the Twin Cities.

One of the problems that we have is that St. Cloud is in three counties. Apparently that causes some problems. I don't know exactly why. This thing is so complicated that I can't figure it out. Anyway, it is a serious problem, and we would like some kind of way that we could get this situation in St. Cloud resolved.

In my new district that is now represented by Representative Kennedy, the hospital in Hutchinson, Minnesota, which is actually closer to the Twin Cities than St. Cloud and the western suburbs have grown out there. This has become a bedroom community for Minneapolis. People commute back and forth. A lot of people actually commute out of the Twin Cities to Hutchinson. We have a 309M plant there and Hutchinson Technology. So, they have a lot of employment out there.

This hospital has actually been reclassified twice; in 1995 for 1 year and then again in 1998. Now, because of some kind of criteria, they don't qualify under the rules, and they have the same kind of problems that St. Cloud has.

I know that this all costs money to fix and money is not in long supply around here. So, I know you have a real dilemma. I wanted to come by and share with you the problems we have in those two hospitals.

As long as I am here, I will mention that last week I got a visit from Fargo, North Dakota, Merit Care, which is in North Dakota, but half the patients come from my district. They were complaining about the same thing, that they were competing with Minneapolis, even those that are 250 miles away. They are in some other kind of area, I am not exactly sure what it is. They are not losing money as well.

They are talking about maybe closing some of the rural clinics in my district because they are going to have to look at cost savings to try to make their whole system operate. They have a big hospital in Fargo, but they have clinics scattered all over in the remote rural areas of Minnesota and North Dakota.

If we don't get this fixed, they are going to be in the same kind of problems, and we may be curtailing services out there for rural people, which we don't need to do.

I appreciate your holding the hearing. I've got a statement I would like to submit for the record. Thank you very much.

[The prepared statement of Mr. Collin Peterson follows:]

Statement of the Hon. Collin C. Peterson, a Representative in Congress from the State of Minnesota

Good afternoon. I am Collin Peterson and I represent the 7th District of Minnesota. I'd like to thank Chairman Johnson and the Subcommittee for inviting me to testify today.

Health Care Worker Shortage

The Committee is well aware of the severe labor shortages within health care professions. The health care industry relies on the majority of its personnel to be licensed and hospitals are experiencing difficulties recruiting and retaining qualified personnel. Facilities are now having to offer signing bonuses and other recruiting incentives which encourage employees to "job hop" between employers, thus increasing turnover costs.

In Minnesota, these shortages are felt across-the-board, including direct caregivers and non-patient care professionals such as nurses, X-ray technologists, pharmacists, medical lab technologists, and others. According to recent findings from the Minnesota Department of Economic Security, the health care industry had 12,543 vacancies this spring. This study also reports 4,532 vacancies in the area of nursing, 69 in hospital pharmacy, and 230 lab technologists.

These vacancies mean patients wait longer before seeing a health practitioner, may be diverted to another facility that could be more than 60 miles away, or experience limited availability to care because there are no personnel to safely expand patient capacities. Facilities are now competing for workers not only across the state but also across the country and around the world. Rural areas are especially hurt by these shortages not only because rural areas lack the cultural advantages that bring in new personnel but also because these facilities lack competitive wages. Rural hospitals are the main employer in the community and if the hospital goes under so does the community.

The wage index needs to reflect only legitimate differences in area wage rates; and the reclassification system needs to be adjusted so that facilities can compete for workers on a level playing field with their urban counterparts. While rural hospitals have a cost structure similar to their urban counterparts, they are paid 100915% less for comparable services provided to Medicare beneficiaries. Not only are these facilities forced to pay higher wages in order to be competitive with other hospitals, but they also receive significantly lower reimbursement from Medicare for services provided to Medicare patients.

Reclassification Problems

The Centers for Medicare and Medicaid Services (CMS) implemented the Inpatient Prospective Payment System (PPS) in the early 1990's. The agency used the Metropolitan Statistical Areas (MSA's) developed by the Census Bureau to organize the varying levels of reimbursement in the Medicare program. CMS created the MGCRB (Medicare Geographic Classification Review Board) to address specific issues of cost and reimbursement arising from the proximity of providers to adjacent urban places with higher costs and reimbursements. CMS developed criteria and a process to determine which providers qualify for reclassification (on an annual basis) into the larger, adjacent MSA's for purposes of Medicare reimbursements.

St. Cloud Hospital, for example, qualified for wage index reclassification in 1992 (for FFY 1993). In 1993 (for FFY 1994), CMS made changes to the reclassification criteria formula that disqualified St. Cloud Hospital from reclassification in subsequent years. CMS added a requirement that a hospital's average wage be 108% of the average wage of all hospitals, in its home MSA, inclusive of its own wages. Only a small number of hospitals in the nation that are candidates for geographic reclassification pay more than 80% of all hospital wages in their home MSA. This change made it statistically impossible for hospitals like St. Cloud to meet the reclassification criteria from 1994 to the present because this hospital pays 90% of all hospital wages in the St. Cloud MSA.

St. Cloud Hospital is a "dominant hospital" in the St. Cloud MSA. The hospital's average hourly wage is about 15% higher than the average paid by the other hos-

pitals in the St. Cloud MSA. Even so, it is not possible to pay 108% of a wage base where 90% of that base is St. Cloud Hospital's own wages.

In BBA'97, Congress addressed the dilemma of dominant hospitals (hospitals which pay a disproportionately high percentage of hospital wages in their MSA's) by creating the dominant hospitals exception to the reclassification process. Dominant hospitals (paying more than 40% of the hospital wages in their home MSAs) are required to pay average hourly wages above 106% of the average hourly wage in their home MSA's exclusive of their own wages. To qualify for reclassification under the dominant hospitals' exception, dominant hospitals must pay at least 40% of the adjusted un-inflated wages in their home MSA and meet all other criteria for reclassification.

In addition, BBA'97 required that a reclassifying hospital have been approved for designation each year from 1992091997. Hospitals like St. Cloud and Hutchinson meet all requirements for geographic reclassification other than the arbitrary requirement that hospitals have been reclassified from 1992091997. These hospitals provide a level of service to their communities that are more commensurate with services provided by hospitals in the neighboring urban MSA and at similar costs.

In St. Cloud's case, more then 30 hospitals in the neighboring Minneapolis-St. Paul MSA have a higher wage index than St. Cloud Hospital. Some of theses are very small hospitals, yet they have 9.16 percent higher Medicare base rate than St. Cloud Hospital. The case mix index measures the complexity of Medicare patients served. Of the 30-plus hospitals in the Minneapolis-St. Paul MSA, only four hospitals have a higher case mix index than St. Cloud Hospital's. This means St. Cloud hospital is treating patients who have more complex cases than all but four of these Twin City hospitals—at a significantly lower rate of reimbursement. This is not how the system should work.

Solutions

Some possible solutions to leveling the playing field between competing hospitals could be to change the wage index to reflect only legitimate differences in area wage rates, not the average per employee expenditures that are biased towards urban areas.

Some less costly adjustments could be eliminating the BBA'97 criteria requiring that a hospital be approved for reclassification each year from 1992091997, and, eliminating the requirement that hospitals have been approved for reclassification from 1992091997 when hospitals pay more than 80% of adjusted, un-inflated wages in their home MSA.

Congress could also modify the requirement that hospitals pay 108% of the average, adjusted, un-inflated wage in their home MSA inclusive of their own wages when the hospital pays more than 80% of the adjusted, un-inflated wages in its home MSA. A hospital paying more than 80% of the adjusted, un-inflated wages in its home MSA could be held to criteria requiring that it pay 108% of the average, adjusted, un-inflated wage in its home MSA exclusive of its own wages.

In conclusion, I would like to thank the Chairman and the Members of the Subcommittee for inviting me to testify today on these important issues.

Minnesota Hospital Snapshot

St. Cloud Hospital

St. Cloud Hospital is located in the City of St. Cloud and in the St. Cloud MSA, consisting of Stearns and Benton Counties in Central Minnesota.

The St. Cloud MSA is immediately adjacent to the Minneapolis-St. Paul CMSA. St. Cloud Hospital is physically located about 1.8 miles north of the boundary between the St. Cloud MSA and the Minneapolis-St. Paul CMSA.

St. Cloud Hospital is a regional referral center, providing a full range of specialty and emergency services to a 12-county area in which it is the only regional referral hospital. The services provided by St. Cloud Hospital are more complex than those of the other hospitals in the St. Cloud MSA and are more complex than most hospitals in the adjacent Minneapolis-St. Paul CMSA.

Medicare insures forty-five percent of all patients served by St. Cloud Hospital. In Fiscal 2001 (ending 6/30/01), St. Cloud Hospital was reimbursed $11 million below its costs for services provided to Medicare patients.

Hutchinson Community Hospital

Hutchinson Community Hospital is located in the City of Hutchinson, which is in McLeod County adjacent to the Minneapolis-St. Paul CMSA.

Hutchinson Community Hospital is physically located 20 miles southwest of Minneapolis-St. Paul CMSA.

Hutchinson Community Hospital is a regional referral center, providing a full range of specialty and emergency services in the area. The services provided by Hutchinson Community Hospital are more complex than other hospitals in the surrounding area and are more complex than some hospitals in the Minneapolis-St. Paul CMSA.

Medicare insures forty-one percent of all patients served by Hutchinson Community Hospital.

Chairman JOHNSON. Thank you very much, Mr. Peterson. Mr. Hinchey?

STATEMENT OF THE HON. MAURICE D. HINCHEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. HINCHEY. Well, Madam Chairman, Mr. Stark, and Members of the Subommittee, I want to thank you very much for holding this hearing, as others have.

I was here for the previous panel and listened to the testimony of each of those Members. Frankly, it sounded very, very familiar, as did the testimony of Mr. Peterson just now. Of course, Mrs. Kelly is right next door to me, so I am very familiar with the situation that she outlined.

This is a problem, obviously, that is of national proportions. It has to do with kind of an antiquated way in which we approach the reimbursement rates that are afforded to the various hospitals across the country.

Medicare sets their rates, to a large extent, based upon geographical location. That may have been a good way of doing it back in 1965, I am not sure. I know very well that it isn't a very good way of doing it today.

We have heard many people talk about the fluidity with which people cross, move around into different areas. That is certainly true of people who are in the wage pool. A number of approaches have been taken to deal with this problem.

There was a local example of that in my situation in the mid-Hudson Valley in New York State, and I am talking now essentially about four counties, Sullivan, Dutchess, Orange, and Ulster, represented by three Members of Congress, two Republican and one Democrat, that being myself.

They are suffering, because of the fact that they are sandwiched in between two metropolitan statistical areas, one in New York City and the other in Albany. They compete with a wage base in those two metropolitan areas.

People who live in these counties can travel very easily either south or north. Back in 1999 the Balanced Budget Refinement Act had a creative provision in it which reclassified hospitals only in Orange County, put it into the New York Metropolitan Statistical area for Medicare reimbursement purposes. That, of course, compounded the problem for the remaining three counties in that region.

So, taking that kind of approach isn't really the solution to the problem and many of us have tried it one way or another. What we need here is a comprehensive solution.

I think first of all a data set that is considered by Medicare in determining geographical cost adjustments is not broad enough to provide a true representation of wage costs. My understanding is that the only data considered by Medicare in making these determinations are the salaries and benefits offered at other hospitals.

This does not consider the many other contributing factors to the wage costs. Medicare does not take into consideration the fluidity of the wage costs. Medicare does not take into consideration the fluidity of today's labor market, as we have heard many people say.

There is another way of approaching it which might make some sense, a broader consideration of wage costs as used elsewhere by the Federal Government and perhaps could be considered for Medicare wage rates.

When the Office of Personnel Management OPM determines locality pay for Federal workers, it not only includes the salary levels for comparable jobs in the private sector, it also assesses the local cost of living, commuting rates and other factors.

So, this is something that the Subcommittee may want to consider.

So, this is a problem that cries out for solution. I know the solution is going to be a costly one, but that is what we are in business to do here. We are in business to make determinations that are going to help the people of this country. The situation that we have now is one that is highly discriminating. If you happen to be in a rural area, the quality of your health care is going to be less than that if you live in a metropolitan area.

The fact of the matter is that doctors and nurses, the most qualified, the best trained, the most competent people are leaving rural areas, whether it is in Iowa or Pennsylvania or New York, or wherever it may be, Connecticut, and going into the cities because that is where the reimbursement rates are highest.

We know that the hospitals in my area, and I have heard other people say the same thing, rely upon Medicare for approximately 70 percent and in some cases even higher, of their income. So, this is a matter that is very critical. The evidence of that is the fact that you are holding this hearing and listening to all of us here with the personal aspects and our personal experiences with these problems.

I thank you very much for doing this, for listening and for the attention that you are going to pay to solving this problem.

I wish you the best of luck and pledge my support and help in any way that I can to help you, to work with you to get a solution to this very different, but very critical issue that needs to be solved.

[The prepared statement of Mr. Hinchey follows:]

Statement of the Hon. Maurice D. Hinchey, a Representative in Congress from the State of New York

Good afternoon Chairman Johnson, Ranking Member Stark, and members of the Subcommittee. Thank you for the opportunity to address the Subcommittee today on an issue of great importance to the future of health care in my district: Medicare's Geographic Cost Adjustors.

Medicare's approach to calculating the relative wage costs among regions is, in my view, rather troubled. The administrative process by which it determines the wage index fails to consider the full range of factors that contribute to wage costs for hospitals. In the absence of an equitable, effective administrative process, many hospitals have turned to their representatives in Congress for a legislative fix. That

approach is also problematic and can lead to greater disparities within localities, but it is the only avenue open to many hospitals.

For the last several years, I have been involved in an effort, both administrative and legislative, to correct an inequity in the wage reimbursement for hospitals in four counties in New York's Hudson Valley region. In many ways, I believe it is illustrative of the inherent flaws in the Medicare system, and appreciate the opportunity to share this experience with you.

The Balanced Budget Refinement Act of 1999 (BBRA) reclassified hospitals in Orange County, New York into the New York Metro Metropolitan Statistical Area (MSA) for Medicare reimbursement purposes. This provision has had what I believe to be an unintended, but negative, economic impact on six hospitals in three adjacent counties in New York's Hudson Valley region.

It is important to note that Dutchess, Orange, Sullivan and Ulster counties had, prior to the enactment of BBRA, been part of the same MSA as Orange County. Dutchess, Sullivan and Ulster counties had met the necessary criteria to be reclassified into the Newburgh, NY09PA MSA (Newburgh is located in Orange County). Based on the Health Care Financing Administration's (HCFA) decision to reclassify them, it in effect acknowledged that the hospitals operate within a similar wage index to hospitals in Orange County and should be treated similarly.

When the Orange County reclassification was under consideration as part of BBRA, my colleagues and I from the Hudson Valley did not oppose the change. At the time, our staff members had been led by representatives of HCFA to believe that the Dutchess, Sullivan and Ulster county hospitals would automatically be reclassified into the New York Metro MSA along with the Orange County hospitals because of their status as part of the Newburgh MSA. We received assurances from HCFA that the legislative fix, which moved the Orange County hospitals into the New York Metro MSA, would correspondingly move the other hospitals into the New York Metro MSA. However, when the other Hudson Valley hospitals pursued the reclassification after BBRA was enacted, HCFA ruled that only those hospitals geographically located in Orange County could receive the New York Metro wage index.

Having failed to correct this imbalance through the administrative appeals process, I have sponsored several efforts on behalf of the hospitals to secure a legislative fix. I understand that this is not the Committee's preferred mechanism for addressing wage reclassifications, but the six hospitals in Dutchess, Sullivan and Ulster counties had no other recourse available to them.

Needless to say, the Orange County legislative fix has placed the six hospitals in the adjoining counties of Dutchess, Sullivan and Ulster at a severe competitive disadvantage. While the hospitals in all four Hudson Valley counties are competing for staff with the rest of the New York Metro MSA, they also compete most directly against each other.

The reclassification of the Orange County hospitals into the New York Metro MSA has resulted in a significant increase in Medicare reimbursement for wage-related costs for those hospitals. As a result of this provision, Orange County hospitals have gained $8—$10 million annually in enhanced reimbursement. This enables the Orange County hospitals to offer much more generous compensation to their employees and to lure staff away from other hospitals.

This ability to pay higher wages has been critical. Our local hospitals, like most across the country, are facing profound shortages in the health care workforce. Competition for registered nurses, technicians and certified aides has been fierce but ultimately the hospitals that can pay the highest wages, provide the most generous fringe benefits and even pay hiring bonuses are winning the battle.

Having worked with the Hudson Valley hospitals on this issue since 1999, I have experienced firsthand the problems that are inherent in the manner in which wage reclassifications are currently handled. I hope that as the Committee prepares to make changes to the system, you will take several concerns into consideration.

First, the data set considered by Medicare in determining geographic cost adjustors is not broad enough to provide a true representation of wage costs. My understanding is that the only data considered by Medicare in making these determinations are the salaries and benefits offered at other hospitals. This does not consider the many other contributing factors to wage costs.

In particular, Medicare does not take into consideration the fluidity of today's labor markets. In the case of the hospitals from my district, it is critically important to take into account that workers are prepared to travel well beyond the towns or counties in which they live to find lucrative work. New York's Hudson Valley region is sandwiched between the New York City metropolitan area and the Albany metropolitan area. Workers that live in the Hudson Valley are accustomed to commuting to either of these metropolitan areas for work. Therefore, when a substantially higher rate of pay is available in Albany or New York, workers will leave the Hudson

Valley for those jobs. Because of the BBRA language that reclassified the Orange County hospitals, workers in Dutchess, Sullivan and Ulster counties need only to travel to Orange County to receive wages that can be as much as 40 or 50 percent higher. This severely compromises the ability of hospitals in the lower-paying counties to retain staff and, ultimately, stay in business.

A broader consideration of wage costs is used elsewhere by the Federal Government and perhaps could be considered for Medicare wage rates. When the Office of Personnel Management determines locality pay for federal workers, it not only includes the salary levels for comparable jobs in the private sector, it also assesses the local cost of living, commuting rates and other factors. I take the liberty of suggesting to the Subcommittee that a similar wage survey could be taken into consideration for Medicare.

Because the administrative process does not currently include adequate mechanisms for assessing wage costs, hospitals may have no other remedy at their disposal except for a legislative correction. As the representative for many of the hospitals that have been endangered by the Orange County reclassification, I have been more than happy to work on their behalf for such a correction.

However, I realize that there are inherent dangers in pursuing legislative corrections. Taking a "rifle shot" approach to wage reclassifications does not necessary make for a fair and equitable system. In the case of the hospitals I represent, the Orange County reclassification plucked one group of hospitals out of an MSA and moved it into a higher paying MSA, despite the fact that HCFA's administrative process had already determined that Orange County shared a similar wage index with hospitals in Dutchess, Sullivan and Ulster counties. Although Medicare should not be in the position of giving unfair advantages to some hospitals over others, making political changes to the wage index certain increases the likelihood that that will happen. Legislative reclassifications of hospitals can directly impact other hospitals in their immediate vicinity, but that is not necessarily part of the decision-making process.

The present system has flaws that need to be addressed. Although I understand that it is a very complex and difficult task, I hope that the Subcommittee will consider serious reforms to Medicare's wage indexing structure. I look forward to working with you to supply any details that the committee may need regarding the situation I have presented today.

Thank you.

Chairman JOHNSON. Thank you very much, Congressman Hinchey. Congressman Smith?

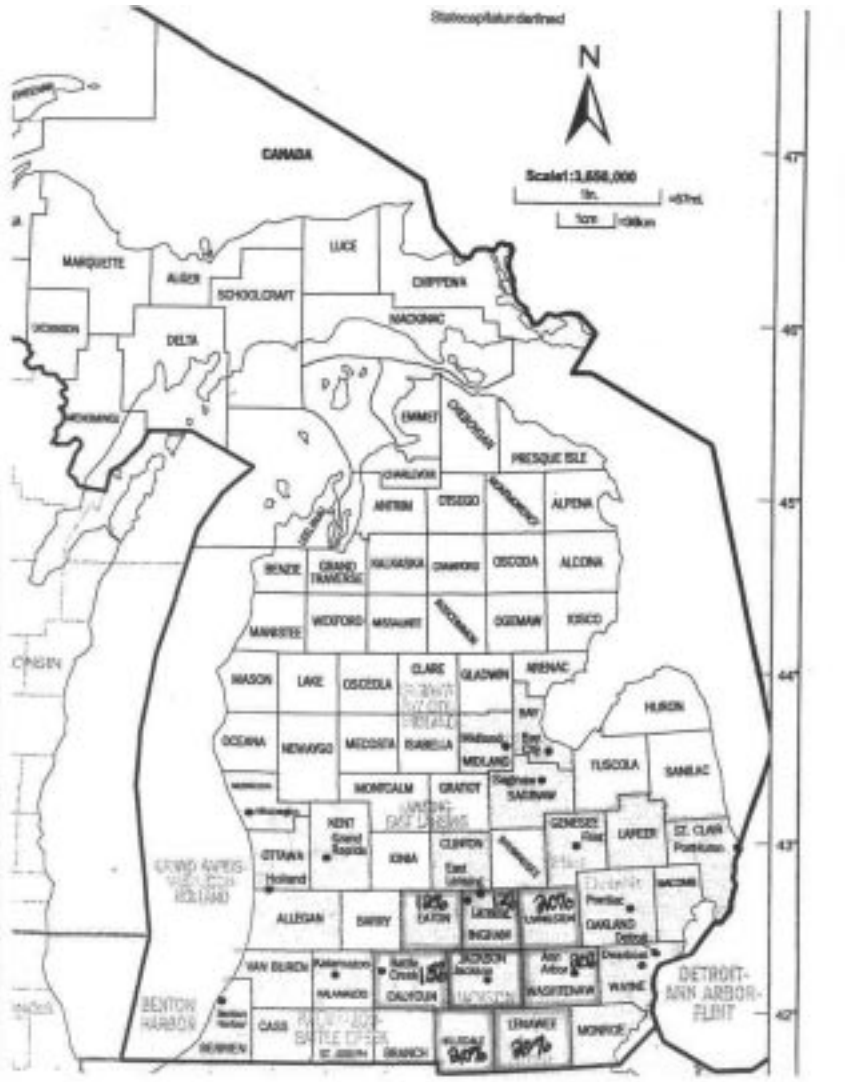
STATEMENT OF THE HON. NICK SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. SMITH. Madam Chair, Pete, everybody, thank you for doing all the listening when you probably also could do a lot of talking about some of the problems.

With your permission, I would like to show a chart. My main concern is Jackson Hospital which is a 359-bed hospital. Madam Chair, this Jackson Hospital, it is a nonprofit. It hires 2,500 people, the highest employer in the MSA.

It is bordered by seven other counties, MSA districts, 11 hospitals all receiving significantly higher reimbursement, 12 percent in Lansing, 20 percent in Livingston, 20 percent in Ann Arbor, these other hospitals receive 20 percent higher reimbursement, 15 over in Battle Creek, and 12 percent in Eaton. Jackson is in the middle.

[The chart follows:]



People are willing to drive, nurses, doctors, 40, 50, and 60 miles.

I just called the financial people about their estimate of what they are going to do this year. They are estimating that they are going to lose between $4 and $9 million at the hospital. So, what we are faced with is a system that puts some hospitals at a competitive disadvantage and therefore is going to deprive the kind of equal service.

We have a lot of different rates, but I think we should make no mistake. Individuals that can get a 10 percent higher salary in one area compared to another are going to travel that 30 or 40 miles.

This is what has happened in the Jackson area. The reason why these wage reimbursement indices are higher and stay higher are complicated, as you know, but are due in large part to the fact that wage indices tend to be self perpetuating. The hospitals in these surrounding areas receive higher than average reimbursement from Medicare and so can offer higher wage, salaries to more hospital staff.

The more labor costs these hospitals incur, the higher the resulting wage index and the higher resulting Medicare reimbursement and the more Medicare reimbursement they receive, the more they can pay their staff.

Now, the inverse is true at Foote Hospital. Foote receives lower than average Medicare reimbursement and like any business, they try to make ends meet. The way Foote does this is by having a different staff mix. Instead of, in Ann Arbor in a certain situation they would have three registered nurses, Foote, in trying to survive, has one registered nurse and then two assistants who are going to work for a lower wage. So, only one registered nurse out of the three is getting the higher wage that has to be competitive of else they would lose that nurse.

Due to the proximity of these other hospitals with higher reimbursement rates, Foote competes and Foote must and does offer the wages. However, with a change in mix, that means that there is a little less quality and service where some people are going to decide to take their business elsewhere.

We have talked about maybe a universal reimbursement. The fact is that we are having doctors more to other States where they think they can make more money.

The University of Michigan has a medical hospital. Michigan State has two, both the regular and the osteopathic. These doctors aren't staying in Michigan. They are looking across the country where they can get the reimbursement they need. Rural areas especially are jeopardized.

One of these hospitals, Hillsdale Hospital is not getting 20 percent because the law we passed several years ago that allows a special consideration to have a change for 3 years, that is going to expire. So, Hillsdale Hospital that is the only rural hospital as far as reimbursement in southern Michigan, is also at a competitive disadvantage.

Let me concluded by saying in addition to Foote Hospital, we have calculated there are 100 additional hospitals in the United States with a similar problem that pays more than 40 percent. Jackson represents 80 percent in the Jackson MSA. They represent about 80 percent of the total medical wages.

So, one of the considerations for being allowed to change your MSA, even though you pay higher wages, is meeting the 108-percent requirement that you are aware of. You can't be 108 percent of your own market.

Doctors Hospital, partially because of the lower reimbursement in the Jackson area, is going out of business. So, Jackson very well could be 100 percent. We need to change this special dominating hospital exception that would allow these or any hospital, and I suggest any hospital, that is more than maybe 60 or 70 percent of

their MSA to be allowed to not meet that 108-percent requirement that is now in the law in terms of changing.

I appreciate the Committee's time. My time is up, but it is a tremendous problem of inequity in a requirement system that puts some hospitals out of business and that is what we are threatened with in Jackson. Thank you.

[The prepared statement of Mr. Smith follows:]

Statement of the Hon. Nick Smith, a Representative in Congress from the State of Michigan

Madam Chairperson and members of the Subcommittee, thank you for the opportunity to testify before you today.

I wish to speak with you today about a shortcoming of the geographic reclassification system, which has directly and adversely affected hospitals within my district.

W.A. Foote Memorial Hospital, a 359-bed non-profit general hospital located in Jackson, Michigan employs 2,500 persons, making it the second largest employer in the Jackson Metropolitan Statistical Area (MSA). The only other hospital in Jackson County serving Jackson residents is Doctors Hospital. Doctors is a 65 bed hospital that employs 300 people. They are a significant provider of health care county-wide.

The Jackson MSA is surrounded by seven counties, with eleven hospitals, all receiving higher reimbursement. The wage indices in those other MSAs are consistently and significantly higher than the wage index applicable to Jackson. As you see by this chart the Jackson wage index is between 6 and 20 percent below the eleven surrounding hospitals.

The reasons why these wage reimbursement indices are higher and stay higher are complicated, but are due in large part to the fact that wage indices tend to be self-perpetuating. The hospitals in surrounding areas receive higher than average reimbursements from Medicare, and so can offer higher than average salaries to more hospital staff. The more labor costs these hospitals incur, the higher the resulting wage index, and the higher the resulting Medicare reimbursements. The more Medicare reimbursement they receive, the more they can pay their staff.

The inverse is true for Foote and Doctors. These hospitals receive lower than average Medicare reimbursements. Like any business, hospitals must operate within a budget, which means costs must try to be held to projected revenues. Because Foote receives a low wage index and low Medicare reimbursements as a result, Foote must constrain its labor costs. Constrained labor costs lead to lower wage indices, and lower Medicare reimbursements, which again lead to constrained labor costs. Foote ends up at a competitive disadvantage for reimbursement and ultimately for survival.

Because of its proximity to these other hospitals with higher reimbursement rates, Foote and Doctors compete with hospitals in those areas for clinical personnel, such as nurses and technicians. They must and do offer wages at least commensurate with, perhaps even greater than, those paid by hospitals in those neighboring cities to induce highly skilled clinical personnel to remain in Jackson, rather than seek jobs elsewhere. However, Foote, for example suppresses its labor costs by adjusting its skill mix, for example. Whereas the University of Michigan Hospital might staff a nursing unit with three registered nurses, Foote would staff a similar unit with one registered nurse and two licensed practical nurses, or other clinicians with lesser skills, therefore requiring lower average wages.

Congress established the geographic reclassification process to address exactly the kind of situation confronted by Foote. Foote is located in close proximity to three MSAs. Its labor costs are higher for a particular skill level than the other hospitals in its area, and comparable to hospitals in the Ann Arbor, Lansing, and Kalamazoo MSAs. Yet, Foote is unable to qualify for geographic reclassification because of a flaw in the criteria that hospitals must satisfy. A hospital seeking wage index geographic reclassification must satisfy three tests, one of which requires that the applying hospital's wages are 108 percent higher than hospitals in the area in which the hospital is physically located. Foote cannot satisfy this 108 percent test.

There are only two hospitals in the Jackson MSA. Foote is the larger of the two, and pays the majority of hospital-related wages. Given the dominance of Foote's own wage data, over 75 percent of the MSA wages, Foote cannot satisfy the 108 percent threshold.

There is a special reclassification opportunity put in by some members of Congress called the" Special Dominating Hospital Exception," that permits an eligible hospital to remove its wage data from the calculation of the 108 percent test. How-

ever, to limit the future application of that amendment, the hospital must also have qualified for reclassification in each of the fiscal years 1992 through 1997, making this exception closed to many hospitals who are today confronted with this situation.

In addition to Foote and Doctors, there are approximately 100 similarly situated hospitals, (that is hospitals that are in MSAs with only one or two other hospitals), which pay more than 40 percent of the wages in their MSA, but which cannot qualify for reclassification, because of the 108 percent test. I suggest the committee consider modifying the "Special Dominating Hospital Exception" to allow any hospital paying over 75 percent of wages and do away with the 920997 restrictions.

Hillsdale Community Health Center, also located in my district, is dealing with similar problems. Hillsdale, while providing vital services to the people of Hillsdale County, is struggling to survive, because of the level of Medicare payments made to it, particularly in comparison with other hospitals in southern Michigan. There are twenty-eight counties in the lower third of Michigan. In twenty-seven of those counties, hospitals are paid Medicare rates as urban hospitals. Hillsdale is the only hospital in the lower third of Michigan paid on the basis of rural hospital Medicare rates. Hillsdale has received limited administrative reclassification for the next two years, however this classification is again temporary. It's important for long term planning that Hillsdale, and other hospitals disadvantaged by a rural designation, receive a permanent legislative reclassification.

The geographic reclassification process works for many hospitals. However, it should be fixed. Because of the low reimbursement rate, Doctors Hospital in Jackson County, the only other hospital in the county besides Foote, reportedly might close. To have a reimbursement system that, because of technicalities, forces some hospitals into insolvency and out of business is not good public policy, is unfair and reduces available health care for particular communities. Congress should remedy the situation that I described by enacting legislation that would amend the "Special Dominating Hospital Exception" to enable Foote and other similarly situated hospitals to qualify for reclassification. And, Congress should consider broader legislation that would allow hospitals, which are struggling with geographic reclassification issues, to permanently reclassify once and for all. Distance between hospitals is no longer the factor it once was. Most hospitals should have similar reimbursement rates.

Thank you for your time and consideration of this request.

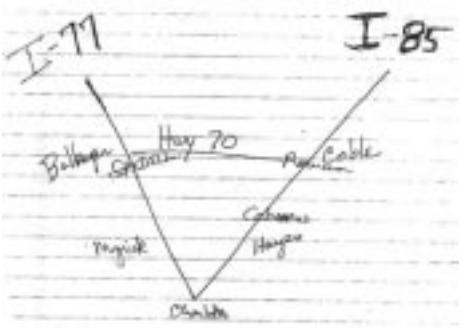
Chairman JOHNSON. Thank you very much for your testimony and for your interesting map. Mr. Watt, welcome.

STATEMENT OF THE HON. MELVIN L. WATT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. WATT. Thank you, Madam Chair and Members of the Subcommittee. I appreciate the opportunity to come and testify. I prepared a written statement, which you have, and I will try not to repeat that.

I am going to try to use a chart that is not quite as sophisticated as Nick's and ask him if he will hold it up. That kind of illustrates the problem here, and it is not different from what you have heard already.

[The chart follows:]



You have Charlotte, North Carolina, right here at the base of a "V" and through Charlotte, North Carolina, runs Interstate 85 and Interstate 77. This is a bipartisan problem because up Interstate 77 is Sue Myrick and Cass Ballenger. Up Interstate 85 is Representative Robin Hayes and Representative Howard Coble.

I am down here at the base and running that direction and that direction. You all know I have this strange congressional district. I run all over the place. I adjoin all of these people.

The problem is that people in Charlotte, Cabarrus County, Rowan County, and Iredell County have always been in the same metropolitan statistical area. They move back and forth. The highway system is there. Patients move back and forth. Doctors move back and forth. Employees of all kinds move back and forth. So, if one is paying more and the other is paying less, they will just move.

They continue to reside where they used to but they go somewhere else to work. They drive down the highway some 15, 20, 25, or 30 miles. I mean it is a 30-minute commute. So, nobody is going to take less money in a system like this and to make matters worse, if you cut across Highway 70, which is not an interstate highway, you can go from Rowan County to Iredell County. People move in that direction. They always have.

Now, what happens? All of a sudden there is a proposal that comes forward that says, "We are going to take Rowan County and put it in a 'micropolitan' statistical area and leave everybody else in a metropolitan statistical area." What is that going to do?

It is going to cost Rowan County Hospital $2.5 million a year when they have to pay the exact same salaries that everybody else in this triangle has to pay. It just can't work that way. Six or 7 years ago we had to solve Iredell County's problem with a legislative fix. I mean that is where they tried to do the same thing with Iredell County, they got back into the Charlotte metropolitan statistical area.

So, everybody in this area is drawing from the same employee base, same physician base, and hopefully providing the same quality of medical care or trying to provide, but if you take Rowan County out and put it into a lower reimbursement rate, they will get some employees. The question is, will they be as qualified as

the employees that they have now, because all their best paid employees pick up and go to Charlotte.

They will get some physicians, yeah, but the question is, will they be the same quality physicians. The problem exists up on the northern end of my district, up in the Greensboro part. They took Greensboro and Winston-Salem and separated them into two. I mean that is a natural Interstate 40 corridor. People move along that corridor everyday. People go from Greensboro to Winston-Salem to work or Winston-Salem to Greensboro to work.

The same thing applies in this area. This simply needs to be fixed. You know, I used to aspire, when I first got here to be on the Committee on Ways and Means. I am glad I am not. I am glad it's you all's problem because I came and listened to the first panel.

This is a serious problem. I know that that solution of putting Rowan County in separate micropolitan area is just going to make the quality of medical care in Rowan Country lower than it currently is because they are not going to be able to pay the same salaries to their employees and that is going to put them at a disadvantage.

[The prepared statement of Mr. Watt follows:]

Statement of the Hon. Melvin L. Watt, a Representative in Congress from the State of North Carolina

Madame Chair and Members of the Subcommittee, thank you for holding this hearing and inviting me to speak on the very important topic of geographic factors in the current Medicare payment system and the need for a comprehensive legislative fix.

I represent a district in North Carolina which includes parts of Charlotte, Greensboro and Winston-Salem, as well as parts of suburban and not so rural areas that connect these metropolitan centers. While my district (like the districts many Members represent) is diverse with a multiplicity of racial, ethnic, demographic, economic and political constituencies, one common bond all these constituencies share is the health care system and, in particular, the network of hospitals that provide critical services to residents in these cities and communities. The financial condition of these hospitals is, therefore, a topic of vital importance.

The specific issue I have come to address today is the new standards issued by the Office of Management and Budget in December 2000 for defining Metropolitan and Micropolitan Statistical Areas. Those standards will change the classification of 713 counties around the country and in some cases will be devastating for hospitals in urban, suburban and rural communities and, in turn, devastating for the patients who depend on these hospitals. Rowan Regional Medical Center is one of those hospitals.

Rowan Regional Medical Center in Salisbury, North Carolina is located in one of the counties that would change from the Metropolitan Statistical Area (MSA) category under the current system to a Micropolitan Statistical Area under the new system. For good reasons, Rowan County (which I share with Representative Howard Coble) has been included in the Charlotte MSA for decades (as has Iredell County, represented by Representative Cass Ballenger and Cabarrus County, represented by Representative Robin Hayes). Under the new plan, the Micropolitan Statistical Area in which Rowan County is being placed would continue to be immediately adjacent to the Charlotte Metropolitan Statistical Area. However, according to PricewaterhouseCoopers, which conducted an independent analysis on behalf of Rowan Regional, the change would reduce Medicare payments for inpatient services to Rowan Regional by $2.9 million per year. In this case, the differential is simply not justified.

Because of the close proximity and ease of access between Charlotte/Mecklenburg County, Cabarrus County and Rowan County along Interstate 85 and the close proximity and ease of access between Charlotte/Mecklenburg County and Iredell County along Interstate 77, these areas have grown almost seamlessly. Patients, as well as nurses, doctors, custodians and workers of all kinds regularly live in one area and commute to and from work in another. Wages and benefits tend, by necessity, to be competitive throughout the area. Rowan Regional is one of the acute care facili-

ties in the area, employing over 1,200 full and part-time staff and serving over 130,000 people from Rowan County and surrounding areas. Rowan Regional can't afford to pay its workers less. If it does, they'll simply choose to work in Cabarrus, Mecklenburg or Iredell.

As is the case with many hospitals around the county that are operating with razor-thin margins, the proposed change could dramatically reduce the quantity of services Rowan Regional provides, compromise its exceptional quality of medical care or, quite possibly, even jeopardize its viability and survival. On the patient level, the people affected most will be those who can afford it least— the elderly, working poor and home-bound patients. The services and programs currently provided that could be adversely impacted include:

- Free mammography for low-income citizens;
- Home health and hospice services;
- A free telephone triage service;
- Health education programs for the general public;
- Reduced-cost Hepatitis B shots for school teachers; and
- A Community Care Clinic for the working poor.

While I recognize that the Federal Government sets different Medicare reimbursement rates because hospitals operate in different market environments, Rowan Regional should be reimbursed at the same level as Charlotte-region hospitals because the two areas are closely connected and part of the same market. The new standards assume that hospitals in smaller communities pay lower wages and, therefore, do not require reimbursements comparable to those hospitals in more urban areas. As I indicated above, however, this is simply not the case for Rowan Regional Medical Center.

Clearly, there are many of us who have hospitals in our districts which will be negatively impacted by MSA reclassifications and lower Medicare payments for inpatient services. But this is not a problem that should be fixed one hospital at a time in the current budget environment. Our hospitals and, more importantly, our patients should not be subject to such a zero-sum game. Congress needs to address the underlying geographic factors in the current Medicare payment system with a comprehensive legislative fix.

Thank you for giving me the opportunity to testify before the Subcommittee today and I welcome any questions you may have.

Chairman JOHNSON. Thank you very much, Mr. Watt. Mr. Sherwood?

STATEMENT OF THE HON. DON SHERWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. SHERWOOD. Thank you very much, Madam Chairman for convening this very important hearing. I appreciate the Members of the Subcommittee and the Ranking Member, Mr. Stark, being here to listen to our concerns.

We have heard today about disparities be regions. That is part of the issue. We know that the system was designed to try and give equal health care across the country, and it took into account the fact that wage rates were different.

Now what we have had, and I have spent years looking at reports like Mr. Stark had on different business ventures, trying to figure out why one in one town was more profitable than one in another town. If they have different rules it is very difficult to compete.

My area, which Paul Kanjorski represents also, we are disadvantaged by 34 percent between the Newburgh, New York, area which butts right up against us. In other words, it is not one, its Montana and the other is New York. This is part of Pennsylvania in the Newburgh, New York, area. My part of Pennsylvania is held by the rural floor and there is a 34-percent difference in the wage reimbursement.

Now, no business, health care or otherwise, can compete when the people next to them can charge 34 percent more than they can charge for 50 or 60 percent of their patients. So, this is an issue that we must address.

I don't want to trash the system. I understand that it was designed to try to be fair. As legislators and representing people from all parts of the country, we have to make sure that the money we spend for health care is fair.

If the people 5 miles down the road are paid more, 34 percent more than the people 5 miles up the road, it just doesn't work.

You know, Wyoming County, Lackawanna County, Lucerne County, Lacoming County, Pennsylvania, are very disadvantaged by this formula and it is driving some of their hospitals, as other people have said, out of business.

Now, we know that health care was overbuilt a little bit and some of this has to happen. We have to be careful about how much of it we make happen and 34 percent is not something that anybody, a disparity that anybody can live with.

Madam Chairman, I worked with you on the milk issue, and I know how hard you fight for your constituents. That is what I am here to do. I appreciate the consideration of the Subcommittee to look into this very important issue.

I would just like you to take that one thought home with you that two hospitals right next to each other can have a 34-percent disparity in what they are paid. It doesn't work. Thank you.

[The prepared statement of Mr. Sherwood follows:]

Statement of the Hon. Don Sherwood, a Representative in Congress from the State of Pennsylvania

Thank you, very much, Madame Chairman, for convening this important hearing on the critical issue of Medicare access disparities caused by inequities built into the historic wage rates. The current Medicare payment system has several adverse affects on the hospitals I represent.

They have been shortchanged rather than rewarded by Medicare for keeping their wages down. Hospitals in the cities of Scranton, Wilkes-Barre have kept wages down and now receive only the Pennsylvania rural floor wage index, which for 2002 is 0.8683 and for 2003 will be 0.8525.

My district borders the higher wage rate areas of Allentown, Pennsylvania to the southeast with a 0.9833 wage index and Harrisburg, Pennsylvania at 0.9315. But by far the greatest threat to our health staff is from hospitals in the Newburgh, New York MSA to the East with a wage index of 1.1434.

A Hospital which is part of the Newburgh MSA classification put up a billboard in my hometown of Tunkhannock, under an hour away by car, to advertise for health workers. How can the hospitals I represent be expected to compete when the Federal Government is giving a nearly 30% wage rate advantage to a neighboring employer?

As the healthcare manpower shortage continues to worsen, the hospitals I represent are in the difficult position of having to retain or attract healthcare workers without adequate resources. Because every time we provide a percentage increase, the gap widens.

According to the 2001 Financial Analysis by the Pennsylvania Health Care Cost Containment Report on General Acute Hospitals, the hospitals in the region I represent posted a negative 1.51% operating margin. That was the worst in the Commonwealth of Pennsylvania and contrary to a statewide improvement in operating margins to 2.10% from 2000.

As you know, I have been working hard to have some of the hospitals I represent reclassified in order to provide a more reasonable wage. In trying to find an administrative solution, Centers for Medicare & Medicaid Services Administrator Tom Scully told me that the solution must come in the form of legislation.

Adequate Medicare reimbursement is vital for my hospitals because they serve a relatively higher population of older Americans. We need to be able to attract and

retain skilled nurses and health professionals to provide quality care for Medicare patients.

Madam Chairman, I know that there is no greater champion in the Congress for health care equity than you. It was my great pleasure to work with you on behalf of your dairy farmers, and I saw how seriously you take your position as an advocate for the people of the Sixth District of Connecticut. As the advocate for the Tenth Congressional District of Pennsylvania, I implore you and your colleagues here to address this issue legislatively.

I thank the Subcommittee for their efforts to find a remedy to this very critical problem and I look forward to supporting your good work.

Chairman JOHNSON. Thank you, Mr. Sherwood. We have our last panel of Members coming. As you depart, it is incredible that there could be such disparities when much of the payment structure is uniform at a national rate. The wage index only applies to about—is it 45 or 55 percent? It is 71 percent of the costs. Even part of the 71 percent of the costs are actually nationally paid.

It is clear this is a very, very big problem in the lives of our hospitals and therefore the lives of our communities. So, we certainly will be working on it.

Mr. STARK. May I?

Chairman JOHNSON. Yes.

Mr. STARK. Thank you, Madam Chair. I have just a couple of things. Bear with me, Mel, for a minute. The change in the wage base has nothing to do directly with what your hospitals pay in salaries

Mr. WATT. That's correct.

Mr. STARK. It is a measure that is used to raise the per-case reimbursement to hospitals in high- or low-wage rate areas from the national setting. So, there is no reason, for instance in a highly unionized area like I am in, all the hospitals pay pretty much, the nurses rates are the same if they are all in the Service Employees Industry Union SEIU.

All it does is adjust the amount of money that your hospital receives from Medicare. There is no difference what your patients pay for all practical purposes, Mr. Sherwood. So, the competition changes. It changes in your area so that in a sense one would wonder why we adjust for a disproportionate share, which is the number of poor people.

A lot of people are in areas which we have come to use as a proxy for the idea that hospitals get stuck with a lot of nonpaying patients. So, we adjust Medicare a little bit to cover that. It doesn't mean the hospitals have to take in more charity cases, but it is an adjustment we use.

Our teaching hospitals, that doesn't necessarily mean that teaching hospitals pay anybody any more, but because of the burden that they have to carry for running the educational thing, we pay them a little extra.

Basically the Medicare reimbursement for every appendectomy, let us say, is the same for every hospital in the country. We adjust it a little bit if you are a low-wage area or a high-wage area. That does affect the ability of hospitals to pay more money, but for hospitals who have a positive margin, they could do it anyway. They just end up which a little less profit.

So, what I am trying to suggest to you is that it is a proxy for trying to adjust the system that is supposed to pay every hospital

the same. Arguably, because we let it come in, I for one would probably do away with the wage-base adjustment because it can and will mean millions of dollars to a hospital, but it doesn't mean they have to pay anybody any more. It just means they have to bring it down to the bottom line.

Then I would say, what the hell, if they are already making a profit, why disadvantage other hospitals in a community who are not, just because this one hospital may have found a way to get closer to a different line?

All I am suggesting is that if we had a more definitive way to look at each hospital, if you assume that we should only pay them what it costs to treat Medicare, and maybe, you would say not, we should pay more for Medicare so they can run charity care. I won't disagree with that, but I'm not sure that is built into the system.

So, what we have is a system that is very difficult to make any sense from. We can respond to your individual hospital pleas, and I heard several people mention hospitals that went broke. Do you know that we have never, I don't think in any year and I have been at this business 15 years or so, and we have never closed 40 or 50 hospitals in the year. There are 6,000 in the country. That isn't so bad. Most of them close because the doctor died or something else happens or they merge.

Basically, it's a constant battle to adjust whatever we can adjust. This happens to be one of the things we can adjust specifically. It would help us. Now, I will shut up.

The hospitals won't give you or us specific financial data because they don't like to let that out. That is what we are up again, how do we do it?

Mr. HINCHEY. Just a practical example, the first part of your statement, Mr. Stark. You have 12 hospitals. Two of them are now suddenly, arbitrarily moved into a metropolitan statistical area. The amount of money that those two hospitals receive is now increased between $8 to $10 million a year.

Mr. STARK. It could very well happen.

Mr. HINCHEY. They are now able to pay 40 to 50 percent more to the employees that they require to deliver health care in those hospitals.

Mr. STARK. Did they?

Mr. HINCHEY. They did, thereby disadvantaging the other hospitals in the group from which they were plucked arbitrarily.

Mr. WATT. My situation is the reverse of that. They were in the same MSA——

Mr. STARK. They changed their wages?

Mr. WATT. Now, they are going into a "micropolitan" statistical area. I mean I didn't do the math. The study they had done, the accountant says, well, I hope they are not Enron accountants, but their accountants say this is going to cost this hospital $2.5 million a year.

If they get $2.5 million less per year, there is no way they are going to be able to pay the same salaries that they are paying employees in Charlotte.

Chairman JOHNSON. Mr. Watt, this only a proposal by the Centers for Medicare and Medicaid Services CMS. It is an effort to look at, if you make the area smaller, will it be more accurate. What

your testimony is it won't be more accurate because the hospital is already a part of a large area and you can't change that. That is not even proposed to go into effect until 2005. There is a long time between now and then. It is one response to his problem. What you are saying is it won't work. Mr. Sherwood and then let's go on to the next panel.

Mr. SHERWOOD. If mine are being reimbursed at a 34-percent less figure than their competition, it is hard for them to pay their people enough to get out of the trap.

Chairman JOHNSON. Yes, I agree with that. I thank you all very much for your testimony. We will invite the last panel up.

Mr. CARDIN. Madam Chairman, while you are doing that, may I just make one brief comment?

Chairman JOHNSON. Yes.

Mr. CARDIN. First, I appreciate the courtesy. I was on the first panel, I couldn't be here, and my statement has been made a part of the record. I just really want to at least put on the table another perspective here. That is these wage indexes not only affect the hospitals, but they affect the skilled nursing facilities.

Chairman JOHNSON. Oh, yeah.

Mr. CARDIN. Even though in 2000 we gave authority to the U.S. Department of Health and Human Services (HHS) to develop wage indexes for skilled nursing facilities, they have not done that. So, we are finding, at least in my State, that the information given by the hospitals was not accurate, and it cost our skilled nursing facilities a couple of million dollars.

So, I would just urge, as we look at this, we also look at making other providers who are impacted by this, that we have a fair way—to me, I think that HHS should develop a wage index for the skilled nursing facilities. There should be a way to correct information that is made available that was inaccurate that affects other providers than the provider who submitted it. I appreciate your attention.

Chairman JOHNSON. Mr. Aderholt, Mr. Moran, Mr. Peterson, Mr. Sandlin, and Ms. Wilson is not going to be able to join us. So, Mr. Sandlin, Mr. Peterson, Mr. Moran, and Mr. Aderholt. Mr. Aderholt, would you just start right in, please?

STATEMENT OF THE HON. ROBERT B. ADERHOLT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. ADERHOLT. Yes. Robert Aderholt, 4th District of Alabama. Madam Chairman and Members of the Subcommittee, thank you for the opportunity to appear today on an issue which is of critical importance in terms of our ability to provide health care. No formula for distributing funds is perfect, and I am grateful for the openness of making some much-needed adjustments, particularly with regard to rural health care.

Since Alabama is a low-income State, hiring and keeping workers in any field can be difficult. However, this problem is particularly severe in the field of health care.

The reason is simple. The market for health care workers is tight; so tight, in fact, that cities and rural areas often compete for the same people. Unfortunately for rural areas, the cities usually win. More and more districts like mine in north Alabama are see-

ing workers move away to large urban areas or drive the long distances to those areas in order to make higher wages.

Rural hospitals provide essential inpatient, outpatient, and post-acute, including skilled nursing, home health care and rehabilitation services to nearly 9 million Medicare beneficiaries. Rural hospitals rely more on Medicare payments, which can be 70 percent or more of their revenue, yet are less able to manage within the prospective payment system because of low financial reserves, thinner margins, and significant fluctuations in patient volume.

These challenges, coupled with their sparse population, high levels of poverty, and shortages of critical health professionals, have significantly impacted the ability of many rural hospitals to remain financially viable under Medicare prospective payment policies. In fact, one out of every three rural hospitals is losing money, and 66 percent have negative total Medicare margins.

As you know, the Federal payment calculations, as they were first designed, there were certain factors used to adjust the payment based on the various geographic locations within the country. One of the factors was an adjustment for the wages paid. Later, the government developed a way to differentiate between payments to large urban facilities and all other hospitals. Once these adjustments were put in place, they were never reevaluated and have penalized States like Alabama for a number of years.

This provides hospitals in large urban areas, like Atlanta, with a larger base rate. The base rate is the starting point upon which all of the other factors are based, and can make a significant difference in the rates paid to facilities in those areas. Alabama has no facilities that qualify for this additional payment to a large urban. We would argue that there are not enough differences in the cost of running a large urban hospital, when compared to all other hospitals, to justify this difference in the base rate. We believe that all hospitals should begin with the same base rate for payment, especially since there are other factors that reflect differences.

In addition to the base rate, the government uses a formula to factor in the wages of an area. It established a national average to represent hospitals' labor costs as a percentage of total costs. As you are aware, that average is 71 percent. Then, each year, the government assigns each MSA, a multiplier that is applied to this national average of 71 percent. Rural areas, or those outside the MSAs, are given another multiplier. These multipliers are supposedly based on the wages paid to persons in a given geographic area, and fluctuate each year.

For Alabama hospitals, there are two main problems associated with the wage calculation. The first is that the Alabama average wages as a percent of total costs are actually about 51 percent. Therefore, when the multipliers for hospitals in Alabama are applied to the national average, they are actually applied to about 20 percent of non-labor costs. In practical terms, what this means is that Alabama hospitals get less, even though their labor costs may be as high as urban areas.

A second reason is that in order to get qualified health care professionals, Alabama hospitals must compete with all areas, including out-of-State locations of Nashville and Atlanta. Therefore, the pay scales cannot be that different. Currently, the national average

of wage index factors goes from about 70 percent to a high of 144 percent. I would submit to you that there is no rationale for having that much of a difference in health care salaries for different parts of the country. In fact, many hospitals in Alabama have to offer competitive salaries in order to attract personnel.

For these reasons, I have given my support to H.R. 1609, which was introduced by a Member of this Subcommittee, Phil English, which establishes a floor on the area wage index to adjust Medicare hospital inpatient and outpatient prospective payments. By setting a floor of.925 on the area wage index, this proposal would bring Medicare payments in areas with the lowest wage index up to just below the national average, which is set at 1.0.

H.R. 1609 has universal support among State hospital associations. It is also supported by the rural hospital administrators, the ones that live with this on a day-to-day basis. I know that many good ideas have and will be presented today, but what I am asking for this Subcommittee to do is look at something practical that will provide immediate assistance to America's rural hospitals. Thank you.

[The prepared statement of Mr. Aderholt follows:]

Statement of the Hon. Robert B. Aderholt, a Representative in Congress from the State of Alabama

Because Alabama is a low income state, hiring and keeping workers in any field can be difficult. However, this problem is particularly severe in the field of healthcare.

The reason is simple. The market for healthcare workers is tight. So tight, in fact, that cities and rural areas often compete for the same people. Unfortunately for rural areas, the cities usually win. More and more, districts like mine in north-central Alabama are seeing workers move away to Atlanta or Birmingham, or make the extra hour and more drive to the city for the promise of higher wages.

Rural hospitals provide essential inpatient, outpatient and post-acute care, including skilled nursing, home health and rehabilitation services, to nearly 9 million Medicare beneficiaries. Rural hospitals rely more on Medicare payments, which can be 70 percent or more of their revenue, yet are less able to manage within a prospective payment system, or PPS, because of low financial reserves, thinner margins and significant fluctuations in patient volume. These challenges, coupled with their sparse populations, high levels of poverty, and shortages of critical health professionals, have significantly impacted the ability of many rural hospitals to remain financially viable under Medicare prospective payment policies. In fact, one out of every three rural hospitals is losing money, and 66 percent have negative total Medicare margins.

When federal payment calculations were first designed, there were certain factors used to adjust the payment based on the various geographic locations within the country. One of the factors was an adjustment for the wages paid. Later, the government developed a way to differentiate between payments to large urban facilities and all other hospitals. Once these adjustments were put in place, they were never re-evaluated and have penalized states like Alabama for a number of years.

This differential provides hospitals in large urban areas, like Atlanta, with a larger base rate. The base rate is the starting point upon which all of the other factors are based and can make a significant difference in the rates paid to facilities in these areas. Alabama has no facilities that qualify for this additional payment of "large urban." We would argue that there are not enough differences in the cost of running a large urban hospital when compared to all other hospitals to justify this difference in base rate. We believe that all hospitals should begin with the same base rate for payment, especially since there are other factors that reflect differences.

In addition to the base rate, the government uses a formula to factor in the wages of an area. It established a national average to represent hospitals' labor costs as a percentage of total costs. Today, that average is 71 percent. Then, each year, the government assigns each metropolitan statistical area (MSA) a multiplier that is applied to this national average of 71 percent. Rural areas—those outside of MSAs—

are given another multiplier. These multipliers are supposedly based on the wages paid to persons in a given geographic area and fluctuate each year.

For Alabama's hospitals, there are two main problems associated with the wage calculation. The first is that Alabama's average wages as a percent of total costs are actually about 51 percent. Therefore, when the multipliers for hospitals in Alabama are applied to the national average (71 percent), they are actually applied to about 20 percent of non-labor costs. In practical terms, what this means is that Alabama's hospitals get less even though their labor costs may be as high as urban areas.

The other is that in order to get qualified health care professionals, Alabama's hospitals must compete with all areas including out-of-state locations like Nashville and Atlanta. Therefore, the pay scales cannot be that different. Currently, the national range of wage index factors goes from about 70 percent to a high of 144 percent. There's simply no rationale for having that much of a difference in health care salaries for different parts of the country. In fact, many hospitals in Alabama have to offer competitive salaries in order to attract personnel.

For these reasons, I have given my support to H.R. 1609. This bill establishes a "floor" on the area wage index used to adjust Medicare hospital inpatient and outpatient prospective payments. By setting a floor of 0.925 on the area wage index, this proposal would bring Medicare payments in areas with the lowest wage index up to just below the national average, which is set at 1.00.

H.R. 1609 has universal support among state hospital associations. It is also supported by rural hospital administrators—the ones who live with the day-to-day consequences of what we do here. I know that many good ideas have and will be presented today, but what I am asking for you to look at is something practical and that will provide immediate assistance to America's rural hospitals.

Chairman JOHNSON. Mr. Aderholt, before we go on to Mr. Moran, I do just want to point out that in the payer package of the prescription drug bill, we do address this large urban issue. That bill does bring all hospitals up to the same standardized amount as the large urbans depend on. So, it will eliminate a longstanding inequity. With your permission, I would like to recognize Mr. Sandlin next because he has to leave. Is that comfortable with you?

Mr. MORAN. That is fine.

Chairman JOHNSON. Mr. Sandlin?

STATEMENT OF THE HON. MAX SANDLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. SANDLIN. Thank you, and I appreciate the other Member of the panel for letting me go. Thank you, Congresswoman and Madam Chairwoman Johnson for holding this hearing. It is good to see all the Members here, and it is always good to see my good friend and next-door neighbor, Congressman McCrery.

I appreciate the opportunity to testify before you. I have submitted my written testimony for the record and won't be reading that to you, I know you will be disappointed to hear. I just wanted to go through a few of the points.

As you know, as has been testified, the geographic adjustors have resulted in significantly lower Medicare rates in rural America. Approximately 15 hospitals in the 1st Congressional District of Texas are facing low Medicare reimbursement rates. Several of these hospitals compete for health care talent and thus face similar costs with hospitals in Dallas, Texas; Tyler, Texas; and other urban areas. However, they are compensated at a much lower rate by Medicare due to the wage index policy.

Among the hardest hit in my district is the Christus St. Joseph's health system in Paris. Christus St. Joseph's is the sole rural referral center hospital in its 8-county service area in northeast Texas

and southeast Oklahoma. Over 60 percent of Christus's patients are on Medicare, and it is the only hospital with tertiary level services between Oklahoma City and Dallas and between Texarkana and Sherman.

Christus St. Joseph's is located in Lamar County, Texas, and it is only about 20 minutes from the Dallas MSA, and it is similarly close to the Sherman-Denison MSA. Since Christus is a high-skilled facility and because of its proximity to those markets, it competes with hospitals in those urban areas for skilled clinical personnel. As a result, Christus's average hourly wage is considerably higher. It is 105 percent higher than other rural Texas hospitals. Unfortunately, because of the wage index, Christus St. Joseph's is receiving about $7 million less in Medicare reimbursements than similar hospitals in the nearby urban MSA.

As a result, Christus St. Joseph's recently announced that it is losing between $1 million and $1.5 million a month, it is closing one of its two locations, and it is laying off over 200 employees. Unless it is reclassified, it is going to close its state-of-the art heart center, close its rural health clinics, further reduce staff, and reevaluate its involvement in hospice, home health, and other community based programs. In fact, it appears that it is very possible that without that relief St. Joseph's will risk closing altogether.

Other hospitals in my district face similar shortfalls—Longview, Texas; Henderson, Texas; and others spring to mind. The most serious is this particular hospital.

Reclassification must be done on a case-by-case basis, I know it can be time-consuming and costly for these rural hospitals. Urban and suburban hospitals don't have to petition to make sure they get adequate Medicare funding, and neither should the rural hospitals.

While I will continue to help Christus St. Joseph's and other hospitals in my district, I hope this Committee will begin to work on a long-term solution to the wage index inequity. I appreciate Congressman Phil English, who was here a moment ago, for H.R. 1609 that would eliminate the wage index disparity across the country. Those of us in rural areas feel that whether you practice in Paris, Texas, or New York City, that we should have some equity and we should be protected against an inaccurate and unfair formula. Thank you, Madam Chairwoman, for letting me testify today, and I appreciate your letting me go out of order.

[The prepared statement of Mr. Sandlin follows:]

Statement of the Hon. Max Sandlin, a Representative in Congress from the State of Texas

Good afternoon, thank you for the privilege of being here today. Congresswoman Johnson, I also want to commend you for your decision to hold this hearing and to focus attention on this important issue.

When Congress passed the Balanced Budget Act of 1997, the goal was to set up a payment system under which health care providers would be adequately compensated for their marginal costs, while eliminating waste in the Medicare system. The new prospective payment systems were designed to take into account, among other factors, differences in costs based on local market factors. Under Medicare Part A, the factor that is supposed to reflect differences in local wages is known as the wage index.

While I support the intent of these geographic adjusters, in practice, many rural areas are receiving significantly lower Medicare reimbursements that do not necessarily reflect true cost differences. The result can be financial difficulties for rural

doctors, hospitals and other health care providers. Congress must begin to address these inequities so that all health care providers—whether they live in Texarkana, Texas, or New York City—are adequately compensated for the services they provide under Medicare.

In its June 2001, Report to Congress, the Medicare Payment Advisory Commission, more commonly known as MedPAC, also raised concerns about the current use of geographic adjusters—and especially of the wage index. It acknowledged that Congress has taken some steps toward eliminating the unwarranted disparities, but also pointed out some areas where policy changes may be needed.

One of the most pressing problems is that the political boundaries of current MSAs—which determine a hospital's wage index, according to the July 2001 report, "often arbitrarily separate facilities that participate in the same labor market." To some extent Congress has helped to alleviate this problem by establishing a process to enable hospitals to appeal their labor market assignments and request reclassification. However, as you will hear, reclassification has not ended the disparities nor addressed the needs of many rural hospitals.

Approximately 15 hospitals in the 1st Congressional District of Texas face low Medicare reimbursement rates due to the current wage index formula. Several of these hospitals compete for health care talent—and thus face similar labor costs—with hospitals in Dallas, Tyler, and other urban areas, but are compensated at a lower rate due to the current wage index policy. Among the hardest hit is Christus St. Joseph's Health System in Paris, Texas. Christus St. Joseph's is the sole Rural Referral Center hospital in its eight-county service area in Northeast Texas and Southeast Oklahoma. Over 60 percent of Christus' patients are on Medicare—and Christus is the only hospital with tertiary level services between Oklahoma City and Dallas and between Texarkana and Sherman.

Christus St. Joseph's should be the type of hospital that Congress intended to help when we established the opportunity for hospitals to apply for wage index geographic reclassification. Christus is located in Lamar County, Texas, only 30 miles from the Dallas MSA and similarly close to the Sherman-Denison MSA. Because Christus is a high-skilled facility, and because of the geographic proximity to these markets, Christus competes with hospitals in those urban areas for skilled clinical personnel. As a result, Christus' average hourly wage (AHW) is considerably higher—105 percent higher—than other rural Texas hospitals.

Unfortunately, however, while Christus qualified for reclassification in FY 1999 and FY 2001, Christus has not met the strict requirements of the reclassification criteria for FY 2002 and FY 2003. The Medicare Geographic Reclassification Review Board requires that a hospital's wage index be at least 82 percent of the closest MSA. While other MSAs surround Lamar County, Dallas is the closest and Christus' average hourly wage is only 81 percent of hospitals in the Dallas MSA. However, Christus' average hourly rate is 91 percent of hospitals in the Sherman-Denison MSA.

The wage index disparity means that Christus St. Joseph's is receiving over $7 million less in Medicare reimbursements than similar hospitals would in a nearby urban MSA. Recently, Christus St. Joseph's announced that it is losing between $1 million and $1.5 million a month, closing one of its two locations, and laying off over 200 employees. Unless it is reclassified this year, it will have to terminate the state-of-the-art heart center and will likely close altogether.

Christus St. Joseph's CEO recently told me that even with the cutbacks and layoffs, that it will continue to lose money—and all the while it is operating at full capacity and having to turn away patients for a lack of beds. That is just not right.

Even more striking is that the Medicare Geographic Reclassification Review Board has already decided to reclassify Christus St. Joseph's as of October 1, 2003. However, given the amount of money the hospital is losing every month—there is a good possibility that Christus—at least in its current form—may not last that long.

One potential problem with the wage index may be the use of MSAs in determining which wage index level is used to compensate individual hospitals. In fact, in a December 27, 2000, Federal Register announcement the Office of Management and Budget (OMB) cautioned that, "MSA definitions should not be used to develop and implement Federal, state, and local non-statistical programs and policies without full consideration of the effects of using these definitions for such purposes." Further, OMB stated that MSAs " may or may not be suitable for use in program funding formulas. Programs that base funding levels or eligibility on whether a county is included in a MSA may not accurately address issues or problems faced by local populations, organizations, institutions, or government units."

In addition, since the reclassification process must be done on a case-by-case basis, it can be a time-consuming and costly effort for the small, rural hospitals that are affected by the wage index inequity.

The problems with the wage index are not unique to my rural, Northeast Texas district. In fact, there are 195 cosponsors of H.R 1609, legislation introduced by Congressman Phil English which would eliminate the wage index disparity across the country.

In addition, individual Members of Congress have sought to help out hospitals in their districts. The most recent example was the addition of the wage index reclassification provisions to the FY 2002 Supplemental Appropriations bill to help specific counties in New York and Pennsylvania.

While I will continue to help Christus St. Joseph's—and other hospitals in my district that seek geographic reclassification—I hope that Congress will seek to find a long-term solution to this inequity. Health care providers who treat Medicare patients must be adequately compensated for their costs. And rural areas must not be discriminated against by the use of an unfair, inaccurate formula.

Again, thank you for the opportunity to testify here today. I appreciate your interest in this important issue.

Chairman JOHNSON. Thank you very much for your input. We appreciate it. Mr. Peterson?

STATEMENT OF THE HON. JOHN E. PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. JOHN PETERSON. Thank you very much. I want to thank Madam Chairman and the Subcommittee for sitting here and listening to this testimony. I am sure you find it real exciting—a little repetitive, but very important to all of us.

Chairman JOHNSON. It is very important.

Mr. JOHN PETERSON. I have 18 hospitals in the largest rural district east of the Mississippi. I have a 5-bed hospital; the majority of my hospitals are from 30- to 100-bed; I have four 200-bed hospitals. So, I have the gamut of rural hospitals.

For 10 years I chaired the Health Committee in the Pennsylvania Senate and worked closely with all hospitals in Pennsylvania. I am quite familiar with the tertiary down to the small rural hospitals and how they function.

The point I want to make today is that both Medicaid and Medicare treat rural hospitals poorly. In most rural hospitals, between 70 to 88 percent of their volume is government pay. I want to tell you, they do not get paid fairly. It is a very complicated, convoluted payment system, that every bill we pass leaves hospitals in my district with no improvement, no matter how we try to engineer it.

The part, I guess, that has always been puzzling to me is that CMS's most cost-effective provider is rural. Rural providers provide the best buy for health care for CMS. Yet they discriminate against them. If I were running CMS, I would be looking to see how I could provide care in the most cost-effective settings. I wouldn't be trying to put them out of business. When rural hospitals diminish their care or eliminate care, they go to tertiary centers where the system pays a whole lot more. Makes sense? I don't think so.

Doctors, equipment, and high-tech people cost about the same, no matter where you go. I cannot be convinced of anything else. The utilization is less. For a hospital to be a good hospital, you have to have all the diagnostic equipment. You don't use it as many times a day or as many times a week. It is the only business in America or in the free-market world where the highest volume pro-

vider gets the highest payment and the low-volume provider, user gets the lowest payment.

When you go to a local five and dime or local Quick-Fill or whatever convenience store, you pay the highest price. If you go to a supermarket, you pay a more competitive price. If you go to Wal-Mart and buy food, you probably buy the lowest price. Volume discounts. Yet in health care, we pay for the everyday services—I am not talking about the tertiary care—we pay the highest rate to those that provide the most volume and have the big centers. We all know that volume saves cost.

Rural health care has been so historically discriminated against, and it is not the most—it is not over-bedded. In my rural district, we are not over-bedded. In fact, at the edge of my district, into the central part of Pennsylvania, all our major hospitals are on divert almost every weekend. There are not a lot of beds. Now, that is different in the suburban-urban markets.

The other problem we have, that I don't think we have adequately addressed at Congress or at the State level, is we have the skilled workers providing health care in a bidding war. I mean, there is a shortage of every kind of skilled worker that we use providing health care today, so we have a bidding war out there. I don't want to tell you who is losing in that bidding war—is rural.

A wage index would be helpful, but I believe we ought to take MedPAC's view that rural, whether it is long-term care, whether it is home health care, or whether it is small rural hospitals, deserve a 10-percent add-on. That is the fairest way. Now, I don't known what percentage of the volume we are, but in my view, if you want to preserve quality health care in rural America, they need an add-on. They need a fair payment.

I have heard those say that they are making a lot of money. Well, I don't have any hospitals in my district that are making money on operations. There are a few that have had benevolent people who leave them money, that is in trust, and they use that money to make their bottom line positive. The majority of my hospitals do not have a positive bottom line. I just had a hospital, after 5 years of losses, just sold out to a chain. I think it was a mistake, but they sold out. That community now is being provided health care by a national chain.

I have a lot of hospitals that are struggling financially and economically. In rural areas, your hospital is often your economic engine. It is your number one employer. It is the base of your community. We do not get Medicare+Choice. We are not a part of that system. That system pays twice as much for urban as it does for rural. How does that make any sense? So, we don't have Medicare+Choice options. We only have fee-for-service care.

So, I urge you to look at giving rural the 10-percent bump they need to keep them in business. They still will be the most cost-effective part of the delivery system.

[The prepared statement of Mr. John Peterson follows:]

Statement of the Hon. John E. Peterson, a Representative in Congress from the State of Pennsylvania

Madam Chairman, thank you for your gracious invitation allowing me to testify before you and the other distinguished Members of the Subcommittee this afternoon

on an issue which I care so deeply about: bringing fairness to the way in which Medicare treats rural America. It is truly a pleasure to be here today. Thank you.

As you know, I have made a personal commitment over many years toward improving the viability of rural health care in America. As Chairman of the Health Committee in the Pennsylvania Senate for ten years, I began tackling the inefficiencies facing our health care delivery system, as well as identifying and growing the positive attributes. Upon coming to Washington, I made rural health care my top priority. In my view, rural America too often receives inadequate health care when viewed next to their urban/suburban counterparts by way of less reimbursement, less choice, less access, and thus, less quality of care. I thank the Subcommittee for recognizing this inequity by way of holding this hearing today on geographic adjusters.

Other Members of this panel have and will discuss the adjusters impacting our rural physicians, and I would like to particularly praise Mr. Bereuter for his efforts to bridge the payment gap between doctors practicing in rural versus urban areas. In fact, I am a proud original co-sponsor of Mr. Bereuter's legislation to do just that, and will let him and others make our case on that issue. I would like to address the wage index issue and its impact on our rural hospitals.

Madam Chairman, from our many personal conversations on the issue, you know how deeply I care about preserving rural health care providers; as it is so critically linked to preserving the rural way of life. Many times, the local hospital is the largest employer in a rural community—acting as the economic engine and primary tax base. Additionally, a strong, vibrant rural hospital is necessary to attract potential employers to the region so they may be assured that their employees will have access to adequate care. If the local hospital is no longer viable, the entire community will no longer be viable. It is that simple. The disparity in the wage index is a major contributing factor of Medicare's unfair treatment toward rural hospitals, threatening their viability and the economic health of the entire region.

Medicare issues are compounded for rural hospitals because a majority of their patients are elderly. Coupled with above-average Medicaid volumes, most of my hospitals rely on government payers for 60 to 85 percent of their patients. One of these hospitals is Bradford Regional Medical Center in northwest Pennsylvania just a few miles south of the New York border. Approximately 55% of the volume of services they offer are utilized by Medicare-eligible patients with approximately another 20% utilized by Medicaid-eligible patients. Bradford is significantly impacted by Medicare's geographic adjustors. Underlying the notion of geographic adjustors are the assumptions that a differential in wages exists from one geographic area to another, and that those differences can be captured by the MSA's defined by the Office of Management & Budget. These assumptions are problematic for two reasons. First, while those differences may exist for some jobs, they either don't exist or are much less significant for key professional positions such as nursing and pharmacy. And second, the boundaries are arbitrary and frequently don't reflect the relevant job market. The difference in wages between MSA's in any region of the country for key health care personnel such as nurses and pharmacists and highly trained technical staff is rapidly diminishing. Additionally, as an example of the arbitrary nature of the boundaries, Bradford is located only 3 miles from the New York State border and competes actively for key staff with the hospital in Olean, New York. Olean is in the Buffalo MSA and therefore, better compensated in comparison to Bradford. The arbitrary nature of the wage boundaries places many rural hospitals at a competitive disadvantage by no fault of their own.

Madam Chairman, this impact is heightened by the current environment of shortages in health care personnel which are reaching crises proportions,

creating a long-term drain on many organizations. These shortages are having the most severe negative impact on rural hospitals' abilities to recruit and retain staff. The problems with the wage index magnify the dilemma.

However, the wage index is only a part of the problem. Medicare reimbursements also obviously contribute to the financial plight of rural hospitals. In fact, given the complexity of the wage index and the cost associated with fixing it completely, perhaps a more realistic way to help rural hospitals immediately is to provide every single rural hospital in America with a simple, across-the-board rural add-on similar to what has been done for rural home health agencies and inpatient rehab facilities. This ensures that the many rural hospitals who do not fit one of the many special rural classifications do not fall through the cracks, as is happening now. I realize that this is a discussion for another hearing; however, this may be a simple solution until Secretary Thompson and the Centers for Medicare and Medicaid Services are able to fully complete their ongoing review of rural health care and provide recommendations to Congress.

Madam Chairman and Members of the Subcommittee, I thank you again for allowing me the opportunity to share with you my thoughts on an issue so important to rural America, and I look forward to working with you in strengthening rural health care. I applaud your concern and commitment.

Chairman JOHNSON. Thank you, Mr. Peterson. Mr. Moran?

STATEMENT OF THE HON. JERRY MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. MORAN. Madam Chair, thank you very much for inviting, allowing me to testify before your Subcommittee today.

There are significant issues that affect rural America. One of the most significant is the access, availability, and affordability of health care. This issue of geographic disparity greatly affects rural areas in my home State of Kansas, but rural areas across the country. Our doctors, our nurses, hospitals, and other health care providers are struggling to meet the needs of our communities.

Our ability to keep a community together is very much directly related to the availability to access health care. Such a large portion of our population in rural America are seniors, and they will reluctantly move from a town that cannot meet their health care needs. Our ability to attract and retain young families to rural America is dependent upon access to health care by those moms and dads, as well as their children.

So, this issue of access to health care is one that affects the future of every rural community across the country. The Medicare Program represents such a significant portion of providing health care needs in States like mine. I think the number is 17 percent nationally—17 percent of the health care costs are paid by Medicare. In my hospitals in the 1st District of Kansas, 67, 70, 80, even 90 percent of the patients seen by physicians or admitted to our hospitals are on Medicare because of the age of the population. Unfortunately, these Medicare payments have not kept pace with rising costs, and the majority of the hospitals now lose money when caring for Medicare patients.

Since Medicare reimbursements do not meet actual costs, county hospitals are putting pressure on local property taxpayers and Kansas citizens and businesses are subsidizing Medicare's shortfall. Federal payments vary dramatically from State to State and from city to city, from hospital to hospital. Rural residents pay their fair share of Federal Insurance Contributions Act FICA taxes and should have the same access to hospitals and health care as anyone else. Whether we are young or old, sickly or healthy, we all want to know that health care will be available when and where we need it.

As you know, Madam Chairman, I am a co-Chair of the Rural Health Care Coalition. Members of the panel are Members of that group. It is 182 of us House Members, Republicans and Democrats, working together on behalf of access and affordability of health care in rural America. It is our goal to bring these kinds of issues to the attention of our colleagues. Legislation that we see in Congress from time to time overlooks the unique challenges of smaller rural communities.

I would like to specifically thank you for your efforts. Our Rural Health Care Coalition works closely with you and with Chairman Thomas for rural health care providers in the legislation that we passed in Congress, the Medicare Modernization and Prescription Drug Act. The items that you mentioned to Mr. Aderholt, the item that you mentioned is awfully important to us, and we appreciate its inclusion.

The Medicare Prospective Payment System (PPS) does not work for us in rural America. The congressional mandate to create a predictable one-size-fits-all payment system for acute inpatient Medicare patients in the early eighties was based upon lots of assumptions that have proven to be inaccurate.

A basic assumption was that if Medicare paid every hospital the same amount for the same procedure, based upon Diagnosis Related Groups (DRG), and then adjust those payments based upon geographic and labor variances, part A of the trust fund would remain solvent well into the future. As promising as the prospective payment seemed to be to policy makers early on, it soon became apparent that the one-size-fits-all solution approach was not working. As a result, a plethora of payment fixes have been proposed and passed, particularly to address the inadequacies of the PPS for rural hospitals.

We have sole community provider hospitals, we have Medicare-dependent hospitals, Medicare geographically reclassified hospitals, critical access hospitals, and each of these fixes has the goal to remove certain hospitals from PPS because of the problems of the wage index and geographic classification.

I have to admit that I have joined in that effort and introduced legislation, H.R. 4514, the Rural Community Hospital Assistance Act, which would expand the critical access hospitals to have additional service covered under cost-based reimbursement, and to allow for a new category of hospitals for those hospitals that have 50 beds or less to qualify, similar to what critical access hospitals do. So, each of us try to put a Band-Aid upon what is a very large wound with PPS.

Although the payment fixes that we have talked about, that I mentioned, have helped, those rural hospitals are still struggling. There are 70 hospitals—I think I have a congressional district that has more hospitals than any congressional district in the country. We have more than 70. While these classifications are constantly changing, we have 14 critical access hospitals, 17 Medicare-dependent hospitals, 25 sole community hospitals, 2 geographically reclassified hospitals, and 14 rural hospitals.

There are no urban hospitals in the district. Eight percent of the hospitals in the district qualify for some form of a payment fix. However, of the 70 hospitals in the district, only 24 were able to break even or make a small profit treating Medicare patients. Even under reasonable cost-based reimbursement, half the critical access hospitals are operating in the negative Medicare margins, and only two of my rural hospitals are operating with positive Medicare margins.

Changes to the standardized base payment and wage index are needed to help rural communities to recruit and retain health care professionals. The base payment standardized amount set by the

government was designed to recognize distinctions in operating costs between rural and urban areas. The assumptions that led government to develop these different payments to rural and urban hospital areas are no longer valid. Given the shortage of nurses, physicians, and other skilled hospital labor, rural areas struggle to compete with their urban counterparts in the current labor market. In addition, the assumption that it costs less to perform medical procedures, less to purchase durable medical equipment, and less to administer small rural hospitals is erroneous.

Again, we would like to thank you for that standardized base payment that was a significant step in our efforts to make things better in rural America, and look forward to working with you to see that that bill ultimately becomes law.

In regard to labor areas, the original concept of a labor market was probably fairly adequate in the early eighties, but they don't reflect the reality of 2002. Due to decreased supply of skilled health care workers, hospitals are expanding their labor market by up to 150 miles routinely. You can't pick up a newspaper in any rural community without seeing an ad for which they are seeking health care professionals. What is surprising is they are advertising in papers 150, 200 miles away, trying to find that nurse, trying to find that skilled health care professional. This has caused a significant shift in what local areas now have to pay for workers. Rural hospitals now have to compete in both wages and benefits with their urban counterparts or they risk losing their employees.

I look forward to working with you on this difficult but very important issue. I think the access and affordability of health care is the number one domestic issue we face as policy makers. Thank you.

[The prepared statement of Mr. Moran follows:]

Statement of the Hon. Jerry Moran, a Representative in Congress from the State of Kansas

Madam Chairman, thank you for inviting me to testify before the House Ways and Means Subcommittee on Health, regarding geographic inequities in the Medicare program.

The issue of geographic disparity greatly affects rural areas in my home state of Kansas. Our doctors, nurses, hospitals and other health care providers are struggling to meet the needs of our communities. Hospitals and health care providers are not only important for our quality of life, but are also essential for the survival of our communities. Our seniors, as well as our younger families, will not be able to remain in communities that lack adequate health care services.

The Medicare program represents a significant portion of funding for health care in our state. 80% of patients visiting hospitals in my district depend on Medicare. Unfortunately, Medicare payments have not kept pace with rising costs and the majority of hospitals now lose money when caring for Medicare patients. Since Medicare reimbursements do not meet actual costs, county hospitals are putting pressure on local property taxes, and Kansas' citizens and businesses are subsidizing Medicare's shortfall.

Federal payments vary dramatically from state to state, and city to city. Rural areas, like Kansas, continue to receive lower reimbursements than other parts of the country. Rural residents pay their fair share of taxes and should have the same access to hospitals and health care as anyone else. Whether we are young or old, sick or healthy, we all want to know that health care will be available when we need it.

As Chairman of the Rural Health Care Coalition, a group of 182 House members working together on behalf of health care in rural America, my goal is to bring this issue to the attention of my urban colleagues. Legislation too often is directed toward large hospitals and metropolitan areas, while overlooking the unique challenges of smaller, rural communities. I would like to thank Chairwoman Johnson

for her recent efforts to provide help for our rural hospitals and other health care providers in the Medicare reform legislation that passed the House last month.

Medicare's Prospective Payment System

The Medicare Prospective Payment system does not work in rural areas. The Congressional mandate to create a predictable, one-size-fits-all, payment system for acute, inpatient Medicare patients in the early 1980's was based upon a lot of assumptions that have proven over time to be inaccurate. Those assumptions were that if Medicare paid every hospital the same amount for the same procedures, based upon Diagnostic Related Groups (DRG's), and adjust those payments based upon geographic and labor variances the Part A Trust Fund would remain solvent well into the future. And while this concept was simplistic in design, it soon became apparent that the "Devil was in the details."

Payment Adjustments

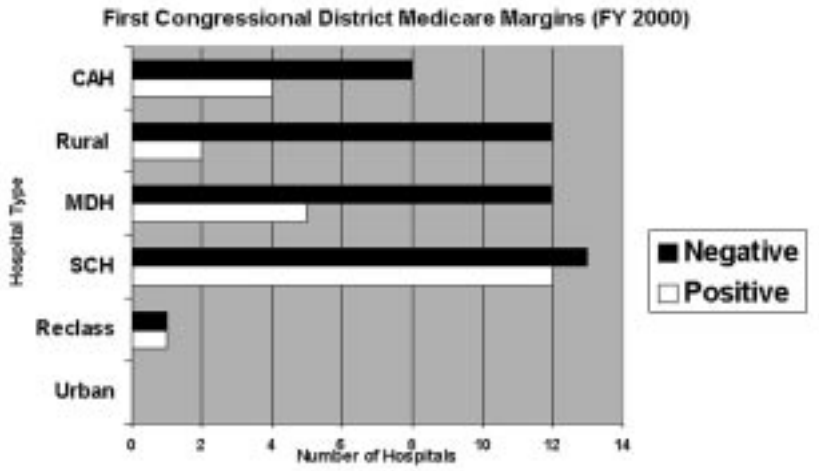
Geographic Adjustment: The first payment adjustment was to differentiate hospitals based upon where they were located geographically. According to Section 1886(d)(3)(E) of the Act, the Secretary of HHS must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." In accordance with this broad directive, the Secretary divided the country into payment areas based upon Metropolitan Statistical Areas (MSA's), Primary MSA's (PMSA's), New England County Metropolitan Areas (NECMA's), Consolidated MSA's (CMSA's) and statewide rural areas. MSA's were further subdivided into large urban MSA's and small urban MSA's. PMSA's, NECMA's and CMSA's were included after the inception of the PPS system when data showed that MSA's alone did not adequately differentiate variances in labor markets—in other words—it didn't work as designed originally.

Wage Index Adjustment: In 1993, Section 1886(d)(3)(E) of the Act was further amended requiring the Secretary to "update the wage index annually based upon a survey of wages and wage-related costs of short-term, acute care hospitals." This gave birth to Worksheet S093 of the Medicare Cost Report. The instructions for the completion of this worksheet from HCFA (CMS) to their intermediaries and providers could best be described as vague, contradictory and confusing from the beginning. Again it was believed that labor markets would routinely behave homogeneously within each labor area as previously designed.

Payment Fixes—Hospital Re-Classifications: As promising as the Prospective Payment System seemed to policy makers early on, it soon became apparent that the one-size-fits-all approach was not working. As a result a plethora of payment "fixes" have been proposed and passed, particularly to address the inadequacies of PPS for rural hospitals. Among those are Sole Community Hospitals, Medicare Dependent Hospitals, Medicare Geographically Reclassified Hospitals and Critical Access Hospitals. Each of these "fixes" has as its goal to remove certain hospitals from the Prospective Payment System because of problems with the wage index and geographic classification.

First Congressional District Hospitals

Although these payment fixes to the Prospective Payment System have helped, our rural hospitals are still struggling. There are 70 hospitals located with the First Congressional District of Kansas. While the specific classifications are constantly changing, as of the close of FY 2000, there were 14 Critical Access Hospitals; 17 Medicare Dependent Hospitals; 25 Sole Community Hospitals; 2 Geographically Reclassified Hospitals, and 14 rural hospitals. There are no urban hospitals in the district. Eighty percent of the hospitals in the district qualify for some form of payment fix. However, of the 70 hospitals in the District only 24 were able either break even or make a small profit treating Medicare patients. Even under reasonable cost-based reimbursement, half the Critical Access Hospitals in my district are operating in negative Medicare margins and only two of my rural hospitals are operating in positive Medicare margins.



For these reasons, I introduced HR 4515, the Rural Community Hospital Assistance Act. This bill would provide enhanced cost-based reimbursement for critical access hospitals and extend such reimbursement to post-acute care services. It would also provide an option for rural hospitals with less than 50 inpatient beds to receive enhanced cost-based reimbursement for inpatient, outpatient and select post-acute care services. An alternative payment structure based on a reasonable cost-based reimbursement system is necessary to ensure that the survival of these essential providers of care and to ensure that Medicare beneficiaries located in small rural areas continue to receive access to quality health care services.

Standardized Payment and Wage Index Problems

Changes with the standardized base payment and wage index are also needed to help rural communities to recruit and retain health care professionals.

Standardized Payment: The base payment or "standardized amount" set by the government was designed to recognize distinctions in operating costs between urban and rural areas. However, the assumptions that led the government to develop different payments to urban and rural areas are no longer valid. Given the shortage of nurses, physicians, and other skilled hospital labor, rural areas struggle to compete with their urban counterparts in the current labor market. In addition, the assumption that it costs less to perform medical procedures, less to purchase durable medical equipment, and less to administer small rural hospitals is erroneous.

I would like to thank Chairwoman Johnson for working with the Rural Health Care Coalition to include a provision to standardize the base payments between rural and urban hospitals in the Medicare reform bill that passed the House last month.

HR 4954, the Medicare Modernization and Prescription Drug Act, would standardize hospital base payments in two years.

Wage Index Survey: There remains considerable variance in the data supplied to CMS for the compilation of the wage index between Medicare Fiscal Intermediaries (FI's). For instance, hospitals in Kansas that use Mutual of Omaha as their FI versus Kansas Blue Cross are subject to different audits and allowances of the basically the same data. Further, the data CMS uses for the calculation of the wage index is four (4) years old. For this upcoming fiscal year (FY 2003), data from the FY 1999 Medicare Cost Report is used. This time frame cannot possible reflect changes in costs or availability of labor.

Relevance of Labor Areas: The original concept of labor market areas was probably fairly adequate in the early 1980's but they do not reflect reality in 2002. Due to the decreased supply of skilled health care workers, hospitals are expanding their labor markets by up to 150 miles routinely, often offering to house workers for a workweek. This has caused a significant shift in what local areas now have to pay for workers. Rural hospitals now have to compete in both wages and benefits with their urban counterparts or risk losing their employees to them.

I look forward to continuing to work with you to improve the access to affordable health care in rural communities. Again, thank you for the opportunity to testimony on this important issue.

Chairman JOHNSON. Thank you very much, Mr. Moran. I really do appreciate the thoughtful input of so many Members. I also want to put on the record that Congressman Doug Bereuter, who has been very active in writing the Committee on this subject, and particularly on the subject of physician reimbursement, had hoped to testify today, but has responsibilities on the Intelligence Committee that could not be delayed. So, we will welcome his testimony in the record as well. Thank you very much for your comments.

[The statement of Mr. Bereuter follows:]

Statement of the Hon. Doug Bereuter, a Representative in Congress from the State of Nebraska

Madam Chairman, thank you for inviting me to testify before the House Ways and Means Subcommittee on Health, regarding geographic inequities which currently exist in the Medicare program. I deeply regret that I am not able to accept the invitation, as I am one of the two bipartisan designated questioners for the Joint Intelligence Committee's Joint Inquiry and the Member briefed and relevantly experienced to perform that role. My commitment and the Inquiry's agenda cannot be changed.

I am very disappointed that I am unable to express my views in-person by testifying at this hearing, as I have been actively pursuing a geographic disparity issue which has a great impact on my home state of Nebraska. I would like to bring two issues to your attention: (1) the geographic adjustment factor as applied to the physician work component of the Medicare physician fee schedule; and (2) the hospital wage index.

1. Physician Work Component of the Medicare Physician Fee Schedule

It has come to my attention that the formula used by the Medicare Program to reimburse health care providers for beneficiaries' medical care is not accurately measuring the cost of providing services, and is reimbursing physicians and other health care providers in a manner that favors urban providers over rural providers.

While the Medicare, Medicaid, and S09CHIP Benefits Improvement Act of 2000 (BIPA) specifically addressed inadequate payment for Medicare+Choice organizations and took steps to stabilize and improve rural hospital payments, nothing substantive in the legislation addressed the underlying issues of inadequate reimbursement of the costs of providing physician services under Medicare part B.

As you are aware, payments for physicians' services under Medicare are made on the basis of a fee schedule. The fee schedule has three components:

- the relative value for the service;
- a geographic adjustment; and
- a national dollar conversion factor.

The relative value for a service compares the relative physician work involved in performing one service with the work involved in providing other physician's services. It also reflects average practice expenses and malpractice expenses associated with the particular service.

Each of the 7,500 physician service codes is assigned its own relative value. The relative value for each service is the sum of three components:

- physician work, which measures physician time, skill, and intensity in providing a service;
- practice expense, which measures average practice expenses such as office rents and employee wages; and
- malpractice expense, which reflects average insurance costs.

Geographic adjustments (Geographic Practice Cost Indicies or GPCIs) for each Medicare locality are then applied to each of the three components of the relative value unit.

I am concerned that the current physician work GPCIs discriminate against rural areas. I recognize that when Congress created the physician fee schedule, it required that the amount of the adjuster for the value of physicians' work be reduced by 25 percent of its nominal value. This was a specific attempt by Congress to en-

courage rural physician practice. Ironically, the opposite has happened. There is, for example, a demonstrated shortage of physicians in non-metropolitan areas, as evidenced by the designation of Health Professional Shortage Areas (HPSAs) and it is still quite difficult to recruit and retain physicians in these rural areas. According to the March, 2002, *CMS Communiqué*; Nebraska currently has a total of 34 full HPSAs and 14 partial HPSAs.

Additionally, some physicians in my congressional district are working through their lunch hours as a result of physician shortages. In order to see as many patients as possible, Dr. Gerald Luckey, a family physician in David City, Nebraska, is working long hours (130914 hours per day) and skipping meals to accommodate the health needs of the community. In fact, he spends his vacation time conducting nursing home rounds and doing necessary paperwork. Clearly, it is evident that the incentives currently used by the Medicare Program to encourage physicians to practice in rural areas are not adequately addressing the health care professional shortages we currently experience.

The current Medicare physician fee schedule discounts the relative value of physician work in localities where physicians are becoming scarce. It seems apparent that relatively low payments in areas where physicians, and the nurses and non-physician practitioners they employ, are in scant supply is bad public policy. Rural communities must compete in a national market to recruit and retain physicians. Thus, sound public policy should provide rural communities with equal access to successfully recruit and retain these vital professionals.

According to the Centers for Medicare and Medicaid Services, "physician work" is the amount of time, intensity, and skill, a physician provides in a patient visit. Physicians and other health care providers in rural areas provide equal time, intensity, skill, and clinical reasoning during a patient visit as do physicians in urban areas. Thus, geographic adjustment of quantifiable work challenges common sense. Physician work should be valued equally, irrespective of where a physician delivers work.

In addition to this fundamental injustice devaluing the clinical decisions of physicians in rural areas, I also find the justification for the methodology of calculating the geographic adjustment applied to the physician work component to be obscure. For example, current geographic adjustment is based on hourly earnings of non-physician, college-educated professionals, such as engineers, natural scientists, and teachers. I am not aware of any data suggesting that this earning distribution mirrors that of physicians.

Medicare payments to rural physicians and other health care providers are less than what their equivalent counterparts are paid in more densely populated areas even though it has been indicated that it costs as much and sometimes even more to provide medical services in rural areas. As a result of this regional inequity and existing physician shortages, I introduced the Rural Equity Payment Index Reform Act (REPaIR, H.R. 3569), which would phase-in a floor of 1.000 for the Medicare "physician work adjuster," thereby raising all localities with a work adjuster below 1.000 to that level. This is a bipartisan bill, which currently has 60 bipartisan cosponsors.

Since it is probably not politically feasible to lower the work adjuster levels of health care providers in urban areas to correct this inequity, this proposed change would be put in place without regard to the budget neutrality agreement in the present law. Thus, Congress would need to change the law in order to authorize an increase to establish a floor of 1.000 to all parts of the nation. The phase-in approach attempts to soften the budgetary ramifications by spreading it over several years. The legislation that I proposed will at least begin to reduce the current inequity in payments.

I am enclosing two spreadsheets for your review. The first spreadsheet illustrates the impact of H.R. 3569 on each of the Medicare localities. The second spreadsheet demonstrates the impact of a compromise agreement, which was included in the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954), which passed in the House on June 28, 2002, with my support. The compromise agreement would establish a floor of 0.985 for the physician work adjuster in 2004 only, thereby raising all localities with a work adjuster below 0.985 to that level. This change would be dependent upon the outcome of a General Accounting Office study and secretarial discretion. The Secretary of the Department of Health and Human Services would determine, after taking into account the GAO report, if there is "a sound economic rationale for the implementation" of such a change. If so, the new floor would go into effect. The change would thereby allow 36 Medicare localities across the country, including this my home state of Nebraska, to receive a higher reimbursement rate without harming other localities. This language is a modified version of H.R. 3569.

2. Hospital Wage Index

On a related note, I have visited a number of hospitals, and at every one, hospital administrators and hospital staff have urged me to do something about the wage index. At each hospital, staff has illustrated for me the amount of money the hospital loses each year as a result of this unfair formula. Time after time it has been cited as one of the key issues for Nebraska's hospitals, as well as the Nebraska Hospital Association.

A complicated and mostly arbitrary formula, the wage index is part of the hospital Perspective Payment System (PPS) which was created in the early nineties in an effort to cut Medicare spending. It established a base rate for Medicare reimbursement based on two components: labor and non-labor related costs. While non-labor related costs are similar nationwide, labor-related costs must be adjusted to account for the regional differences in wage costs. This adjustment is made according to a wage index.

Rural hospitals, although providing quality, efficient patient care, consistently have the lowest Medicare margins. Nebraska's non critical-access rural hospitals' total margins have declined five straight years.

Small rural hospitals simply do not have the financial resources to compete with neighboring rural referral centers or urban hospitals for nurses and other hospital staff. The wage index is applied to approximately 72 percent of Medicare payment, which is based on national cost data. The percentage of labor cost to total cost can be lower than 72 percent in rural hospitals; therefore, the wage index is applied to too high of a percentage of Medicare cost, which again penalizes rural hospitals.

To cope with the growing gap between Medicare reimbursements and actual costs, hospitals must transfer this deficit to the private sector. Therefore, due to flaws in the wage index calculation, Nebraska citizens and businesses have historically subsidized Medicare's failure to pay equitably. County hospitals are causing taxes to be raised, and all hospitals are forced to raise charges.

This situation threatens the very future of Nebraska hospitals, which employ more than 30,000 workers and spend more than $2 billion on salaries and operations each year. Initiatives such as offering alternative health plans to Medicare beneficiaries and adding a prescription drug benefit do little to enhance the overall Medicare situation in Nebraska. Because of Nebraska's low payment rates, Medicare+Choice managed care plans are virtually nonexistent in the state; increasing payments to insurance companies will not make such plans available in Nebraska. Only a change in the payment formula, ultimately bringing equity to Nebraska and other poorly reimbursed states, can create the financial incentive necessary for these plans to exist in Nebraska.

Nebraska hospitals depend on Medicare, and so do Nebraskans. Nearly half of all rural hospital revenue comes from Medicare payments, and more than 230,000 Nebraskans are eligible for Medicare. The number of those eligible will only continue to grow as the baby boomer generation ages.

Again, thank you for the opportunity to submit testimony on these very important health care issues.

Medicare Payment Locality	2004 Floor = 0.985					
	Work GPC	Work Payment 2001 CMS Data	Work GPCI	Work Payment	% Increase	Net Payment Increase From Base
Alabama	0.978	$490,817,777	0.985	$494,330,788	0.716%	$3,513,011
Alaska	1.064	$20,987,417	1.064	$20,987,417	0.000%	$0
Arizona	0.994	$358,157,589	0.994	$358,157,589	0.000%	$0
Arkansas	0.953	$280,059,972	0.985	$289,463,875	3.358%	$9,403,903
California.						
26 Anaheim/ Santa Ana, CA	1.037	$184,923,615	1.037	$184,923,615	0.000%	$0
18 Los Angeles, CA	1.056	$785,520,296	1.056	$785,520,296	0.000%	$0
03 Marin/Napa/ Solano, CA	1.015	$37,183,815	1.015	$37,183,815	0.000%	$0
07 Oakland/ Berkeley, CA	1.041	$107,656,658	1.041	$107,656,658	0.000%	$0
05 San Francisco, CA	1.068	$69,297,111	1.068	$69,297,111	0.000%	$0

Medicare Payment Locality	Work GPC	2004 Floor = 0.985 Work Payment 2001 CMS Data	Work GPCI	Work Payment	% Increase	Net Payment Increase From Base
06 San Mateo, CA	1.048	$34,742,869	1.048	$34,742,869	0.000%	$0
09 Santa Clara, CA	1.063	$80,663,146	1.063	$80,663,146	0.000%	$0
17 Ventura, CA	1.028	$47,653,454	1.028	$47,653,454	0.000%	$0
99 Rest of California*	1.007	$863,291,754	1.007	$863,291,754	0.000%	$0
Colorado	0.985	$213,737,613	0.985	$213,737,613	0.000%	$0
Connecticut	1.050	$344,474,114	1.050	$344,474,114	0.000%	$0
Delaware	1.019	$92,557,169	1.019	$92,557,169	0.000%	$0
DC + MD/VA Suburbs	1.050	$310,834,805	1.050	$310,834,805	0.000%	$0
Florida.						
03 Fort Lauderdale, FL	0.996	$640,346,767	0.996	$640,346,767	0.000%	$0
04 Miami, FL	1.015	$294,157,698	1.015	$294,157,698	0.000%	$0
99 Rest of Florida	0.975	$1,306,673,956	0.985	$1,320,075,740	1.026%	$13,401,784
Georgia.						
01 Atlanta	1.006	$248,889,978	1.006	$248,889,978	0.000%	$0
99 Rest of Georgia	0.970	$418,862,789	0.985	$425,340,049	1.546%	$6,477,260
Hawaii/Guam	0.997	$76,743,547	0.997	$76,743,547	0.000%	$0
Idaho	0.960	$81,615,001	0.985	$83,740,392	2.604%	$2,125,391
Illinois.						
16 Chicago, IL	1.028	$509,665,467	1.028	$509,665,467	0.000%	$0
12 East St. Louis, IL	0.988	$50,593,569	0.988	$50,593,569	0.000%	$0
15 Suburban Chicago, IL	1.006	$164,367,363	1.006	$164,367,363	0.000%	$0
99 Rest of Illinois	0.964	$349,128,505	0.985	$356,734,001	2.178%	$7,605,496
Indiana	0.981	$592,510,463	0.985	$594,926,408	0.408%	$2,415,945
Iowa	0.959	$344,790,897	0.985	$354,138,721	2.711%	$9,347,824
Kansas*	0.963	$242,175,916	0.985	$247,708,491	2.285%	$5,532,575
Kentucky	0.970	$428,227,400	0.985	$434,849,473	1.546%	$6,622,073
Louisiana.						
01 New Orleans, LA	0.998	$108,863,072	0.998	$108,863,072	0.000%	$0
99 Rest of Louisiana	0.968	$316,136,675	0.985	$321,688,662	1.756%	$5,551,987
Maine.						
03 Southern Maine	0.979	$55,969,778	0.985	$56,312,800	0.613%	$343,022
99 Rest of Maine	0.961	$80,532,703	0.985	$82,543,926	2.497%	$2,011,223
Maryland.						
01 Baltimore/ Surr. Cntys, MD	1.021	$270,041,065	1.021	$270,041,065	0.000%	$0
99 Rest of Maryland	0.984	$109,968,412	0.985	$110,080,169	0.102%	$111,757
Massachusetts.						
01 Metropolitan Boston	1.041	$321,095,572	1.041	$321,095,572	0.000%	$0
99 Rest of Massachusetts	1.010	$313,421,317	1.010	$313,421,317	0.000%	$0
Michigan.						
01 Detroit, MI	1.043	$594,767,786	1.043	$594,767,786	0.000%	$0
99 Rest of Michigan	0.997	$524,342,991	0.997	$524,342,991	0.000%	$0
Minnesota	0.990	$350,744,499	0.990	$350,744,499	0.000%	$0

Medicare Payment Locality	2004 Floor = 0.985					
	Work GPC	Work Payment 2001 CMS Data	Work GPCI	Work Payment	% Increase	Net Payment Increase From Base
Mississippi	0.957	$278,777,323	0.985	$286,933,817	2.926%	$8,156,494
Missouri.						
02 Metropolitan Kansas City, MO	0.988	$100,323,973	0.988	$100,323,973	0.000%	$0
01 Metropolitan St. Louis, MO	0.994	$195,771,938	0.994	$195,771,938	0.000%	$0
99 Rest of Missouri*	0.946	$255,934,246	0.985	$266,485,446	4.123%	$10,551,200
Montana	0.950	$78,311,124	0.985	$81,196,271	3.684%	$2,885,147
Nebraska	0.948	$159,489,529	0.985	$165,714,331	3.903%	$6,224,802
Nevada	1.005	$137,828,181	1.005	$137,828,181	0.000%	$0
New Hampshire	0.986	$106,363,444	0.986	$106,363,444	0.000%	$0
New Jersey.						
01 Northern NJ	1.058	$669,989,716	1.058	$669,989,716	0.000%	$0
99 Rest of New Jersey	1.029	$406,179,441	1.029	$406,179,441	0.000%	$0
New Mexico	0.973	$103,305,844	0.985	$104,579,914	1.233%	$1,274,070
New York.						
01 Manhattan, NY	1.094	$360,963,758	1.094	$360,963,758	0.000%	$0
02 NYC Suburbs/Long I, NY	1.068	$920,258,886	1.068	$920,258,886	0.000%	$0
03 Poughkpsie/N NYC Suburbs, NY	1.011	$104,839,656	1.011	$104,839,656	0.000%	$0
04 Queens, NY	1.058	$149,267,348	1.058	$149,267,348	0.000%	$0
99 Rest of New York	0.998	$581,393,070	0.998	$581,393,070	0.000%	$0
North Carolina	0.970	$807,383,158	0.985	$819,868,465	1.546%	$12,485,307
North Dakota	0.950	$67,915,157	0.985	$70,417,294	3.684%	$2,502,137
Ohio	0.988	$1,112,061,200	0.988	$1,112,061,200	0.000%	$0
Oklahoma	0.968	$310,754,921	0.985	$316,212,394	1.756%	$5,457,473
Oregon.						
01 Portland, OR	0.996	$55,833,828	0.996	$55,833,828	0.000%	$0
99 Rest of Oregon	0.961	$118,667,883	0.985	$121,631,493	2.497%	$2,963,610
Pennsylvania.						
01 Metropolitan Philadelphia	1.023	$416,204,339	1.023	$416,204,339	0.000%	$0
99 Rest of Pennsylvania	0.989	$948,618,029	0.989	$948,618,029	0.000%	$0
Puerto Rico	0.881	$306,581,596	0.985	$342,772,840	11.805%	$36,191,244
Rhode Island	1.017	$90,906,095	1.017	$90,906,095	0.000%	$0
South Carolina	0.974	$409,802,472	0.985	$414,430,631	1.129%	$4,628,159
South Dakota	0.935	$78,565,176	0.985	$82,766,522	5.348%	$4,201,346
Tennessee	0.975	$656,184,654	0.985	$662,914,753	1.026%	$6,730,099
Texas.						
31 Austin, TX	0.986	$65,731,707	0.986	$65,731,707	0.000%	$0
20 Beaumont, TX	0.992	$42,378,361	0.992	$42,378,361	0.000%	$0
09 Brazoria, TX	0.992	$8,267,256	0.992	$8,267,256	0.000%	$0
11 Dallas, TX	1.010	$183,407,037	1.010	$183,407,037	0.000%	$0
28 Fort Worth, TX	0.987	$78,152,298	0.987	$78,152,298	0.000%	$0
15 Galveston, TX	0.988	$14,234,587	0.988	$14,234,587	0.000%	$0
18 Houston, TX	1.020	$333,251,087	1.020	$333,251,087	0.000%	$0
99 Rest of Texas	0.966	$963,274,096	0.985	$982,220,481	1.967%	$18,946,385
Utah	0.976	$126,223,102	0.985	$127,387,045	0.922%	$1,163,943
Vermont	0.973	$52,502,348	0.985	$53,149,859	1.233%	$647,511

Medicare Payment Locality	Work GPC	2004 Floor = 0.985 Work Payment 2001 CMS Data	Work GPCI	Work Payment	% Increase	Net Payment Increase From Base
Virgin Islands ..	0.965	$2,474,182	0.985	$2,525,460	2.073%	$51,278
Virginia	0.984	$532,672,197	0.985	$533,213,531	0.102%	$541,334
Washington.						
02 Seattle (King Cnty), WA	1.005	$117,755,518	1.005	$117,755,518	0.000%	$0
99 Rest of Washington ...	0.981	$256,949,210	0.985	$257,996,913	0.408%	$1,047,703
West Virginia ...	0.963	$214,946,053	0.985	$219,856,555	2.285%	$4,910,502
Wisconsin	0.981	$461,845,879	0.985	$463,729,043	0.408%	$1,883,164
Wyoming	0.967	$34,746,922	0.985	$35,393,711	1.861%	$646,789
TOTAL EXPENDITURE		$26,594,480,185		$26,803,033,132	0.784%	
INCREASE FROM PREVIOUS YEAR		$0		$208,552,947		

*Payment locality is serviced by two carriers

Medicare Payment Locality	Work GPC	Work Payment 2001 CMS Data	YEAR 1 Floor = 0.976			YEAR 2 Floor = 0.987			YEAR 3 Floor = 0.995			YEAR 4 Floor = 1.000			Net Payment Increase From Base to Year 4
			Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	
Alabama	0.978	$490,817,777	0.978	$490,817,777	0.000%	0.987	$495,334,505	0.920%	0.995	$499,349,374	0.811%	1.000	$501,858,668	0.503%	$11,040,891
Alaska	1.064	$20,987,417	1.064	$20,987,417	0.000%	1.064	$20,987,417	0.000%	1.064	$20,987,417	0.000%	1.064	$20,987,417	0.000%	$0
Arizona	0.994	$358,157,589	0.994	$358,157,589	0.000%	0.994	$358,157,589	0.000%	0.995	$358,517,909	0.101%	1.000	$360,319,506	0.503%	$2,161,917
Arkansas	0.953	$280,059,972	0.976	$286,819,027	2.413%	0.987	$290,051,618	1.127%	0.995	$292,402,594	0.811%	1.000	$293,871,954	0.503%	$13,811,982
California															
26 Anaheim/Santa Ana, CA	1.037	$184,923,615	1.037	$184,923,615	0.000%	1.037	$184,923,615	0.000%	1.037	$184,923,615	0.000%	1.037	$184,923,615	0.000%	$0
18 Los Angeles, CA	1.056	$785,520,296	1.056	$785,520,296	0.000%	1.056	$785,520,296	0.000%	1.056	$785,520,296	0.000%	1.056	$785,520,296	0.000%	$0
03 Marin/Napa/Solano, CA	1.015	$37,183,815	1.015	$37,183,815	0.000%	1.015	$37,183,815	0.000%	1.015	$37,183,815	0.000%	1.015	$37,183,815	0.000%	$0
07 Oakland/Berkeley, CA	1.041	$107,656,658	1.041	$107,656,658	0.000%	1.041	$107,656,658	0.000%	1.041	$107,656,658	0.000%	1.041	$107,656,658	0.000%	$0
05 San Francisco, CA	1.068	$69,297,111	1.068	$69,297,111	0.000%	1.068	$69,297,111	0.000%	1.068	$69,297,111	0.000%	1.068	$69,297,111	0.000%	$0
06 San Mateo, CA	1.048	$34,742,869	1.048	$34,742,869	0.000%	1.048	$34,742,869	0.000%	1.048	$34,742,869	0.000%	1.048	$34,742,869	0.000%	$0
09 Santa Clara, CA	1.063	$80,663,146	1.063	$80,663,146	0.000%	1.063	$80,663,146	0.000%	1.063	$80,663,146	0.000%	1.063	$80,663,146	0.000%	$0
17 Ventura, CA	1.028	$47,653,454	1.028	$47,653,454	0.000%	1.028	$47,653,454	0.000%	1.028	$47,653,454	0.000%	1.028	$47,653,454	0.000%	$0
99 Rest of California*	1.007	$863,291,754	1.007	$863,291,754	0.000%	1.007	$863,291,754	0.000%	1.007	$863,291,754	0.000%	1.007	$863,291,754	0.000%	$0
Colorado	0.985	$213,737,613	0.985	$213,737,613	0.000%	0.987	$214,171,598	0.203%	0.995	$215,907,538	0.811%	1.000	$216,992,501	0.503%	$3,254,888
Connecticut	1.050	$344,474,114	1.050	$344,474,114	0.000%	1.050	$344,474,114	0.000%	1.050	$344,474,114	0.000%	1.050	$344,474,114	0.000%	$0
Delaware	1.019	$92,557,169	1.019	$92,557,169	0.000%	1.019	$92,557,169	0.000%	1.019	$92,557,169	0.000%	1.019	$92,557,169	0.000%	$0
DC + MD/VA Suburbs	1.050	$310,834,805	1.050	$310,834,805	0.000%	1.050	$310,834,805	0.000%	1.050	$310,834,805	0.000%	1.050	$310,834,805	0.000%	$0
Florida															
03 Fort Lauderdale, FL	0.996	$640,346,767	0.996	$640,346,767	0.000%	0.996	$640,346,767	0.000%	0.996	$640,346,767	0.000%	1.000	$642,918,441	0.402%	$2,571,674
04 Miami, FL	1.015	$294,157,698	1.015	$294,157,698	0.000%	1.015	$294,157,698	0.000%	1.015	$294,157,698	0.000%	1.015	$294,157,698	0.000%	$0
99 Rest of Florida	0.975	$1,306,673,956	0.976	$1,308,014,134	0.103%	0.987	$1,322,756,097	1.127%	0.995	$1,333,477,524	0.811%	1.000	$1,340,178,416	0.503%	$33,504,460
Georgia															
01 Atlanta	1.006	$248,889,978	1.006	$248,889,978	0.000%	1.006	$248,889,978	0.000%	1.006	$248,889,978	0.000%	1.006	$248,889,978	0.000%	$0
99 Rest of Georgia	0.970	$418,862,789	0.976	$421,453,693	0.619%	0.987	$426,203,683	1.127%	0.995	$429,658,222	0.811%	1.000	$431,817,308	0.503%	$12,954,519
Hawaii/Guam	0.997	$76,743,547	0.997	$76,743,547	0.000%	0.997	$76,743,547	0.000%	0.997	$76,743,547	0.000%	1.000	$76,974,470	0.301%	$230,923
Idaho	0.960	$81,615,001	0.976	$82,975,251	1.667%	0.987	$83,910,423	1.127%	0.995	$84,590,548	0.811%	1.000	$85,015,626	0.503%	$3,400,625
Illinois															
16 Chicago, IL	1.028	$509,665,467	1.028	$509,665,467	0.000%	1.028	$509,665,467	0.000%	1.028	$509,665,467	0.000%	1.028	$509,665,467	0.000%	$0

Medicare Payment Locality	Work GPC	Work Payment 2001 CMS Data	YEAR 1 Floor = 0.976			YEAR 2 Floor = 0.987			YEAR 3 Floor = 0.995			YEAR 4 Floor = 1.000			Net Payment Increase From Base to Year 4
			Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	
12 East St. Louis, IL	0.988	$50,593,569	0.988	$50,593,569	0.000%	0.988	$50,593,569	0.000%	0.995	$50,952,025	0.709%	1.000	$51,208,066	0.503%	$614,497
15 Suburban Chicago, IL	1.006	$164,367,363	1.006	$164,367,363	0.000%	1.006	$164,367,363	0.000%	1.006	$164,367,363	0.000%	1.006	$164,367,363	0.000%	$0
99 Rest of Illinois	0.964	$349,128,505	0.976	$353,474,503	1.245%	0.987	$357,458,334	1.127%	0.995	$360,355,666	0.811%	1.000	$362,166,499	0.503%	$13,037,994
Indiana	0.981	$592,510,463	0.981	$592,510,463	0.000%	0.987	$596,134,380	0.612%	0.995	$600,966,270	0.811%	1.000	$603,986,201	0.503%	$11,475,738
Iowa	0.959	$344,790,897	0.976	$350,902,936	1.773%	0.987	$354,857,785	1.127%	0.995	$357,734,038	0.811%	1.000	$359,531,697	0.503%	$14,740,800
Kansas*	0.963	$242,175,916	0.976	$245,445,165	1.350%	0.987	$248,211,453	1.127%	0.995	$250,223,298	0.811%	1.000	$251,480,702	0.503%	$9,304,786
Kentucky	0.970	$428,227,400	0.976	$430,876,229	0.619%	0.987	$435,732,416	1.127%	0.995	$439,264,189	0.811%	1.000	$441,471,546	0.503%	$13,244,146
Louisiana															
01 New Orleans, LA	0.998	$108,863,072	0.998	$108,863,072	0.000%	0.998	$108,863,072	0.000%	0.998	$108,863,072	0.000%	1.000	$109,081,234	0.200%	$218,162
99 Rest of Louisiana	0.968	$316,136,675	0.976	$318,749,375	0.826%	0.987	$322,341,837	1.127%	0.995	$324,954,537	0.811%	1.000	$326,587,474	0.503%	$10,450,799
Maine															
03 Southern Maine	0.979	$55,969,778	0.979	$55,969,778	0.000%	0.987	$56,427,141	0.817%	0.995	$56,884,504	0.811%	1.000	$57,170,355	0.503%	$1,200,577
99 Rest of Maine	0.961	$80,532,703	0.976	$81,789,717	1.561%	0.987	$82,711,527	1.127%	0.995	$83,381,935	0.811%	1.000	$83,800,940	0.503%	$3,268,237
Maryland															
01 Baltimore/Surr. Cntys, MD	1.021	$270,041,065	1.021	$270,041,065	0.000%	1.021	$270,041,065	0.000%	1.021	$270,041,065	0.000%	1.021	$270,041,065	0.000%	$0
99 Rest of Maryland	0.984	$109,968,412	0.984	$109,968,412	0.000%	0.987	$110,303,682	0.305%	0.995	$111,197,734	0.811%	1.000	$111,756,516	0.503%	$1,788,104
Massachusetts															
01 Metropolitan Boston	1.041	$321,095,572	1.041	$321,095,572	0.000%	1.041	$321,095,572	0.000%	1.041	$321,095,572	0.000%	1.041	$321,095,572	0.000%	$0
99 Rest of Massachusetts	1.010	$313,421,317	1.010	$313,421,317	0.000%	1.010	$313,421,317	0.000%	1.010	$313,421,317	0.000%	1.010	$313,421,317	0.000%	$0
Michigan															
01 Detroit, MI	1.043	$594,767,786	1.043	$594,767,786	0.000%	1.043	$594,767,786	0.000%	1.043	$594,767,786	0.000%	1.043	$594,767,786	0.000%	$0
99 Rest of Michigan	0.997	$524,342,991	0.997	$524,342,991	0.000%	0.997	$524,342,991	0.000%	0.997	$524,342,991	0.000%	1.000	$525,920,753	0.301%	$1,577,762
Minnesota	0.990	$350,744,499	0.990	$350,744,499	0.000%	0.990	$350,744,499	0.000%	0.995	$352,515,936	0.505%	1.000	$354,287,373	0.503%	$3,542,874
Mississippi	0.957	$278,777,323	0.976	$284,312,087	1.985%	0.987	$287,516,424	1.127%	0.995	$289,846,851	0.811%	1.000	$291,303,368	0.503%	$12,526,045
Missouri															
02 Metropolitan Kansas City, MO	0.988	$100,323,973	0.988	$100,323,973	0.000%	0.988	$100,323,973	0.000%	0.995	$101,034,770	0.709%	1.000	$101,542,483	0.503%	$1,218,510

01 Metropolitan St. Louis, MO	0.994	$195,771,938	0.994	$195,771,938	0.000%	0.994	$195,771,938	0.000%	0.995	$195,968,892	0.101%	1.000	$196,953,660	0.503%	$1,181,722
99 Rest of Missouri*	0.946	$255,934,246	0.976	$264,050,554	3.171%	0.987	$267,026,534	1.127%	0.995	$269,190,882	0.811%	1.000	$270,543,600	0.503%	$14,609,354
Montana	0.950	$78,311,124	0.976	$80,454,376	2.737%	0.987	$81,361,136	1.127%	0.995	$82,020,598	0.811%	1.000	$82,432,762	0.503%	$4,121,638
Nebraska	0.948	$159,489,529	0.976	$164,200,190	2.954%	0.987	$166,050,807	1.127%	0.995	$167,396,710	0.811%	1.000	$168,237,900	0.503%	$8,748,371
Nevada	1.005	$137,828,181	1.005	$137,828,181	0.000%	1.005	$137,828,181	0.000%	1.005	$137,828,181	0.000%	1.005	$137,828,181	0.000%	$0
New Hampshire	0.986	$106,363,444	0.987	$106,471,318	0.101%	0.987	$106,471,318	0.000%	0.995	$107,334,307	0.811%	1.000	$107,873,675	0.503%	$1,510,231
New Jersey															
01 Northern NJ	1.058	$669,989,716	1.058	$669,989,716	0.000%	1.058	$669,989,716	0.000%	1.058	$669,989,716	0.000%	1.058	$669,989,716	0.000%	$0
99 Rest of New Jersey	1.029	$406,179,441	1.029	$406,179,441	0.000%	1.029	$406,179,441	0.000%	1.029	$406,179,441	0.000%	1.029	$406,179,441	0.000%	$0
New Mexico	0.973	$103,305,844	0.976	$103,624,362	0.308%	0.987	$104,792,259	1.127%	0.995	$105,641,639	0.811%	1.000	$106,172,502	0.503%	$2,866,658
New York															
01 Manhattan, NY	1.094	$360,963,758	1.094	$360,963,758	0.000%	1.094	$360,963,758	0.000%	1.094	$360,963,758	0.000%	1.094	$360,963,758	0.000%	$0
02 NYC Suburbs/ Long I, NY	1.068	$920,258,886	1.068	$920,258,886	0.000%	1.068	$920,258,886	0.000%	1.068	$920,258,886	0.000%	1.068	$920,258,886	0.000%	$0
03 Poughkpsie/ N NYC Suburbs, NY	1.011	$104,839,656	1.011	$104,839,656	0.000%	1.011	$104,839,656	0.000%	1.011	$104,839,656	0.000%	1.011	$104,839,656	0.000%	$0
04 Queens, NY	1.058	$149,267,348	1.058	$149,267,348	0.000%	1.058	$149,267,348	0.000%	1.058	$149,267,348	0.000%	1.058	$149,267,348	0.000%	$0
99 Rest of New York	0.998	$581,393,070	0.998	$581,393,070	0.000%	0.998	$581,393,070	0.000%	0.998	$581,393,070	0.000%	1.000	$582,558,186	0.200%	$1,165,116
North Carolina	0.970	$807,383,158	0.976	$812,377,281	0.619%	0.987	$821,533,172	1.127%	0.995	$828,192,002	0.811%	1.000	$832,353,771	0.503%	$24,970,613
North Dakota	0.950	$67,915,157	0.976	$69,773,888	2.737%	0.987	$70,560,274	1.127%	0.995	$71,132,191	0.811%	1.000	$71,489,639	0.503%	$3,574,482
Ohio	0.988	$1,112,061,200	0.988	$1,112,061,200	0.000%	0.988	$1,112,061,200	0.000%	0.995	$1,119,940,176	0.709%	1.000	$1,125,568,016	0.503%	$13,506,816
Oklahoma	0.968	$310,754,921	0.976	$313,323,143	0.826%	0.987	$316,854,449	1.127%	0.995	$319,422,672	0.811%	1.000	$321,027,811	0.503%	$10,272,890
Oregon															
01 Portland, OR	0.996	$55,833,828	0.996	$55,833,828	0.000%	0.996	$55,833,828	0.000%	0.996	$55,833,828	0.000%	1.000	$56,058,060	0.402%	$224,232
99 Rest of Oregon	0.961	$118,667,883	0.976	$120,520,139	1.561%	0.987	$121,878,460	1.127%	0.995	$122,866,330	0.811%	1.000	$123,483,749	0.503%	$4,815,866
Pennsylvania															
01 Metropolitan Philadelphia	1.023	$416,204,339	1.023	$416,204,339	0.000%	1.023	$416,204,339	0.000%	1.023	$416,204,339	0.000%	1.023	$416,204,339	0.000%	$0
99 Rest of Pennsylvania	0.989	$948,618,029	0.989	$948,618,029	0.000%	0.989	$948,618,029	0.000%	0.995	$954,373,042	0.607%	1.000	$959,168,887	0.503%	$10,550,858
Puerto Rico	0.881	$306,581,596	0.976	$339,640,905	10.783%	0.987	$343,468,825	1.127%	0.995	$346,252,767	0.811%	1.000	$347,992,731	0.503%	$41,411,135
Rhode Island	1.017	$90,906,095	1.017	$90,906,095	0.000%	1.017	$90,906,095	0.000%	1.017	$90,906,095	0.000%	1.017	$90,906,095	0.000%	$0
South Carolina	0.974	$409,802,472	0.976	$410,643,956	0.205%	0.987	$415,272,115	1.127%	0.995	$418,638,049	0.811%	1.000	$420,741,758	0.503%	$10,939,286
South Dakota	0.935	$78,565,176	0.976	$82,010,280	4.385%	0.987	$82,934,576	1.127%	0.995	$83,606,792	0.811%	1.000	$84,026,926	0.503%	$5,461,750
Tennessee	0.975	$656,184,654	0.976	$656,857,664	0.103%	0.987	$664,260,773	1.127%	0.995	$669,644,852	0.811%	1.000	$673,009,902	0.503%	$16,825,248
Texas															
31 Austin, TX	0.986	$65,731,707	0.986	$65,731,707	0.000%	0.987	$65,798,372	0.101%	0.995	$66,331,692	0.811%	1.000	$66,665,017	0.503%	$933,310
20 Beaumont, TX	0.992	$42,378,361	0.992	$42,378,361	0.000%	0.992	$42,378,361	0.000%	0.995	$42,506,521	0.302%	1.000	$42,720,122	0.503%	$341,761
09 Brazoria, TX	0.992	$8,267,256	0.992	$8,267,256	0.000%	0.992	$8,267,256	0.000%	0.995	$8,292,258	0.302%	1.000	$8,333,927	0.503%	$66,671
11 Dallas, TX	1.010	$183,407,037	1.010	$183,407,037	0.000%	1.010	$183,407,037	0.000%	1.010	$183,407,037	0.000%	1.010	$183,407,037	0.000%	$0
28 Fort Worth, TX	0.987	$78,152,298	0.987	$78,152,298	0.000%	0.987	$78,152,298	0.000%	0.995	$78,785,751	0.811%	1.000	$79,181,660	0.503%	$1,029,362

Medicare Payment Locality	Work GPC	Work Payment 2001 CMS Data	YEAR 1 Floor = 0.976			YEAR 2 Floor = 0.987			YEAR 3 Floor = 0.995			YEAR 4 Floor = 1.000			Net Payment Increase From Base to Year 4
			Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	Work GPCI	Work Payment	% Increase	
15 Galveston, TX	0.988	$14,234,587	0.988	$14,234,587	0.000%	0.988	$14,234,587	0.000%	0.995	$14,335,439	0.709%	1.000	$14,407,477	0.503%	$172,890
18 Houston, TX	1.020	$333,251,087	1.020	$333,251,087	0.000%	1.020	$333,251,087	0.000%	1.020	$333,251,087	0.000%	1.020	$333,251,087	0.000%	$0
99 Rest of Texas ..	0.966	$963,274,096	0.976	$973,245,878	1.035%	0.987	$984,214,837	1.127%	0.995	$992,192,262	0.811%	1.000	$997,178,153	0.503%	$33,904,057
Utah	0.976	$126,223,102	0.976	$126,223,102	0.000%	0.987	$127,645,698	1.127%	0.995	$128,680,314	0.811%	1.000	$129,326,949	0.503%	$3,103,847
Vermont	0.973	$52,502,348	0.976	$52,664,226	0.308%	0.987	$53,257,777	1.127%	0.995	$53,689,451	0.811%	1.000	$53,959,248	0.503%	$1,456,900
Virgin Islands	0.965	$2,474,182	0.976	$2,502,385	1.140%	0.987	$2,530,588	1.127%	0.995	$2,551,100	0.811%	1.000	$2,563,919	0.503%	$89,737
Virginia	0.984	$532,672,197	0.984	$532,672,197	0.000%	0.987	$534,296,198	0.305%	0.995	$538,626,866	0.811%	1.000	$541,333,534	0.503%	$8,661,337
Washington															
02 Seattle (King Cnty), WA	1.005	$117,755,518	1.005	$117,755,518	0.000%	1.005	$117,755,518	0.000%	1.005	$117,755,518	0.000%	1.005	$117,755,518	0.000%	$0
99 Rest of Washington	0.981	$256,949,210	0.981	$256,949,210	0.000%	0.987	$258,520,765	0.612%	0.995	$260,616,171	0.811%	1.000	$261,925,800	0.503%	$4,976,590
West Virginia	0.963	$214,946,053	0.976	$217,847,713	1.350%	0.987	$220,302,964	1.127%	0.995	$222,088,601	0.811%	1.000	$223,204,624	0.503%	$8,258,571
Wisconsin	0.981	$461,845,879	0.981	$461,845,879	0.000%	0.987	$464,670,624	0.612%	0.995	$468,436,952	0.811%	1.000	$470,790,906	0.503%	$8,945,027
Wyoming	0.967	$34,746,922	0.976	$35,070,316	0.931%	0.987	$35,465,576	1.127%	0.995	$35,753,038	0.811%	1.000	$35,932,701	0.503%	$1,185,779
TOTAL EXPENDITURE		$26,594,480,185		$26,710,386,933	0.436%		$26,827,161,108	0.437%		$26,942,290,587	0.429%		$27,025,503,201	0.308%	
INCREASE FROM PREVIOUS YEAR ...		$0		$115,906,748			$116,774,174			$115,129,480			$83,212,613		
CUMULATIVE INCREASE		$0		$115,906,748			$232,680,923			$347,810,402			$431,023,016		$431,023,016

*Payment locality is serviced by two carriers

Mr. JOHN PETERSON. I have two letters here I received from hospitals that have some detail. Could I enter them into the record?

Chairman JOHNSON. You certainly can.

[The letters follow:]

Charles Cole Memorial Hospital
Coudersport, Pennsylvania 16915–9762
July 19, 2002

Jeffrey Vorberger
Legislative Assistant
Office of Congressman John Peterson
307 Cannon House Office Building
Washington, DC 20515

Dear Jeff:

In response to your request for information concerning the impact of the wage index upon the hospitals in Northern Pennsylvania, I have examined a number of issues which may be helpful.

Among the most critical challenges which rural hospitals currently face is the inability to recruit and retain professional staff. During the last 2 years we have consistently had nursing vacancy rates in excess of 10%. We currently have 11 vacant nursing positions. As a result, mandatory overtime is frequently imposed and recently nursing supervisors have been asked to fill nursing staff holes in the daily working schedule. Last week one of our best nursing supervisors resigned in large measure as a result of having to work night shifts to staff the floor for a position that we have been unable to fill.

We have been recruiting heavily in Canada in an attempt to fill the vacancies and have had some limited success. Last year in an attempt to recruit and retain nurses, we gave unbudgeted wage increases to the nursing staff in excess of 11%. In November of this year we must negotiate the nursing union contract and are anticipating once again substantial increases. In non-nursing areas, such as respiratory therapy, speech therapy, occupational therapy, and pharmacy, we have been compelled to use agency staff at exorbitant rates in order to fill these vacancies. Over the last 3 years our wages have increased in the aggregate of 13% which in total represents $2 million of additional wage costs. It is our projection that this hospital will show an operating loss of in excess of $2.5 million for the fiscal year ended June 30, 2002.

Among the problems that are created by inadequate reimbursement from Medicare and Medicaid is that we simply do not have adequate funds to compete for these workers on the same level as more urban hospitals within our region. As shortages for these skilled professionals have worsened, the region from which we attempt to recruit has expanded so that we are now recruiting nurses from all over the states of Pennsylvania and New York. Further difficulty which we are seeing with the inadequate reimbursements is that the wage index calculations are predicated upon data which I understand is at least 2 years old. As can be seen in the case of Charles Cole Hospital, the increase in wages over that period of time is skyrocketing and is not recognized in the wage index calculations.

The flaws in the current wage index system which have long been recognized to disadvantage rural hospitals can be broken down into a few succinct categories:

1) Rural hospitals are competing with urban hospitals for the same workers in a system which compensates those urban hospitals at a higher rate than rurals, making the rurals unable to compete on a level playingfield.

2) Because urban hospitals invariably offer services which allow them to treat more acutely ill patients, their reimbursement is higher as a result of a higher case mix. In other words, on a per case basis urban hospitals receive higher reimbursement by virtue of that fact alone which in a large measure dilutes the need, if any exists, to pay them at a higher wage index rate.

3) Given the fact that the data used to calculate the wage index is, at a minimum, 2 years old, in an environment where there are rapidly rising wages due to acute shortages of skilled health care workers, the current indexes do not come close to reflecting the current labor costs.

4) Last, a singular wage index for all of the rural hospitals in a state such as Pennsylvania does not recognize the huge differences in the availability of labor and the costs of that labor that exists in the very different rural communities in the state. As a general proposition, the more remotely located the hospital the higher the price you will have to pay to recruit skilled health care workers, whereas rural

hospitals more proximate to urban areas typically find a greater pool of available workers at a lesser cost.

Given the fact that there are so many inequities in the wage index system and that the urban hospitals are so distinctly advantaged by the current Medicare reimbursement scheme, the implementation of a wage index floor would be one small step toward normalizing and making more fair our current system of reimbursement.

Yours truly,

David B. Acker
Chief Executive Officer

Titusville Area Hospital
Titusville, Pennsylvania 16354
July 19, 2002

Hon. John Peterson
307 Cannon House Office Building
Washington, DC 20515

Dear John:

Thank you for the opportunity to comment on the wage index deliberations being held by the Subcommittee on Health of the Committee on Ways and Means. Congresswoman Johnson is correct. The Medicare wage index formula is extremely complex. The following are some observations as to how this impacts on Titusville Area Hospital.

The wage index is formulated on wage, salary and benefit information provided by Pennsylvania rural hospitals. These figures reflect the levels of wages being paid by these hospitals; however, once the wage index is calculated, it is then applied to payment rates set by Medicare meant to reflect prices paid for other services such as consultants, attorneys and other purchased medical services utilized by the hospital. The prices of these services are often very different than the wages paid employees. For instance, in Titusville's case our attorneys are in Pittsburgh, our accountants are in Pittsburgh and our medical services are purchased from a wide variety of vendors as far away as San Antonio, Texas. How a wage index calculated on rural Pennsylvania wages and salaries can adequately reflect these costs is a mystery to me.

I would be very much opposed to segregating rural areas and thus their wage index based upon large town, small town. My reason for this is that Titusville would no doubt be considered small town and assigned a lower wage index. On the other hand, our neighbors (Meadville and Franklin) would no doubt be designated as large towns and assigned the higher wage index. My point being, we must compete for labor with both these towns. A lower wage index, thus a lower reimbursement, would put us at a competitive disadvantage when trying to attract employees. We are already at a disadvantage and find employees leaving to accept higher wages at neighboring hospitals.

Finally, once again we find ourselves in a situation that holds the potential to short-change us based upon past performance and what I consider to be responsible management. Wages, and thus the wage index, are impacted not only by dollars per hour but also hours worked. Hospitals with higher productivity will have lower wage costs and thus lower benefit costs than less efficient, less well-managed hospitals. Titusville Area Hospital has had a long track record of high productivity and low cost per case. This has been documented by every government agency that benchmarks hospital operating statistics as well as several private agencies. In 2000 this high efficiency, coupled with superior clinical outcomes, earned Titusville Area Hospital recognition as a Top 100 Hospital by Solucent, a national benchmarking firm. Should Congress allow CMS to again set the future reimbursement on past cost history, Titusville Area Hospital will once again be short-changed and penalized for being efficient and managing well. I encourage you to make Congress be prospective not retrospective. My belief is that a fair and equitable index should be developed which recognizes not penalizes efficient performance.

Sincerely,

Anthony J. Nasralla, FACHE
President/CEO

Chairman JOHNSON. Thank you very much. We appreciate hearing from you all, and I would like to now call the panel. Those

of you who can either stay or have staff who can stay, I think it would be worth it for them to stay and hear the testimony of Mr. Scanlon of the GAO, Mr. Hackbarth of the Medicare Payment Advisory Commission, and Mr. Zuckerman of the Urban Institute. Mr. Hackbarth, would you please open for MedPAC?

STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you, Chairman Johnson.

As you know, the purpose of the wage index is to adjust Medicare's payment rates for costs beyond the control of a hospital. As you pointed out earlier, we use averages. This whole payment formula is built on averages, and the reason for that, of course, is to try to set prices that, so far as possible, mimic what a competitive market would set. What we don't want to do is set up payment amounts that reflect the individual hospital's costs and not an average; otherwise, we would be creeping back toward a cost reimbursement system.

That said, the wage index used by Medicare is imperfect. There are four major problems that have been touched on today. One is that the areas used, the geographic areas do not correspond with labor markets. Basically they are too big.

A second is that the data we use for wage adjustment reflect both hourly wage rates and occupational differences, differences in occupational mix among hospitals. So, we are not really comparing wages for the same type of employees, but also differences in the mix of hospital employees across labor markets.

A third problem with the wage index is that, arguably, too large a share of the payment is adjusted by the wage index. As you pointed out, Chairman Johnson, 71 percent of the rate is subject to adjustment. Some think that is marginally too high and the number ought to be at least a few percentage points lower.

Finally, the wage index uses old data.

The effect of these imperfections can be pretty large for a given hospital. As your colleagues testified, for an individual hospital near the boundary of one of the geographic areas, the difference in payment can be very large, from being on one side of the border versus the other. Even the occupational mix problem, as we refer to it, could result in payment differences of 2 or 3 percent for a hospital, and for a hospital on a small margin, 2 or 3 percent at the bottom line is quite significant.

The good news is that these imperfections can be fixed with the proper data. The bad news is that we don't have the proper data on hand, and to collect the proper data and develop better adjustments, is a 2- or 3-year proposition.

I should note that the MSAs that currently are at the heart of the wage index system are about to be modified as a result of the 2000 Census. Whether that will make things better or worse for individual hospitals, of course, remains to be seen.

In the interim, the geographic reclassification system has been a useful tool for resolving at least some problems for some hospitals along the borders of the wage index areas. In our view, it is useful precisely because it is targeted to hospitals that meet particular criteria. We think that the Congress needs to be careful to avoid

fixes for this problem that are not so targeted and result in large-scale, widespread increases in payment. A wage index floor, for example, would be too indiscriminate in how it spreads money around.

The problem with that sort of poorly targeted fix is not just that it costs a lot of money or, if it is done on a budget-neutral basis, takes money away from other hospitals. Another problem is that it creates a constituency opposed to future reform among hospitals that now have a big payment that they want to hold on to. They don't want a system with new data and more accurate market areas. They now like the old system. We have to be very wary about creating such a constituency.

One last observation. As Mr. Stark pointed out, having a low-wage index does not necessarily mean that the hospital performs poorly on its Medicare business. In fact, we find that there is little correlation between the wage index and poor financial performance. What does that mean? Well, I think one thing that it means is that, for all of its imperfections, the system is adjusting in the aggregate fairly well. Again, there are individual problems, but it is not true that if you have a low-wage index you are doomed to failure under the Medicare Program. That is simply not supported by the data. Thank you.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission

Chairman Johnson, Mr. Stark, Members of the Subcommittee. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss MedPAC's views on how Medicare's payment systems account for differences in local market prices for the goods and services providers must buy to furnish care.

Medicare's payments for services in the traditional program

In the traditional fee-for-service program, Medicare generally uses prospective payment systems (PPSs) to set market-like prices that are intended to encourage efficient delivery of health care services to its beneficiaries. Two of these systems—the PPS for acute inpatient hospital care and the physician fee schedule—are mature systems that have been in place for over a decade. New systems are being phased in for care furnished by hospital outpatient departments, home health agencies, skilled nursing facilities, rehabilitation hospitals, and starting soon, long-term care hospitals.

To ensure access to care for Medicare beneficiaries without imposing undue costs on taxpayers, these payment systems should set payment rates that approximate the costs that efficient providers would incur in furnishing high quality care. Efficient providers' costs will vary because of local market factors—such as prices for labor—that are beyond their control. Consequently, Medicare's payment rates must vary to account for such factors or risk creating undesirable financial incentives and payment inequities.

Adjusting for local market conditions

Market input prices for labor and supplies vary widely across the nation. These input-price differences have substantial effects on providers' costs but are largely beyond their control. Consequently, Medicare's payment rates in each market should be adjusted to reflect the local price level.

How to make these adjustments accurately is one of the most important problems for payment system design and operation. Because input-price differences can account for one-third or more of the variation in unit production costs among providers, errors in input-price adjustments can result in payment inequities and undesirable financial incentives.

Medicare's prospective payment systems generally address this problem by establishing a national base payment rate and then adjusting the rate for the expected relative costliness of the specific case or service and for the local input-price level

where the service is furnished. To carry out this design, policymakers must have one or more measures of geographic variation in input prices—such as the area wage index in the acute inpatient hospital care PPS or the geographic practice cost indexes in the physician fee schedule. Policymakers also must know what portions of providers' unit costs are affected by variations in input prices. This information is used to determine how much of the national base payment rate should be adjusted by the geographic input price factor for each market area. Most Medicare payment systems use a version of the hospital wage-index.

The hospital wage index

Medicare's prospective payment systems for inpatient (and other facility) services include input-price adjustments that raise or lower payment rates to reflect the hourly wages of health care workers in each local market, as measured by the hospital wage index. The Centers for Medicare&Medicaid Services (CMS) constructs the hospital wage index for each market area using compensation data from annual hospital cost reports filed by the hospitals located in the area. By law, CMS must define market areas using the 325 Metropolitan Statistical Areas (MSAs) designated by the Office of Management and Budget and 49 statewide rural areas for counties not included in MSAs. The wage index for 2002 varies from a high of 1.53 in Oakland, California to a low of 0.74 for providers in rural Alabama (Figure 1). To address inequities in labor market definitions, particularly for rural hospitals located near the edges of MSAs, Medicare policy allows acute care hospitals to apply for reclassification from one market area to another for the wage index under certain conditions. In FY 2001, 490 hospitals (about 10 percent of all acute care hospitals) were reclassified (Figure 2).

Wage index issues

MedPAC and others have identified four problems with the hospital wage index.[1] One, the so-called occupational mix problem, in which differences among areas in the mix of workers employed affect the average wage rate, distorting the measurement of market prices for labor. Second, market areas as defined by MSAs and statewide rural areas can be too large, encompassing more than one distinct health care labor market. Third, the wage data that underlie the adjustment are four years old. Finally, the share of the payment to which the input price adjustment is made may include cost components—for example, billing services—that may be purchased in regional or national markets (and whose prices, therefore, should not vary with local market wages).

The effect of differences in the mix of occupations across labor market areas. The objective of the geographic adjustor is to account for differences beyond the control of the provider—local market prices—and not for differences created by management decisions—the mix of labor. Thus, using aggregate wages and hours may distort the wage index by elevating the average wage per hour in markets (such as urban areas with large teaching hospitals) where providers employ a costly mix of labor and depressing the average wage in markets (such as many rural areas) where hospitals employ a relatively inexpensive labor mix. These inaccuracies in the wage index may have substantial effects on payment accuracy. Addressing the occupational mix problem directly will require occupation-specific data that CMS has not yet begun to collect. In the meantime, MedPAC recommended that the Secretary accelerate the planned phase-out from the hospital wage index of salaries and hours for teaching physicians, residents, and certified registered nurse anesthetists. Although the impact would not be large, this policy would improve the distribution of payments. CMS incorporated this suggestion in its proposed rule for hospital payments during fiscal year 2003. We also believe that CMS should collect occupation-specific data on wages and hours using hospitals' annual Medicare Cost Reports, as is done for the aggregate wage and hour data needed to construct the current wage index.

Labor market size. MSAs and statewide rural areas are frequently too large to capture homogeneous labor markets for health care workers. Research has shown a strong pattern of systematic differences in hospital wage levels within many urban and rural labor market areas.[2] Hospitals in outlying suburban counties generally appear to face lower market wage rates than those located in the central core of the same MSA. Similarly, hospitals located in outlying rural areas appear to face

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[1] For a more detailed discussion of wage index issues please see Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2001.

[2] See Dalton, K., Slifkin, R.T., Howard, H.A. Rural hospital area wages and the PPS wage index: 1990–1997, available at http://www.shepscenter.unc.edu/research_programs/Rural_Program/wp.html.

lower wage rates than those located in counties adjacent to MSAs. In addition, MSA and state boundaries often separate nearby hospitals (and give them substantially different wage index adjustments) although they are obviously competing in the same labor market. As I mentioned earlier, the Congress established the geographic reclassification policy to ameliorate this boundary problem. But inequities within large market areas remain.

These problems are difficult to resolve, in part because developing consistent criteria that can be used to define labor market areas is technically very difficult. A further barrier, however, is that any change in market definitions creates financial benefits for some providers and financial disadvantages for others, thereby generating great political resistance to reform.

Timeliness of CMS wage data. By the time the wage index is applied to adjust payments, the underlying wage data are four years old. Although the age of the data has often been cited as an important problem, recent research (Dalton et al. 2000) suggests that relative wage levels across geographic areas do not change much over time. Occupation-specific wage data (when available) will allow a more thorough investigation of this issue.

Proportion of costs affected by locally purchased inputs. We also recommend that the Secretary reevaluate current assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets. This so-called labor share estimate is developed and periodically revised by the Office of the Actuary in CMS. The labor share is based on the weights for certain components (categories of inputs) of the hospital market basket index—a measure of annual inflation in the prices of goods and services hospitals buy to produce health care services, which is used in determining annual updates for Medicare's PPS payment rates. Some have argued that the current labor share overstates the proportion of costs that rural hospitals devote to labor and other locally purchased inputs. The components included in the labor share were originally designated in 1983, and many of these are still largely purchased in local markets. However, other inputs may be purchased wholly or partly in national markets, and including them overstates the labor share to some extent. Applying the wage index adjustment using an overstated labor share would lead to underpayment in low-wage areas and overpayment in high-wage areas. For fiscal year 2003, CMS proposes increasing the labor-related share of hospital costs used to apply the wage index from 71.1 percent to 72.5 percent. But analysis sponsored by the Commission indicates that the labor share is at least modestly lower than that currently used, not higher.

The limitations of the hospital wage index have led some advocates to propose that a floor be put under the index. This would raise payments in market areas with low hospital wage rates (and, if done budget neutrally, lower them in areas with high wage rates), but it would do so in an arbitrary fashion. Moreover, if the objective is to help hospitals with poor financial performance, a wage index floor is a poor way to do so because it would raise payments to both low—and high-margin hospitals. Our analysis shows that there is no correlation between hospitals' Medicare inpatient margins and the wage index; hospitals with low margins are just as likely to be located in areas that have high wage indexes as they are to be in areas that have low wage indexes.

Figure 1. Hospital wage index values 2002

Source: MedPAC analysis of CMS data

Figure 2. Reclassified hospitals 2002

Note: Alaska and Hawaii not shown.
*There is one reclassified hospital in Hawaii

Source: MedPAC analysis of CMS data

each dot is a reclassified hospital

MSAs in gray

Chairman JOHNSON. Thank you, Mr. Hackbarth. Dr. Scanlon?

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Dr. SCANLON. Thank you very much, Madam Chairwoman, Mr. Stark, and Members of the Subcommittee. I am very happy to be here today as you look into how the Medicare Program adjusts payments to hospitals and physicians to account for geographic differences in costs.

Over the past 20 years at the Congress' direction, Medicare has implemented a series of payment reforms designed to promote efficient delivery of services and control program spending. A key requirement for these payment methods is that besides the incentives for efficiencies, payments must be calibrated to assure beneficiary access and fairness to providers. Adjustment of payment levels for geographic cost differences is a critical element of that calibration.

As you have heard, there have been considerable concerns about the geographic cost adjustors, and I would like to expand upon some of the points that Mr. Hackbarth made as the Congress has asked us to look into the geographic adjustments as well a Medicare's reclassification policies. Let me now provide you the highlights of our findings.

As you have heard, Medicare adjusts payments to hospitals for differences in wages based upon the averages in each hospital's designated geographic area compared to wage rates nationally. As the designated or labor market areas, Medicare has used the 324 metropolitan statistical areas identified by the Office of Management and Budget (OMB) and then treats all the non-metropolitan areas in each State as another labor market area. While this is a reasonable approach to adjust for cost differences across areas, the fundamental problem, as Mr. Hackbarth indicated, is that Medicare's defined areas are simply too large and likely subsume multiple labor markets.

The MSAs often include multiple counties which can exhibit different patterns of urban-ness, commuting patterns, and so forth. The Washington, DC, MSA is a prime example. If you will look at the chart over there, you will see that the Washington, DC, MSA includes 18 counties which stretch into Maryland, Virginia, and West Virginia. Across these counties, wage rates that hospitals pay differ significantly. Hospitals in the District of Columbia and the nearby suburban counties, the red areas, pay an average of $23 per hour, while hospitals in several of the outlying counties pay below $20 an hour. All these hospitals receive the same labor cost adjustment based on an average wage of $23 per hour.

We found the same pattern in many other MSAs, central county hospitals paying wages in excess of outlying county wages. The range was from 7 percent in Houston to a 38-percent difference in New York City.

The non-metropolitan areas in each State are also ill-defined. These areas can be huge. If you will look at the other chart of Washington State, all of the white-colored area in Washington State is the State's non-metropolitan area. From east to west, this area stretches more than 350 miles. There is no illusion that this comprises a single labor market. It would be appropriate, however, to use this large area as the basis for adjusting payments if wage rate levels were similar throughout. However, what we found is

that in most States there is systematic variation in wage levels within these non-metropolitan areas. Wages in large towns were often higher than in small towns and rural areas. Such systematic variations suggest that labor markets in the non-metropolitan areas differ enough that a single labor cost adjustment for the entire area is not appropriate.

The geographic reclassification process was created to address some of these problems resulting from Medicare's labor area designations. Hospitals whose wages exceed the average for their designated area by specified amounts and are physically close to another area with higher wages can be reclassified and receive higher payments. Reclassification has helped significant numbers of hospitals paying higher wages. Three hundred and ten hospitals with wages exceeding the required threshold were reclassified in 2001. Large-town hospitals in particular benefited as almost three-quarters of those paying higher wages reclassified. About half of other non-metropolitan and only 12 percent of metropolitan higher-wage hospitals also reclassified.

The disproportionate share of large-town hospitals reclassifying is attributable in part to another provision which allows rural referral centers to be exempt from having to meet the higher-wage requirement or the requirement of being near another high-wage area in order to reclassify. While this exemption benefits large-town hospitals which may be adversely affected by Medicare's definition of labor cost areas, it also allows hospitals paying lower wages to reclassify. The rural referral center, other exemptions, and special provisions allowed 116 hospitals with wages not meeting the threshold to reclassify in 2001, including 55 hospitals that were initially paying wages below the average for their original area.

Let me conclude with some of the implications of all of this for Medicare payment.

First, Medicare's geographic area definitions should be reviewed with the idea that the number of smaller areas be created and it will likely result in more homogeneous areas and more appropriate labor cost adjustments.

Second, refining the geographic area definitions will reduce reliance on reclassification as a means of redressing inappropriate payment levels. Limiting the need for reclassifications would be a positive step. Making appropriate reclassification decisions is difficult. The fact that a hospital pays higher wages than neighboring hospitals, as Mr. Hackbarth indicated, is not sufficient to justify a reclassification. Consequently, reclassification policy has involved not only that hospitals pay higher wages, but that they also be proximate to a higher-wage area as an evidence of their operating in a different labor market and have a need to reclassify.

This, however, leaves vulnerable hospitals that must pay higher wages but are not located near another area. For example, a large-town hospital, one of the circled areas in the map of Washington State, may not be able to re-qualify because it is distant from any MSA in Washington State.

Exemptions for rural referral centers and sole community hospitals have helped some of these hospitals, but have also allowed lower-wage hospitals to receive higher payments. Some or all of

these additional payments may be needed because of higher wage rates, but also due to other factors affecting cost, and may be necessary to assure continued access for beneficiaries.

The difficulties I have outlined in making payments appropriate for each hospital may stem from our reliance on essentially one lever, the labor cost adjustment, to vary payments to hospitals. To achieve the calibration of payments that encourages efficiency and assures access and provides fairness that I mentioned at the outset, we need to assess whether other types of adjustments are necessary and indeed could be more effective in assuring appropriate payment.

Thank you very much, Madam Chairman. I would be happy to answer any questions you or Members of the Subcommittee may have.

[The prepared statement of Dr. Scanlon follows:]

Statement of William J. Scanlon, Director, Health Care Issues, U.S. General Accounting Office

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss how the Medicare program adjusts payments to hospitals and physicians to account for geographic differences in costs.

Because Medicare's hospital and physician payment systems are based on national rates, these geographic cost adjustments are essential to account for costs beyond providers' control and to ensure that beneficiaries have adequate access to services. If these adjustments are not adequate, Medicare could financially reward or penalize providers due only to where they are located. Over time, this could affect some providers' financial stability and their ability or willingness to continue serving Medicare patients.

Some providers contend that Medicare's geographic cost adjustments are inadequate.

Medicare's payments to hospitals are intended to vary with the average wages paid in a hospital's labor market. Yet, some hospitals believe that the labor cost adjustment applied to their payments does not reflect the average wage they face in their labor market area. Hospitals that meet certain criteria can qualify to have their payments increased through Medicare's reclassification process. But concerns remain about the geographic variation in payments to hospitals and disparities in hospital financial performance under Medicare's hospital payment system. Similarly, physicians have raised concerns about the appropriateness of Medicare's geographic adjustment to their fees.

My comments today are based on our forthcoming report on the Medicare program's labor cost adjustment for hospital services and our preliminary work on the program's physician payment adjustment. I will focus on (1) how Medicare determines the labor cost adjustment for hospitals in an area; (2) whether Medicare's labor cost adjustment accounts appropriately for geographic variation in wages paid by hospitals; (3) the extent to which geographic reclassification addresses potential problems with Medicare's labor cost adjustment for hospitals; and (4) how Medicare determines geographic adjustments to physician fees. My comments are based primarily on our analysis of hospital Medicare cost report data and other information, including that compiled by the Centers for Medicare and Medicaid Services, the agency within the Department of Health and Human Services that oversees the Medicare program.

In summary, Medicare's labor cost adjustment does not adequately account for geographic differences in hospital wages in some areas because a single adjustment is applied to all hospitals in an area even though the area may encompass multiple labor markets or different types of communities within which hospitals pay significantly different average wages.

Geographic reclassification addresses some inequities in Medicare's labor cost adjustments by allowing some hospitals that pay wages enough above the average in their area to receive a higher labor cost adjustment. At the same time, however, some hospitals can reclassify even though they pay wages that are comparable to the average in their area. To help ensure that beneficiaries in all parts of the country have access to services, Medicare adjustments its physician fee schedule based on indexes designed to reflect cost differences among 92 geographic areas. The ad-

justment is designed to help ensure that the fees paid in a geographic area appropriately reflect the cost of living in that area and the costs of operating a practice. We are beginning an analysis of the methodology and data that Medicare uses to make the adjustment to determine whether it appropriately reflects underlying costs and, if not, whether beneficiary access to physician services has been impaired in certain areas.

A Hospital's Labor Cost Adjustment Is Based On Average Wages Paid in a Geographic Area

Medicare's prospective payment system (PPS) provides incentives for hospitals to operate efficiently by paying them a predetermined, fixed amount for each inpatient hospital stay, regardless of the actual costs incurred in providing the care.

Although the fixed, or standardized, amount is based on national average costs, actual hospital payments vary widely across hospitals, primarily because of two payment adjustments in PPS. There is an adjustment that accounts for cost differences across patients due to their care needs, and a labor cost adjustment that accounts for the substantial variation in average hospital wages across the country. The fixed amount is adjusted for these two sources of cost differences because they are largely beyond any individual hospital's ability to control.

The Medicare labor cost adjustment for a geographic area is based on a wage index that is computed using data that hospitals submit to Medicare. The wage index for an area is the ratio of the average hourly hospital wage in the area compared to the national average hourly hospital wage. The wage indexes ranged from roughly 0.74 to 1.5 in 2001.[1] Only the portion of the hospital payment that reflects labor-related expenses (71 percent) is multiplied by the wage index. The rest of the payment, which covers drugs, medical supplies and certain other non-labor-related expenses, is uniform nationwide because prices for these items are not perceived as varying significantly from area to area.[2]

The geographic area for which a wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify.[3]

The Medicare program uses the Office of Management and Budget's (OMB) "metropolitan/non-metropolitan" classification system to define the geographic areas used for the labor cost adjustment. Medicare calculates labor cost adjustments for 324 metropolitan areas and 49 "statewide" non-metropolitan areas. Medicare specifies an OMB metropolitan statistical area (MSA) as a distinct region within which wages are assumed to be relatively uniform.[4] Medicare specifies the rest of a state—all the non-MSA counties[5]—as a single, non-metropolitan area in which hospitals are assumed to face similar average wages. These non-metropolitan areas can be quite large and not contiguous (see fig. 1).

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[1] The fiscal year 2001 Medicare wage indexes were based on 1997 data from Medicare cost reports—which hospitals submit annually to Medicare.

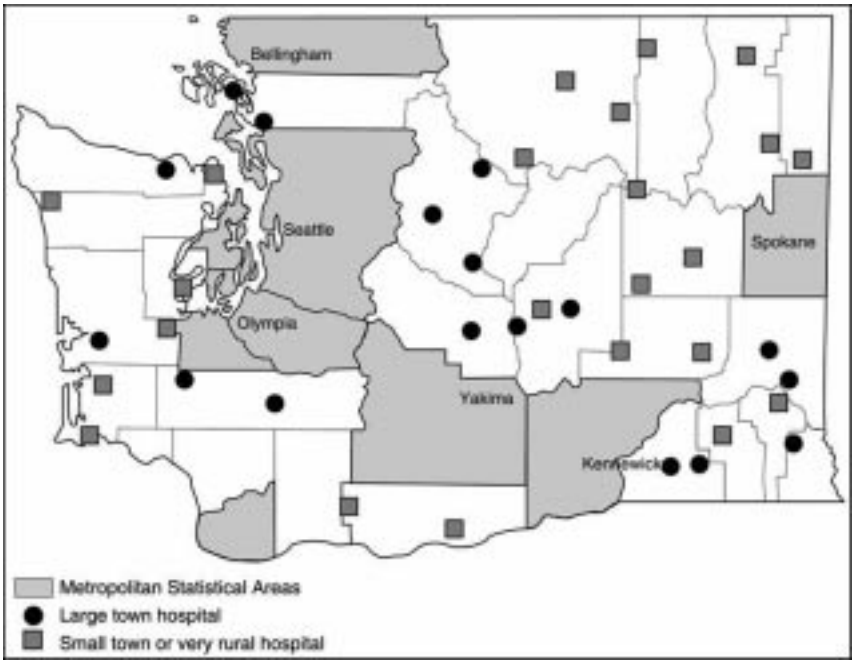
[2] For hospitals in Alaska and Hawaii, the non-labor portion of the payment is subject to a cost-of-living adjustment.

[3] In addition to being affected by wage differences, the wage index is affected by differences in the occupational mix of hospital employees across geographic areas: The wage index can be higher in areas with a concentration of hospitals employing a more skilled (and more expensive) mix of staff, and lower in areas where hospitals employ a less skilled mix of staff. The Congress has required the Secretary of Health and Human Services to take into account the effects of occupational mix on the wage index beginning October 1, 2004.

[4] In general, MSAs are groups of counties containing a core population of at least 50,000, together with adjacent areas having a high degree of economic and social integration with that core. OMB defines the central county or counties of an MSA as those containing the largest city or urbanized area. An outlying county or counties qualify for inclusion in a metropolitan area based on commuting ties with the central counties and other specified measures of metropolitan character. The current geographic areas may change when OMB updates MSA boundaries in 2003 using population data from the most recent decennial census and revised OMB standards for including counties in an MSA.

[5] In New England, the MSAs are defined in terms of cities and towns, rather than counties.

Figure 1: Washington State Non-metropolitan Hospitals



Source: GAO analysis of Medicare Provider of Services file, fiscal year 2001.

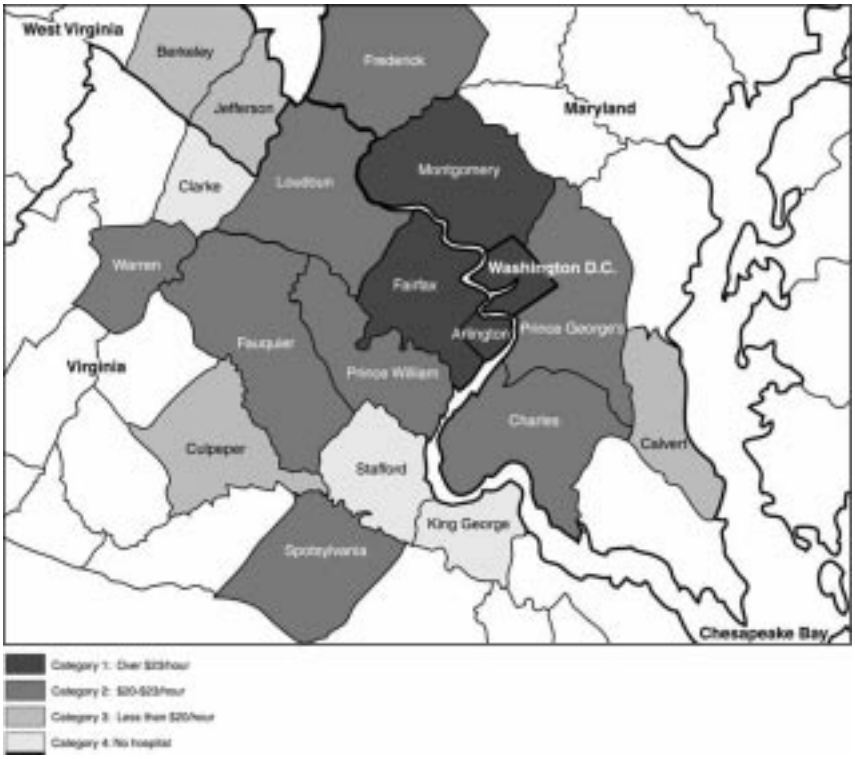
Labor Cost Adjustment Does Not Adequately Account for Wage Differences Within Certain Areas

The variation in hospital wages within some Medicare geographic areas—MSAs or the non-metropolitan areas in a state—is systematic across different parts of these areas. While wages paid by hospitals are expected to vary within a labor market, such systematic variation suggests that some Medicare geographic areas include multiple labor markets within which hospitals pay different average wages. For example, average hospital wages in outlying counties of MSAs tend to be lower than average hospital wages in central counties. Average wages in non-metropolitan large towns tend to be higher than in other non-metropolitan areas within a state. Because the labor cost adjustment does not take this kind of systematic variation into account, the adjustment sometimes does not appropriately reflect the average wages that hospitals pay.

Medicare Metropolitan Geographic Areas May Encompass Multiple Labor Markets With Varying Average Wages

Because an MSA may extend over several thousand square miles, the hospitals within an MSA may not be competing with each other for the same pool of employees. Therefore, these hospitals may need to pay varying wages to attract workers. The Washington, D.C. MSA illustrates how hospital wages in a large MSA can vary across different counties (see fig. 2). It includes hospitals located in the central city of the District of Columbia and in 18 counties in Maryland, Virginia, and West Virginia. Hospital wages averaged $23.70 per hour in fiscal year 1997 in the District of Columbia and in most adjacent suburban Maryland and Virginia counties, but averaged $20.14 per hour in the outlying counties. Yet, the labor cost adjustment for hospitals within this MSA is based on an average wage of $23.41 per hour and is the same for hospitals within all its counties.

Figure 2: Hospital Wages, by County, Washington, D.C. MSA, Fiscal Year 1997



Source: GAO analysis of fiscal year 1997 hospital wages used in calculating the fiscal year 2001 wage index, as reported in Medicare cost reports.

Hospitals in central counties of an MSA typically pay higher wages than hospitals in outlying counties. Central county hospital wages ranged from 7 percent higher than outlying county hospital wages in Houston to 38 percent higher in New York City. In most of the MSAs with the highest population, the difference was from 11 to 18 percent in fiscal year 1997.

Some Medicare Non-metropolitan Geographic Areas Encompass Multiple Community Types with Varying Wages

Medicare uses the same labor cost adjustment for all hospitals in the non-metropolitan areas of a state. The adjustment would be adequate for all hospitals in these sometimes vast areas if the hospitals paid similar average wages. However, we found wage variation across non-metropolitan areas that appears to be systematically related to type of community. In three-quarters of all states, the average wages paid by hospitals in large towns are higher than those paid by hospitals in small towns or rural areas. About 38 percent of hospitals in large towns paid wages that were at least 5 percent higher than the average wage in their area, and 16 percent paid wages that were at least 10 percent higher than the area average.

As a result, the Medicare labor cost adjustment for non-metropolitan areas may be based on average wages that are lower than wages paid by large town hospitals and based on average wages that are higher than wages paid by hospitals in small towns and rural areas. For example, the fiscal year 2001 labor cost adjustment for non-metropolitan Nebraska was based on an average hourly wage of $17.65. Yet, Nebraska hospitals in large towns had an average wage that year that was 11 percent higher; small town Nebraska hospitals had an average wage that was 5 percent lower; and hospitals in rural areas of the state had an average wage that was 16 percent lower.

Through Reclassification, Some Hospitals
Receive a More Appropriate Labor Cost Adjustment

The administrative process for geographic reclassification allows hospitals meeting certain criteria to be paid for Medicare inpatient hospital services as if they were located in another geographic area with a higher labor cost adjustment.[6] The first criterion concerns the hospital's proximity to the higher-wage "target" area. The proximity requirement is satisfied if the hospital is within a specified number of miles of the target area (15 miles for a metropolitan hospital and 35 miles for a non-metropolitan hospital) or if at least half of the hospital's employees reside in the target area. The second criterion pertains to the hospital's wages relative to the average wages in its assigned area and in the target area. This criterion is satisfied if the hospital's wages are a specified amount higher than the average in its assigned area and if its wages are comparable to the average wages in the target area.[7]

Rural referral centers (RRC) and sole community hospitals (SCH) can be reclassified by meeting less stringent criteria. These hospitals receive special treatment from Medicare because of their role in preserving access to care for beneficiaries in certain areas. RRCs are relatively large rural hospitals providing an array of services and treating patients from a wide geographic area. SCHs are small hospitals isolated from other hospitals by location, weather, or travel conditions.[8] RRCs and SCHs do not have to meet the proximity requirement to reclassify. RRCs are also exempt from the requirement that their wages be higher than those of the average wages in their original market.

Not All Higher-Wage Hospitals Can Be Reclassified

Of the 756 hospitals that paid wages high enough to qualify for reclassification, only 310, or 41 percent, were reclassified in fiscal year 2001. More than one-quarter of these higher-wage hospitals were in large towns, and 73 percent of them were reclassified.

Higher-wage hospitals in large towns are likelier to be reclassified than other higher-wage hospitals because many are RRCs, which are exempt from the reclassification proximity criterion.

In contrast to the nearly three-quarters of large town higher-wage hospitals that reclassified in fiscal year 2001, about half of higher-wage hospitals in small towns and rural areas were reclassified.

Almost 39 percent of the reclassified higher-wage small town and rural hospitals were exempt from the proximity criterion because they were RRCs or SCHs. Some non-reclassified, higher-wage small town or rural hospitals that were SCHs may have opted out of PPS to receive cost-based payments from Medicare, making reclassification irrelevant.

Moreover, even though metropolitan area higher-wage hospitals made up 42 percent of the higher-wage hospitals, only 12 percent of them were reclassified in fiscal year 2001—a percentage far lower than that for higher-wage hospitals in other areas.

Reclassified metropolitan hospitals paid wages that were about 10 percent above the average wage in their former area; those average wages are equal to the average wage in the new areas to which these hospitals were reclassified in fiscal year 2001.

The likely reason that so few metropolitan higher-wage hospitals were reclassified is that few are close enough to a higher-wage MSA to meet the proximity criterion. More than two-thirds of the metropolitan hospital reclassifications in fiscal year 2001 were concentrated in two areas—California and a region that includes parts of New York, Connecticut, New Jersey and Pennsylvania—where metropolitan areas are close enough to each other that more higher-wage hospitals in these areas may be able to meet the reclassification proximity requirement.

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[6] This discussion pertains only to the reclassification option to be paid based on a higher wage index. Other, less common reclassification options, such as county-wide reclassifications, are available.

[7] A metropolitan hospital's average wage must be at least 8 percent higher than the average in its assigned area and at least 84 percent of its target area's average wage. A non-metropolitan hospital's average wage must be at least 6 percent higher than the average in its assigned area and at least 82 percent of its target area's average wage.

[8] In general, SCHs may elect to be paid based on their own hospital-specific costs or the applicable PPS payment amount. SCHs electing payments under PPS may qualify to be reclassified. Payments to SCHs that do not elect the PPS option are not subject to a labor cost adjustment. See U.S. General Accounting Office, *Medicare's Rural Hospital Payment Policies* GAO/HEHS090009174R, Washington, D.C.: Sept. 15, 2000), for more detail on rural hospital designations.

Certain Hospitals Can Be Reclassified Without Meeting Wage Criterion

While reclassification is designed to increase payments to hospitals paying wages significantly above the average for their area, certain provisions allow some hospitals that pay lower wages to reclassify. For example, an additional 116 hospitals were reclassified for a higher wage index in fiscal year 2001, even though they paid wages that were too low to meet the wage criterion.

Prior to reclassification, these non-metropolitan hospitals had average wages that were close to the area average. With reclassification, these hospitals were assigned to areas with a labor cost adjustment based on wages that averaged 8 percent higher than their own.

Of the 116 hospitals that reclassified for a higher wage index in fiscal year 2001, but failed to meet the wage criterion, 89 were RRCs (see table 1).

About 42 percent of these had wage costs below their statewide non-metropolitan average. The other hospitals that reclassified, but did not pay wages that met the wage criterion, include those that were part of county-wide reclassifications and those reclassified through legislation.

Table 1: Reclassified Hospitals That Did Not Satisfy the Wage Criterion, by Reclassification Category, Fiscal Year 2001

Reclassification Category	Hospitals with average wages too low to satisfy the wage criterion	Hospitals with average wages below the average in their original area
RRCs	89	37
Legislative	20	15
County-wide	7	3

Source. GAO analysis of fiscal year 1997 hospitals wages used in construction of fiscal year 2001 wage index, as reported in Medicare cost reports.

Physician Fees Are Adjusted for Cost-of-Living, Practice Expense and Malpractice Premium Differences

Medicare's physician fee schedule, which specifies the amount that Medicare will pay for each physician service, includes an adjustment to help ensure that the fees paid in a geographic area appropriately reflect the cost of living in that area and the costs associated with the operation of a practice. This geographic adjustment is a critical component of the physician payment system. An adjustment that is too low can impair beneficiary access to physician services, while one that is too high adds unnecessary financial burdens to Medicare. Although much attention in recent months has focused on the method used to annually update the physician fee schedule, concerns have also been voiced about the appropriateness of the geographic adjustments.[9] H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002, would require that we evaluate the methodology and data that Medicare uses to geographically adjust physician payments.[10] We are beginning an analysis of the methodology and the available data to determine whether Medicare's geographic adjustment appropriately reflects underlying costs and whether beneficiary access to physician services has changed in certain areas.

In adjusting 2002 fees for physician services, Medicare has delineated 92 separate geographic areas. In some instances, these areas consist of an entire state. For example, physician fees are uniform across Connecticut. In other cases, a large city or group of cities within a state is classified into one geographic area and the rest of the state is classified into another. Maryland illustrates this case: Baltimore and surrounding counties are classified into one geographic area and the rest of Maryland is classified as another. Finally, some large metropolitan areas, such as New York City and its suburban counties, are split into multiple geographic areas.

Medicare's geographic adjustments for physician fees are based on indexes that are designed to reflect cost differences among the 92 areas. There are three separate indexes, known as geographic practice cost indexes (GPCI), that correspond to the three components that comprise Medicare's payment for a specific service: (1) the

[9] U.S. General Accounting Office, *Medicare Physician Payments: Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees,* GAO090209441T (Washington, D.C. Feb. 14, 2002).

[10] H.R. 4954 was passed by the House of Representatives on June 28, 2002.

work component, reflecting the amount of physician time, skill, and intensity; (2) the practice expense component, reflecting expenses, such as office rents and employee wages; and (3) the malpractice insurance component, reflecting the cost of personal liability insurance premiums. The overall geographic adjustment for each service is a weighted average of the three GPCIs where the weights represent the relative importance of the components for that service. Across all physician services in 1999, the average weights were approximately 55 percent for the work component, 42 percent for the practice expense component, and 3 percent for the malpractice insurance component.

The GPCIs are calculated from a variety of data sources. The work GPCI is based on a sample of median hourly earnings of workers in six professional categories. Physician earnings are not used because some physicians derive much of their income from Medicare payments, and an index based on physician earnings would be affected by Medicare's existing geographic adjustments. The work GPCI is a weighted average of the median earnings of these professions in the area and their median earnings nationwide.[11] If the work GPCI was based solely on the median earnings in each area, physician payments would likely increase in large metropolitan areas and decrease in rural areas. The practice expense GPCI is based on wage data for various classes of workers, office rent estimates, and other information. The malpractice insurance GPCI is based on average premiums for personal liability insurance.

Concerns have been raised that the current geographic adjustments for physician fees do not appropriately reflect the underlying geographic variation in physicians' costs and that, as a result, beneficiary access to services may be impaired in certain areas. Unfortunately, information on physicians' willingness to see Medicare patients is dated—although it does not indicate access problems. Data from the 1990s show that virtually all physicians were treating Medicare beneficiaries and, if they were accepting new patients, accepted those covered by Medicare. A 1999 survey conducted by the Medicare Payment Advisory Commission (MedPAC) from that year found that 93 percent of physicians who had been accepting new patients were continuing to do so. It is unclear whether the situation has deteriorated since 1999. MedPAC is updating its survey, and the new results may shed light on this issue. However, MedPAC's survey results may not be able to identify access problems if they occur only in certain areas. As I said in my testimony before this Subcommittee in February, it is important to identify beneficiary access problems quickly and take appropriate action when warranted. As part of the work we are beginning on access to physician care, we will examine Medicare claims data to get the most up-to-date picture possible of access by area, by specialty, and for new versus established patients.

Concluding Observations

Medicare's PPS for inpatient services provides incentives to hospitals to deliver care efficiently by allowing them to keep Medicare payment amounts that exceed their costs, while making hospitals responsible for costs that exceed their Medicare payments. To ensure that PPS rewards hospitals because they are efficient, rather than because they operate in favorable circumstances, payment adjustments are made to account for cost differences across hospitals that are beyond any individual hospital's control. If these payment adjustments do not adequately account for cost differences, hospitals are inappropriately rewarded or face undue fiscal pressure. The adjustment used to account for wage differences—the labor cost adjustment—does not do so adequately because many of the geographic areas that Medicare uses to define labor markets are too large.

Geographic reclassification provides relief to some hospitals that pay wages that are higher than the average in their area. Yet, other hospitals paying higher wages cannot be reclassified. Still other hospitals get a higher labor cost adjustment than is warranted by the wages they pay, and many are in rural areas and may be facing financial problems. Their labor cost adjustment, however, is not necessarily the cause of these problems. Therefore, reclassification may not be the most effective mechanism to address the financial pressure faced by these rural hospitals.

Madam Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other Members of the Subcommittee may have.

Chairman JOHNSON. Thank you very much, Dr. Scanlon. Dr. Zuckerman?

[11] An area's median earnings are weighted by 0.25, and the national average by 0.75.

STATEMENT OF STEPHEN ZUCKERMAN, PH.D., PRINCIPAL RESEARCH ASSOCIATE, URBAN INSTITUTE

Dr. ZUCKERMAN. Thank you, Chairman Johnson and Members of the Committee. I appreciate the opportunity to appear before you today to discuss the geographic practice costs adjustment in the Medicare Physician Fee Schedule. Along with Greg Pope at the Center for Health Economics Research in Waltham, Massachusetts, and Pete Welch, a former colleague of mine at the Urban Institute, I co-directed the development of the practice cost adjustors that were adopted for use in the fee schedule in 1992. The conceptual basis for the geographic cost adjustors has not changed in the intervening years.

There has been widespread agreement that fees should be adjusted for geographic differences in costs that are beyond physicians' control. This suggests that a geographic practice cost index should definitely reflect differences in wages for clinical and administrative staff, office rents, and malpractice insurance premiums. I am not going to talk about these today, but these factors are addressed in my written statement. However, the largest share of practice revenues represents the costs of compensating physicians for his or her own time, and there has been considerable debate over how geographic differences in these costs should be taken into account.

In the interest of creating an equitable compensation system, payments for physicians' own time should vary in relation to costs of living and other factors. The fundamental reason to allow for geographic variation in the cost of physicians' own time is to create fees that compensate physicians at the same real rate in all areas of the country. To equalize real rates, fees should be higher in areas with higher costs and lower in areas with lower costs. Properly adjusted, Medicare physician payments should tend to promote an adequate supply of physicians in both urban and rural areas.

Although a cost-of-living adjustor is an intuitively appealing measure of an area's costs, a cost-of-living adjustor would over-adjust fees by not taking into account the impact that an area's amenities might have on compensation. For example, physicians are willing to locate in Boston despite its high cost of living, in part because of the area's modern hospitals and large numbers of potential colleagues. Alternatively, for low-cost areas with poor amenities to recruit and retain physicians, compensation probably has to exceed cost of living. If physicians value urban amenities, they would need to be paid more relative to the cost of living to locate in rural areas. Due to these differences in amenities, compensation will vary less across areas than cost of living.

Well, if not cost of living, what can be used as a geographic adjustor of physician time cost? We used hourly earnings of highly educated workers in professional occupations to derive a geographic adjustor for the physicians' work component of the fee. These highly educated workers should be similar to physicians with respect to the types of goods and services they purchase and their preference for area amenities. Essentially, we argued that the geographic variation in payments for physicians' own time should reflect the variation in earnings for other highly educate professionals.

The geographic adjustor that was incorporated in the fee schedule reflected only one-quarter of the variation in professional earnings as we measured it with Census data. This means, for example, that an area like rural Missouri that had a work adjustment of about 20 percent below the national average based on professional earnings currently has a work adjustment only 5 percent below the national average.

We were aware of concerns about the level of fees in rural areas, and we gave explicit consideration to this issue. Our analysis suggested that the indices we developed did a reasonably good job of tracking actual practice cost expenses across rural and urban physicians. However, we pointed out that one way of raising fees in low-cost rural areas would be to set an arbitrary floor on practice cost adjustors. An arbitrary change in the adjustor would mean that it was no longer capturing practice cost differences, and we did not see this as a desirable path to follow.

Instead, if the policy goal is to raise Medicare fees in areas that have problems recruiting and retaining physicians, it is reasonable to build on a different mechanism that already exists. Currently, the Medicare fee schedule includes a 10-percent bonus payment for fees in health professional shortage areas. This bonus could be increased and/or extended to more areas. This could explicitly achieve the desired policy objective as opposed to making a less transparent change, such as putting an arbitrary floor on the work cost adjustor.

Let me conclude by saying that as the debate over the geographic adjustment in the Medicare physician fee schedule continues, the adjustor for the work component remains the most contentious issue. Some argue that the physician labor market is a national market and, as such, physicians should be paid the same in all areas. Even if physicians are recruited from all areas of the country, that does not mean that their dollar level of compensation needs to be the same everywhere.

As implemented, 75 percent of the payment for the work component of the Medicare fee is already the same in all areas. Any change in this work adjustor is going to have very little impact on the payments that physicians receive. The remaining 25 percent is appropriately adjusted to reflect differences in earnings that capture differences in costs of living and area amenities. Although this partial adjustment may not fully achieve the original objective of the method we proposed, namely, an equalization of real compensation rates across areas, it moves fees in the desired direction and should be retained. Thank you.

[The prepared statement of Dr. Zuckerman follows:]

Statement of Stephen Zuckerman*, Ph.D., Principal Research Associate, Urban Institute

Chairman Johnson and members of the committee, I appreciate the opportunity to appear before you today to discuss the geographic practice costs adjustment in the Medicare Physician Fee Schedule. My name is Stephen Zuckerman and I am a Principal Research Associate at the Urban Institute, a non-profit, non-partisan research institute located in Washington, D.C. Along with Gregory Pope at the Center for Health Economics Research in Waltham, MA and W. Pete Welch, a former col-

**The views expressed in this testimony are those of the author and do not necessarily represent the Urban Institute, its Board of Trustees, or its sponsors.*

league of mine at the Urban Institute, I co-directed the development of the practice cost adjusters that were adopted for use in the Fee Schedule in 1992. I also worked on the first revision of the adjusters in 1995. The conceptual basis for the geographic cost adjusters has not changed in the intervening years.

There has been widespread agreement that, under the Medicare Fee Schedule, fees should be adjusted for geographic differences in costs incurred by physicians that are beyond their control. This suggests that a geographic practice cost index should reflect differences in wages for clinical and administrative staff, office rents and malpractice insurance premiums. However, the largest share of physician practice revenues represents the costs of compensating the physician for his or her own time, and there has been considerable debate over how geographic differences in these costs should be taken into account.

In my testimony today I will review the conceptual foundation for the geographic practice cost adjusters used in the Medicare Fee Schedule, emphasizing why we felt it was, and still is, appropriate to adjust for geographic differences in the costs of physicians' own time.[1] I recognize that at the time the Fee Schedule was being developed some felt that physicians' work was the same in all areas of the country and, therefore, should be paid for at the same rate in all areas. This view still persists. However, I hope to show why, in the interest of creating an equitable compensation system, payments for physicians' own time should be allowed to vary in relation to costs of living and other factors.

Physicians' Own Time. The fundamental reason to allow for geographic variation in the costs of physicians' own time is to create fees that compensate physicians at the same *real* rate in all areas of the country. An area's real rate of compensation can be thought of as the ratio of the dollar payment to the area's costs. Although a cost-of-living adjuster is an intuitively appealing measure of an area's costs, that is not what we viewed as a desirable adjuster for the costs of physicians' own time. A cost-of-living adjuster would over-adjust fees by not taking into account the impact that an area's amenities might have on compensation. Amenities differ across areas due to professional factors such as access to quality colleagues and the presence of modern hospitals and medical technologies, and due to personal factors such as availability of good schools, proximity to cultural events, and clean air. Because of these differences in amenities, compensation will vary less across areas than costs of living.

Economics predicts that compensation would not fully reflect an area's high costs of living if the area had desirable amenities. Desirable amenities would be a type of compensation of their own and offset some of the high costs of living. For example, workers are willing to locate in Honolulu despite its high cost of living because of its attractive environment. Similarly, for low-cost areas with poor amenities to attract and retain physicians, compensation would have to exceed costs of living. For example, if physicians value urban amenities, they would need to be paid more relative to the cost of living to locate in rural areas. Over time, compensation differences across areas would adjust so that a physician who is deciding where to locate would not care in which area he or she locates. Properly adjusted, Medicare physician payments should tend to promote an adequate supply of physicians in *both* urban and rural areas.

If not costs of living, what can be used as a geographic adjuster of physician time costs to equalize real compensation? Data on geographic variation in physician earnings are available from the Census. However, it would have been inappropriate to use these data to adjust payments under the Medicare Fee Schedule because these earnings were, in part, determined by historical patterns of Medicare payment rates. Further, these data are hard to work with because they cannot be adjusted to control for specialty mix differences across areas and because they reflect the profitability of physicians' practices as well as earnings.

As an alternative, we used hourly earnings of workers in professional occupations with five or more years of college education to derive a proxy for the physician work component of the geographic practice cost adjuster. This group of highly educated workers can be viewed as being similar to physicians with respect to the types of goods and services they purchase and their preferences for area amenities. Therefore, they should have earnings that reflect the appropriate amount of geographic variation that should be captured in the Medicare Fee Schedule. In addition, this adjuster did not perpetuate distortions that may have been present in the geographic distribution of physician earnings. Essentially, we argued that the geo-

[1] A great deal of this testimony is based on research summarized in Zuckerman, S., W.P. Welch and G. Pope, "A Geographic Index of Physician Practice Costs," *Journal of Health Economics* 90(1), June 1990, pages 390969.

graphic variation in payments for physicians' own time should reflect the variation of earnings for other highly educated professionals.

The adjuster we developed based on professional earnings ranged from about 24 percent above the national average in Manhattan, New York to about 20 percent below the national average in rural areas of Missouri. After considerable sensitivity analysis, we concluded that this appeared to be the most defensible adjuster for physicians' own time costs. As the policy was implemented, a geographic adjuster was incorporated into the Medicare Fee Schedule that reflected only one-quarter of the geographic variation in professional earnings. Primarily as a result of this decision, the physician work value in Manhattan, New York is about 9 percent above average and about 5 percent below average in rural Missouri.

These examples show that there is considerably less variation in the actual physician work adjuster used in the Fee Schedule than in the one we had derived in our original research. The three legislatively required revisions to the index over the past decade have not resulted in movement away from the decision to reflect only one-quarter of the variation in professional earnings in the physicians' work adjuster. Although the one-quarter work approach is not consistent with our original conceptual and empirical work, it still may be a credible geographic adjuster. Research has shown that geographic variation in employee physician wages is very closely related to the variation in the one-quarter work adjuster.[2] Therefore, retaining that adjuster throughout the three revisions may have been a good decision. However, this research also concluded that the one-quarter adjuster is superior to allowing for no geographic adjustment, suggesting that an adjuster with less geographic variation would not be advisable.

Because we were aware of concerns about the level of fees that could exist in rural areas under the Fee Schedule, we gave explicit consideration to this issue in our final report to the Health Care Financing Administration.[3] Our analysis suggested that the indices did a reasonably good job of tracking actual practice expenses across rural and urban physicians. However, we pointed out that one way of raising fees in low-cost rural areas would be to set an arbitrary floor on the practice cost adjusters. Depending on how such a policy was implemented, this could lead to lower fees in high-cost areas. Moreover, an arbitrary change in the index would mean that it was no longer capturing practice costs differences.

If the policy goal is to raise Medicare fees in areas that have problems recruiting and retaining physicians, it is reasonable to build on a different mechanism that is already a part of the payment system. Currently, the Medicare Fee Schedule includes a 10 percent bonus payment that is added to fees in Health Professional Shortage Areas. The bonus could be increased and/or extended to other areas. This could achieve the desired objective explicitly as opposed to a less transparent change, such as putting an arbitrary floor in the practice cost adjuster.

Other Practice Expenses and Malpractice Insurance. Aside from physicians' own time, the largest component of physician practice expenses is employee wages. To calculate an employee price adjuster, we used median hourly earnings of administrative support occupations, Registered nurses, Licensed practical nurses, and Health technologists and technicians (excluding LPNs). To reflect the occupation mix in physicians' offices, each category of hourly earnings was weighted to reflect the occupation's share of physician expenditures for employees.

The next most important expense category is office rents, but there are no nationwide data on rental rates for physician office space. However, the U. S. Department of Housing and Urban Development annually derives a "fair market rent" for all areas with a Section 8 housing assistance program. These data represent the 45th percentile rent for various sized units in each geographic market and were used as a proxy for a geographic adjuster of physician office rents. A key advantage of this price information is that it is available for all metropolitan areas and rural counties. A weakness of this proxy is that physician offices are in commercial as well as in residential buildings. However, residential and commercial rents are likely to be highly correlated because the same factors—such as population density, construction costs, and area income—are likely to affect both. The limited evidence shows that residential and commercial rents do tend to track each other across areas.

Geographic differences in malpractice costs are measured by comparing premiums charged for a mature claims-made insurance policy with $1 million/ $3 million limits of coverage. Premiums are averaged across the top twenty Medicare specialties, according to their shares of Medicare physician spending, so as to represent the full

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[2] Gillis, K., R, Willke and R. Reynolds, "Assessing the Validity of the Geographic Practice Cost Indices," *Inquiry* 30(3), Fall 1993, pages 26509280.

[3] Welch, W., S. Zuckerman and G. Pope, "The Geographic Medicare Economic Index: Alternative Approaches," Urban Institute Working Paper 3839–01–01, June 1989.

range of malpractice risk classifications. The data are derived from periodic surveys of malpractice insurers in all states and, where necessary, reflect intrastate variation in premiums charged.

Our review of available data uncovered no information on geographic differences in the prices of medical supplies and equipment. Anecdotal evidence suggested that price variation in these inputs is minimal. In computing the geographic adjuster, we assumed that the costs of these inputs as well as prices for "other" expense items were the same in all areas. Since only about 14 percent of total practice revenues are accounted for by these inputs, our approach with respect to the other inputs still captured the bulk of the variation in practice input prices.

Geographic Areas. Prior to the implementation of the Fee Schedule, carriers administered physician payments within state boundaries and had a great deal of discretion as to how fees would vary across geographic areas within their jurisdictions. Although there were many statewide "payment localities," some states had highly disaggregated payment areas. For example, Texas was divided into 33 payment areas for some specialties. We developed the set of geographic adjusters based on a more consistent set of criteria to define areas in all states. We wanted to base the index on areas that (1) had reasonably consistent prices for practice inputs within their borders; (2) were large enough to be a fairly self-contained market for practice inputs; and (3) were compatible with Medicare's administrative practices. Our decision was to use metropolitan areas and state rural areas as were and are being used in the Medicare Prospective Payment System for hospitals. We viewed this as striking an acceptable balance across the three criteria we had established.

The original localities were retained during the initial stages of the Fee Schedule implementation and our index was adapted for use in this geographic configuration of payment areas. Subsequently, Medicare has changed to a greater reliance on statewide payment areas with exceptions that allow for intrastate variation in those states with substantial within state practice cost variation.

Conclusion. As the debate over a geographic adjustment in the Medicare Physician Fee Schedule continues, the adjuster for physicians' own time costs remains the most contentious issue. Some argue that the physician labor market is a national market and, as such, physicians should be paid the same in all areas. Even if physicians are recruited from all areas of the country, that does not mean that their nominal level of compensation needs to be the same everywhere. However, as implemented, 75 percent of the payment for the physician work component of a Medicare fee is the same in all areas. The remaining 25 percent is appropriately adjusted to reflect differences in earnings that capture differences in costs of living and area amenities. Although this partial adjustment may not achieve the original objective of the geographic adjuster that we proposed—an equalization of *real* compensation across areas, it moves fees in the desired direction in all areas and should be retained.

Chairman JOHNSON. Thank you very much to all of you. I am sorry you had to sit so many hours and listen, but, frankly, it is good for you.

[Laughter.]

Dr. ZUCKERMAN. It is interesting.

Chairman JOHNSON. Just like it is good for us. I am going to yield my time to Congresswoman Dunn because she has to leave, like now.

Ms. DUNN. Thank you very much, Madam Chairman. Mr. Scanlon, thank you for that chart. It helps us understand the problems in Washington State a little bit better. Dr. Zuckerman, right now I want to invite you to come to my office, and I think Congressman McDermott would join us, because we have got a lot to talk over on physician reimbursements.

Dr. ZUCKERMAN. Okay.

Ms. DUNN. I think I have time before I have to race to run a Member meeting just to ask you one question. Let me tell you what the problem is in Washington State. In Washington State, Medicare spends just about $3,921 per beneficiary, and that compares

to $5,490 for the national average in the year 2000. We are at $3,921; national average is $5,490.

One reason for the variation in Medicare's reimbursements for physician services in Washington State is that they are lower than other States. This has resulted in many physicians leaving the State to practice in areas where the reimbursement levels are higher. We all heard a lot of testimony, have over the last few months, about this.

I want to better understand why physicians' work is not valued equally, whether it is provided in King County, Washington, or in New York City. It seems to me that reimbursements for physicians' work should be the same because they have the same education and clinical skills within a specialty. So, let me ask you one question, and I have got a lot more to do, and as I say, if we can do it in my office, we can just zip through this stuff, and I will know exactly why our State is being under-reimbursed.

Can you change the physician formula to include an additional reimbursement to account for quality or efficiency of health care? For example, the existence of managed care in an area like Seattle could hold health care costs down overall. Is there a way we could change that formula to include the efficiency of the provision of care?

Dr. ZUCKERMAN. When you think about aggregate payments within a State like Washington, you are dealing with a lot of different factors. You are not only dealing with Medicare physician fees and hospital payment rates. The volume of care that patients receive plays an important role in determining aggregate payments. When you think about what determines payments for physicians' work, it is important to recognize at the heart of the fee schedule is the relative value scale, and is uniform across the country.

What the geographic cost adjustors do is simply vary the average payment for physicians' work, and there is not much that is actually varied. Three-quarters of the payment is constant across the country. The remainder of the average payment varies to reflect differences in costs of living, offset somewhat by the fact that some areas are more attractive to professionals to live in than other areas.

So, physician work is treated uniformly through the relative value scale. It is just that the payment rate that varies slightly to reflect differences in cost of living and other factors.

Ms. DUNN. Except that is a huge variation, I think, those numbers that I gave you.

Dr. ZUCKERMAN. Well, those aggregate payments could be driven largely by the volume of services that patients receive, not simply by Medicare fees.

Mr. STARK. California is overpaid. It is not that you are underpaid.

Chairman JOHNSON. Excuse me. Would you pursue that? What you just said I think needs to really be understood. Seventy percent of the payment is the same across the whole Nation.

Dr. ZUCKERMAN. Seventy-5 percent of the physician work payment is the same across the country, and in total, about 55 percent of the overall Medicare fee is not adjusted by any geographic index.

Ms. DUNN. So, you are saying that 75 percent is predetermined, is equal across the Nation, but because we have Mount Rainier or we have better traffic—they will be interested in hearing that—that my doctors are being reimbursed at a lesser amount.

Mr. STARK. Would the gentlelady yield——

Dr. ZUCKERMAN. Well, let me point out that in Seattle, the work payment is adjusted to be just at the national average, and in the rest of Washington, the work payment is about 1.9 percent below the national average, the cost adjustment. So, there is not a lot of difference in the work payment between Washington and the national average.

Mr. STARK. If the gentlelady would yield, a lot of it is they may do more procedures in other parts—you guys may be more efficient——

Ms. DUNN. I understand that. We are more efficient, and that is the point that I am trying to make. When you look at these numbers, $3,900 per person in Washington State versus $5,400, almost $5,500, the national average—that is just an average—the people in my State say we deliver health care at a much higher quality, we are proud of our hospital systems, proud of our doctors who practice there. We have had health maintenance organizations (HMOs) for many, many years. The system works well. It cuts the cost of health care. We are sitting there being told, in effect, because salary or reimbursement is everything, that we are at a lower quality.

So, I need to be able to tell my people back home why we are being paid at well below the national average, and it can't just be because of Mount Rainier.

Dr. ZUCKERMAN. No, I don't think that, and I don't think that is what the cost adjustors in the fee schedule are designed to capture. I think one of the reasons that the aggregate payments in Washington are much lower than the national average is because the volume of services that residents of Washington receive is probably lower. This may very well be due to the historical influence of HMOs in the State of Washington. This is probably an issue for another hearing on Medicare+Choice payment rates and how those are determined.

Chairman JOHNSON. Dr. Zuckerman, this was brought up earlier by some other Members as well. In my part of the country, I call it the "old Yankee syndrome." Where you have very efficient care, you might also have more conservative practice and so lower volume. The formula does make it harder for efficient providers to survive.

Ms. DUNN. It seems to me we should be rewarding efficiency in some way. For me, this formula is skewed and it doesn't work. So, what I am going to be looking for is how do we have a more realistic formula. We have talked about having more up-to-date numbers or not projecting numbers, using actual numbers, but the reality is that with such a huge difference, our physicians are fleeing or they are not serving Medicare patients. They are choosing a lot of different routes, especially in eastern Washington where the payments are even lower.

So, what I have to do on this Committee, and I would suspect that Congressman McDermott is going to be with me on this one,

we have to figure out what to do to make our people feel like they are at least being considered as a part of a high quality health care provider system and are being reimbursed for the quality of their care, not penalized for the efficiency of the provision of care.

Dr. ZUCKERMAN. I think that these issues you are talking about are not really related to the Medicare fee schedule. The fee schedule is pretty close to the national average in the State of Washington.

Ms. DUNN. Well, reimbursements aren't, and we have to figure out what the answer to that is. Anyway, thank you.

Chairman JOHNSON. I do just want to clarify that part of this conversation is like ships passing in the night. When you use those average amounts nationwide, they reflect also a different pattern of practice. How we separate out the pattern of practice issue from the actual reimbursement rate is a problem. What I was trying to raise and what I want you all to sort of help us with is that I think there is an issue here that we don't attend to in the formula, that as you have a more conservative pattern of practice, you have a lower volume. In my State, the hospitals that are okay are the ones that are doing cardiac. Why? Because we pay more for cardiac.

So, sometimes when you are doing a lower volume because you have conservative practice, then you are not doing well. So, it means that in figuring this formula of practice expenses—and remember how many hearings we had about how bad the practice expenses studies were and how many times it took us to, quote, get it right. My confidence that we have got it right frankly isn't very high, nor is my confidence that the Resource Based Relative Value Scale RBRVS system is accurate over time either.

So, you know, I think we have to look at the fact that in an area like Washington that has historically had managed care and other structures that we know promote efficiency and lower costs, that at a certain point they begin to do badly. In Iowa, that sort of has, for a variety of reasons is there a problem that when you start with a disparate base, which often are reflected in my part of the country, old Yankee parsimoniousness, and then you have to add on expensive equipment, and you still have conservative practice so the expensive equipment can't be allocated over and blah, blah, blah, I think we are missing something about these areas that have now cost pressures from all sides, have gotten much more efficient. We are still treating them like we are treating everybody else.

So, that is why I wanted to enlarge on that. There is a lot of misunderstanding amongst Members. I can't say that I really understand this. You don't get this much of an outcry—and you are hearing Members testify here about 17 hospitals, not one that needs to be reclassified. The number of applications for reclassification and the number that actually get reclassified are very small. Yet you have got this group of rural health centers and sole providers, I would love to have some of those in my district because we wouldn't have to go through this reclassification system that we can't survive in.

So, the problems are truly manifold, and I wanted to point out that as Members use these average statistics, you know, they do mask practice patterns. It isn't enough to say that, we aren't going to be able to fix that. We have to be sure that that doesn't mask

a more serious problem in our own technology, which was developed in a different era. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair. I just have a quick question for Dr. Scanlon. I scanned through your testimony real quick, and I am sorry I didn't get to hear it personally. Can you discuss what the resolve might be to the problems that we are talking about? I think you mentioned something about a State-specific budget neutrality proposal.

Dr. SCANLON. That actually was a policy option that the Congress asked us to look at, because right now the way the reclassification policy works is that a national budget neutrality application is used. In other words, for all the hospitals that are reclassified, all the hospitals across the country have a change in their payment due to those hospitals' being reclassified.

What we were asked to look at was what would be the difference between a State-specific and a national budget neutrality. State-specific budget neutrality would mean that in a State where a significant number of hospitals reclassify, the other hospitals would have a bigger change in their payments. In States where no hospital is reclassified, there would be no change in payments.

In terms of hospitals reclassifying in 2001, the national adjustment is in the range of about 1 percent. If there was a State-specific adjustment, it could be as high as 3 or 4 percent in some States where more hospitals reclassify.

Mr. KLECZKA. Now if you do the State within the State, wouldn't you still have to contend with the national disparity? Then we have all these colleagues coming from the various States comparing us to California or to Wisconsin or whatever the case may be.

Dr. SCANLON. Well, I think that this doesn't deal with the fact that there are going to be huge variations in payment rates across the country that still remain. Some of that variation is appropriate because costs of services do differ, not just health care service but costs of all kinds.

Our problem is we have got to get the rates we pay in the health care system, particularly in Medicare, calibrated correctly to the cost differences that exist across areas. I think what our work shows is that that calibration is not correct today. We have done it at too crude a level, and the net result is we are paying inappropriately in a large number of areas.

Mr. KLECZKA. If we are going to correct the problem, either nationally or within each State, aren't we looking at a rather vast expenditure of additional dollars through the Medicare Program?

Dr. SCANLON. I think we have to think about this potentially in terms of a reallocation of Medicare dollars. We are putting a lot of money into Medicare at this point, and——

Mr. KLECZKA. Yes, but then we start—in Congress we start playing with hold harmlesses, and, you know, in my lifetime you are not going to see any disparity erased.

Dr. SCANLON. Well, I think we see——

Mr. KLECZKA. The haves and have-nots—the haves are not going to give to the have-nots, and let's not kid a kidder. Unless we are willing to throw in a whole bunch of new dollars for the have-nots, it is just not going to get done.

Dr. SCANLON. As you heard today, there are changes, though, in payment rates over time for individual providers. The other factor is that each year, new money is infused into the Medicare Program through the updates. So, part of what we may be talking about is how we distribute the new moneys going into Medicare and over a period of time achieve the kinds of readjustments that are necessary to make rates——

Mr. KLECZKA. What period of time do you judge it would have to be?

Dr. SCANLON. I think it would depend on different providers.

Mr. KLECZKA. You can talk in millenniums if you want, but——

Dr. SCANLON. No, I think we need to be talking much more in terms of a 5-year timeframe or less, because I think we may not be talking about that significant a set of changes. Again, as I said, you know, the budget neutrality impact nationally for the reclassifications is 1 percent. It is not a huge change.

As we think about the changes that we are trying to make, we are going to be targeting them on a subset of providers, and they may not, in the aggregate, add up to that much that the transition can't be more prompt.

Mr. KLECZKA. Would any of the other panelists like to chime in?

Mr. HACKBARTH. My perspective is pretty much the same as Bill's. I think that there needs to be some redistribution. That would be far and away the preferable way to go.

You hear from the hospitals that, if you like, believe they are being underpaid and in some cases they are making a legitimate argument. The flip side of that coin is that there are hospitals that currently benefit, sometimes in a substantial way, from the same imperfections that we have talked about. If our solution to all of these problems is just to add new money to the system, it could get very expensive indeed.

So, from our perspective, the preferred approach would be get better data, which will take time, correct the market areas, and address the underlying problems in the wage index. If that can't be done quickly, if something needs to be done in the short run—and I understand the political demands—make the solutions as targeted as possible. Proposals like wage index floors spend money indiscriminately. A lot of additional money will go to hospitals that are undeserving, that already have high Medicare margins, and given the short supply of dollars, that doesn't seem a very prudent course.

Chairman JOHNSON. Excuse me. Do you want to comment?

Dr. ZUCKERMAN. No.

Chairman JOHNSON. Mr. Hackbarth—and, actually, you can all come in on this, but, first of all, I find it very disturbing that any Member can come before this panel and show adjacent counties with a 20-percent differential in payment. I think mobility has made the existence of those hospitals by definition impossible, the ones that are under the—that are the 0 versus the 20 percent. That isn't about management. So, if our formulas—if our payment systems have resulted in that level of disparity, I think we have big problems. I don't think we have little problems. We need a lot of help in this.

Personally, I don't see any way that you can say this has to be—that we should reallocate money. I don't see any evidence with current-year data that there are hospitals out there that are making a profit when you look at inpatient and outpatient. You look at the number of drugs that are taking the entire DRG payment, and you look at what is coming down the road. So, I don't think there is a reallocation opportunity here, not of the dimensions of the problem that we are seeing.

Let's go through some of the possibilities for change from the testimony that we have received. First of all, this issue of occupational mix, I appreciated your breaking out the wage index issue so cleanly for us, and it affects a number of the adjustors, I believe. How accurate is that, not including physicians in your occupational mix to find out what their average wages are?

Mr. HACKBARTH. Well, in the case of the hospital wage index, it would not be appropriate to include hourly wage rates for physicians that are paid separately through part B. What we want to do is capture differences among hospitals in their underlying costs. Indeed, one of the historic problems with the wage index, albeit a pretty small one, has been that the data included information on teaching physicians and residents, and that needs to be stripped out of the wage index calculation to have an accurate comparison of how hospital salaries and wages differ.

Chairman JOHNSON. You mean because the residents are being paid under a separate system?

Mr. HACKBARTH. Those costs, hospitals' costs for residents' salaries, are paid separately under the graduate medical education payment policy. Physician costs and nurse anesthetists are paid separately under part B. So, CMS is in the process, as I understand it, of stripping out that information which will improve the accuracy of the wage index. It will have a small effect for rural hospitals. It will increase payments for rural hospitals and reduce them for facilities in market areas that have many teaching hospitals. That is a relatively modest impact, though.

The bigger problem with the wage index is that you don't have data you need to accurately capture how much Hospital A pays for a nurse versus Hospital B. What you have now in the wage index is not just differences in apples to apples comparisons, but that some teaching hospitals have a wholly different mix of employees than most rural hospitals. The effect of that is to drive up the wage index for urban areas with teaching hospitals and push down the wage index for hospitals in rural areas. That is not consistent with the underlying purpose of the wage index and needs to be corrected. The problem, as I said earlier, is that collecting the data to construct a proper wage index is a 2- or 3-year proposition from the date of collection to date of implementation.

Chairman JOHNSON. On the issue of the size of the MSAs, you know, we heard some testimony that actually making them smaller could make the problem worse. You are saying they are too large. I think you both said they are too large.

Dr. SCANLON. We do think they are too large, because, when you look within the MSAs, you see some systematic variations in the wages that are being paid that are consistent with the kind of variation that you may see in the cost of other services. Think

about the cost of housing, the cost of rent for office space. As you move from the central city, these things become less expensive.

Chairman JOHNSON. Well, that certainly changes, but, you know, if your workforce is as mobile as our work force is, I am not sure that smaller is going to be more accurate.

Dr. SCANLON. Let me talk about both those things. One is: I do think that in order to attract workers into the central city, companies, both in health care and outside of health care, will tell you that they have to pay premiums. People don't want to go into congested central cities. They don't want to go into unsafe central cities to work. They need to be compensated more to attract them there. So, central city hospitals may end up paying more.

Parking for employees and transportation costs may be higher as you move into the central city, and so workers take that into account. So, I think that some of the reality we are seeing is that as you do move out from the central city, wages that need to be paid can decline. Think of the geographic area that is encompassed in the Washington, DC, metropolitan area. Yes, there are some people from West Virginia who do commute to Washington, DC, but it is not the norm. The norm is going to be that people in West Virginia are likely to work in West Virginia.

Making smaller metropolitan statistical areas is going to eliminate some of the problem that you talked about in terms of the large gaps at the borders of the MSA's. Right now some of that gap, when you take a West Virginia county that is not in the metropolitan statistical area, is due to the fact that what we are doing is we are comparing that county's rural wages with wages from Washington, DC, which are much, much higher.

Chairman JOHNSON. Your averaging process does not——

Dr. SCANLON. It is an averaging process.

Chairman JOHNSON. Those disparities.

Dr. SCANLON. Right. I hate to introduce those because we always talk about how complicated our systems are. If you were to bring economists here and ask them how to define labor markets, they would tell you that you can't draw very bright lines between labor markets.

Chairman JOHNSON. Right.

Dr. SCANLON. The labor markets overlap. We have to do the best job we can to make the system both understandable and appropriate, and I think the way we get to being more appropriate is if we look into reducing the size of the metropolitan statistical areas that are used for Medicare geographic areas. Even as important is to think about the non-metropolitan areas, these huge sections of States which are treated identically, yet that have large towns, small towns, very rural areas, where wages do—we see over and over again—differ systematically. I think recognizing some of those differences is going to make this geographic reclassification much more reasonable and provide a much more solid basis to defend it.

Chairman JOHNSON. I appreciate your comments in terms of New York City versus outlying areas, but I think in terms of most cities, even like Ann Arbor—I am not as familiar with that area as I am with many, but say Hartford, Connecticut, then you take the suburbs and then you take the rural areas. Any rural areas

from Connecticut you can commute in. On the other hand, there is no question but that wages vary. That is not even as good an example because New England has such a uniform high cost of living.

Dr. SCANLON. Right. I am a former Chicagoan so I relate to the example from Lake County. There is commuting within these areas, but to go from Lake County in Indiana or to go from Lake County in Illinois down into the city of Chicago is a major commute. It is not done regularly by the majority of workers. People take commuting into account, and it reduces the value of your having a job, and, therefore, you are going to want more if you are going to put up with that. So, I think what we do see is this pattern in wages, and we need to recognize that in terms of the payment levels.

Mr. HACKBARTH. Could I just underline one point? We have two problems with the current areas. One is that they are so big and so diverse that you are averaging very different populations together, different wage groups together. The second problem is these steep cliffs as you move across boundaries. So, ideally I think what you want is more areas, more homogeneous areas, and then you will have smoother movement across the boundaries. You won't have big changes, as large a change in the wage index as you move from the central city to suburban areas to rural areas. It just needs to be a smoother gradient than we have right now.

Chairman JOHNSON. I think that has potential, but to do that you would almost have to do that within an understanding of regions as opposed to sort of automatic, I don't know what Federal delineations you would use.

Mr. HACKBARTH. Ideally, you need to develop new area definitions from the raw data.

Chairman JOHNSON. Right.

Dr. SCANLON. Right, I agree. I think one of the things that we are suffering from is that we have taken off the shelf OMB's designation of metropolitan statistical areas, which were not created for Medicare hospital payment or any other kind of payment. We have used it without really considering the modifications that might be necessary to make it appropriate for hospital payment.

Dr. ZUCKERMAN. Can I make one comment?

Chairman JOHNSON. Yes.

Dr. ZUCKERMAN. The issues of the geographic areas and the occupation mix adjustment are probably not as separate as this discussion suggests. An occupation mix adjustment will go a long way toward getting a more appropriate geographic differential across areas. If you have very different types of workers in the hospital work force across geographic areas, this will be reflected in the payments. Some of the difference across areas is due to a "cliff" at the boundary states created, in part by the geographic gradient of wages. Some of the difference is also due to fairly dramatic changes in the composition of the hospital work force across areas.

When we were doing the physician cost adjustors, both the work adjustor and the employee adjustor, we didn't have the luxury of provider-based data. We built up the indices from Census-based data. We used median wages within fairly detailed classifications of workers at the county level and aggregated this data up to the

Medicare payment localities, controlling for occupational mix. We found that occupation mix made a big difference.

If we looked at aggregate median wages across all workers, we got a very different pattern of geographic cost differences than if we looked at median wages within a class of occupation and then aggregated that information up to the area.

I think the occupation mix adjustment and the area definition in the hospital wage rates interact with one another and you probably need to do both.

Chairman JOHNSON. That combined with more—I assume you are looking at both different data and more current data.

Mr. HACKBARTH. Ideally, more current. As you pointed out, the data used for the wage index are 4 years old, which seems quite old. We have, however, looked at how quickly the relative wage rates across areas change over time—that is what we are trying to measure here. If you look back into the nineties, actually there is not that much change in the relative position of different markets.

Now, whether that continues to be true today, you know, with the shortage of various types of health care workers, I don't know, frankly. If you look back, the data lag has not been that big of a problem. In other areas, the data lag is a real big problem.

Chairman JOHNSON. I appreciate the accuracy of the proportionality, but I worry about the fact that that formula cannot take into account spikes in costs, real costs, and the market basket may or may not take into account those costs. Over time you get a spike of malpractice, you get a spike of something else, and pretty soon you have a tension within the system that the formula doesn't represent but life represents.

Mr. HACKBARTH. Yes. Well, the spikes, as you put it, do need to be accounted for in the update process. The wage index, again, is just trying to measure relative wage levels and not the effect of shortages or the malpractice situation, and so forth.

Chairman JOHNSON. I appreciate your patience very much, and I also appreciate the hour and the soggy state of most everyone's mind by about now. I do appreciate your testimony, and I appreciate your sitting through all the Members, and I look forward to working with you. I don't think this is a problem we cannot do something about, so, we will look forward to more informal discussions as we search for answers. Thank you very much for your expertise and your time.

Dr. ZUCKERMAN. Thank you.

Dr. SCANLON. Thank you.

Mr. HACKBARTH. Thank you.

[Whereupon, at 4:56 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of J. Michael Horsley, President, Alabama Hospital Association, Montgomery, Alabama

The Alabama Hospital Association (the "Association") and its members submit this written statement to the Subcommittee on Health of the Committee on Ways and Means regarding the geographic cost adjustors used in calculating Medicare hospital payments. More than one hundred of Alabama's acute care hospitals are members of the Association. The Medicare and Medicaid programs are the two largest payors for hospital services furnished in the State. Therefore, any adjustment to the payment levels under the Medicare program, including an adjustment to the

calculation and application of the wage index, will have a significant impact on the financial wherewithal of these hospitals.

Background

The Subcommittee's examination of Medicare payments is well-timed. For fiscal year 2002, CMS attributed 71.066 percent of the PPS payment to the "labor component." This amount is adjusted by a "wage index" assigned to each geographic area in the country. The wage index reflects the wage costs in the local area relative to the wage costs in the country as a whole.

All areas in Alabama have a wage index that is under 1.0. In the fiscal year 2002, for example, the Huntsville MSA has the highest wage index in the State at only 0.8883. The rural wage index in Alabama is 0.74, one of the lowest in the country. When the large labor component is adjusted by these low wage indices, Medicare payments to Alabama hospitals are artificially reduced.

As the Subcommittee evaluates the formula for wages and the appeals process it should consider several specific actions.

I. CONGRESS AND CMS SHOULD IMMEDIATELY IMPLEMENT AN OCCUPATIONAL MIX ADJUSTMENT OR A COMPENSATING INTERIM ADJUSTMENT TO THE WAGE INDEX.

Wage indices are not accurately calculated under the current regulations. They do not reflect the "occupational mix" variations from hospital to hospital. The "occupational mix" is the distribution of workers among various occupational groups delineated by their skills, training, and wages. *See* 66 Fed. Reg. 22,674 (May 4, 2001). By failing to make these adjustments, CMS mistakenly presumes that the "occupational mix is constant across markets." MedPAC, *Report to Congress, Medicare Payment Policy,* at 52 (March 2001). Due to this mistake, hospitals that truly need more highly skilled and specialized, and higher wage workers receive duplicate payments: once through their higher wage index and once through the higher DRG weights attributable to their higher case mix index. 66 Fed. Reg. 22,674 (May 4, 2001). At the same time, due to this mistake, PPS rewards hospitals that have a lower case mix index but unnecessarily elect to have a more specialized staff with higher labor costs. These higher payments are at the expense of more efficient hospitals.

Congress has directed CMS to implement an occupational mix adjustment no later than October 1, 2004. Pub. L. No. 106–554, § 304(c), 114 Stat. 2763A–495 (2000). Meanwhile, this delay in adjusting wage indices for occupational mix variations is a disadvantage to virtually all hospitals in Alabama. Therefore, the Association believes that an occupational mix adjustment should be implemented immediately.

If it is not possible to implement an occupational mix adjustment for 2003, Congress at least should direct CMS to implement one of two interim, compensatory adjustments to the wage index. First, Congress could establish a wage index "floor," *i.e.,* a fixed index that constitutes the lowest wage index that is assigned to any area. MedPAC, *Report to the Congress: Medicare in Rural America,* 72–73. (June 2001). Hospitals in any area with a wage indices less than this floor amount would use the floor index in computing their PPS payments.

Further, a wage index floor will be necessary even after CMS finally develops an occupational mix adjustment. CMS itself recognizes the problems in developing an accurate occupational mix adjustment. 66 Fed. Reg. 22,674–675 (May 4, 2001). Hospitals with a low occupational mix may still be disadvantaged after the adjustment is implemented. An index floor will limit the residual distortions in the wage index due to occupational mix variations.

A permanent floor is also needed because the wage index inherently is based on short term analysis, *i.e.,,* that in the short run, employers compete for labor in a local labor market. In the long run, however, labor markets are national because workers readily migrate from one area in the country to another due to wage differentials. The current payment system freezes existing wage differentials—and, effectively, long term migration patterns—because hospitals in areas with exceptionally low wage indices cannot raise wages to be competitive in the long term labor markets. Therefore, Congress and CMS should set a floor for the wage index to eliminate the long term disadvantages of wage indices based exclusively on current wage data.

As an alternative to a wage index floor, Congress could require CMS to implement a "compression factor," *i.e.,* an adjustment that reduces the wide variations in the wage index due to the differences in occupational mix. A compression factor would slightly reduce the wage index of those hospitals with an extraordinarily high occupational mix, while it would increase the wage index of those hospitals with an extraordinarily low occupational mix. MedPAC has endorsed a compression factor from

0.959 to 1.032. MedPAC, *Report to Congress, Medicare Payment Policy,* at 52 (March 2001).

Pending the implementation of an occupational mix adjustment, either of these adjustments would minimize the effects of occupational mix variations on those hospitals hit hardest by such variations.

II. CONGRESS SHOULD ENSURE THAT THE WAGE INDEX AND THE LABOR COMPONENT ARE CALCULATED AND APPLIED ON A CONSISTENT AND UNIFORM BASIS THROUGHOUT THE COUNTRY.

A. CMS Should Establish a Consistent Method For Calculating the Labor Component and the Wage Index.

Congress must direct CMS to develop a consistent policy governing the labor component and the wage index. Currently, the wage index is based on one set of data but it is applied to the labor component which includes a completely different set of costs. There is no discernable relationship between the wage index and these other costs.

CMS now bases the wage index on salaries and fringe benefits. However, CMS includes "nonmedical professional fees" and "all other labor intensive services" in the labor component. 67 Fed. Reg. 31,447 (May 9, 2002). These two categories of costs amount to about 10 percent of the 71.066 percent of all costs assigned to the labor component. *Id*. This adjustment is made even though CMS does not include "nonmedical professional fees" and "labor intensive services" in the calculation of the wage index. CMS has no data demonstrating that costs in these categories vary from area to area like wages and fringe benefits.

The adjustments to labor costs must be internally consistent. Otherwise, hospitals with a low wage index are penalized while hospitals with a high wage index are overcompensated.Thus, Congress should enact legislation requiring CMS to apply the wage index only to the costs that are included in the calculation of the wage index.

B. CMS Should Establish a Method for Calculating the Wage Index That is Uniform For All Hospitals.

Congress and CMS also must develop uniform rules governing the calculation of the wage index for all areas in the country. CMS now uses different data from area to area in calculating the wage indices. For example, CMS recognizes that some hospitals contract out certain services that are typically lower wage—such as dietary and housekeeping services—that other hospitals furnish with their own employees. 67 Fed. Reg. 31,433. Still, CMS excludes the costs of the contracted services in the calculation of the wage index of the areas in which these contracting hospitals are located. *Id.*

The exclusion of contract labor in the calculation of the wage index skews the wage indices assigned to different areas. The best evidence available suggests that contract labor is used predominately in urban areas, and that the exclusion of these predominately lower-wage services in the calculation of the wage indices overstates the wage index assigned to these areas.

Congress and CMS must identify all disparities in the calculation of the wage indices of the different areas of the country and must ensure that the wage index is calculated in a uniform manner.

III. CONGRESS SHOULD REQUIRE CMS TO REVISE THE LABOR COMPONENT TO MORE ACCURATELY ESTIMATE WAGE AND WAGE-RELATED COSTS.

Congress also should modify the methodology that CMS uses to calculate the labor component. There are several actions the Subcommittee should consider.

A. Congress Should Exclude From the Labor Component Costs That do Not Vary by the Wage Index.

First, Congress should enact legislation to limit CMS's over-inclusive definition of the labor component. Right now, CMS includes costs that are neither "wage or wage-related costs" and are not likely to vary with the local labor markets. These costs should not be included in the labor component and should not be adjusted by the wage index.

Insurance costs are a good example of costs that should not be adjusted by the wage index. Most insurance premiums are not "wage or wage-related" or, at most, have only a tenuous relationship to local wage levels. For example, premiums for workers compensation insurance are based in large part on estimates of payments to claimants for medical expenses, pain and suffering, legal fees in defending cases, administrative costs in processing claims, and other costs. These elements are not

related to the hospital's wages. Further, to the extent lost wages are included the estimate of expected losses, lost wages are calculated on a statewide basis rather than a local level.

This same analysis is applicable to other kinds of insurance. Premiums for fire and property insurance are based on the replacement value of the assets insured. Premiums for general liability insurance are based on the cost of professional malpractice insurance, and CMS already has determined that premiums of malpractice insurance are not wage-related.

Other costs that are included in the labor component do not vary with local wage levels. For example, CMS includes accounting fees in the labor component. However, most hospitals retain national accounting firms whose fees are set on a national basis. Those fees do not vary by local wage levels.

More generally, it appears that Congress intended that CMS would apply the wage index to that portion of the PPS payment attributable to wages paid by hospitals. CMS has drastically expanded application of the wage index to a wide variety of costs, including the fees or charges of independent contractors. However, CMS does not have any information showing that these fees or charges vary by the local wage levels in the area in which a hospital is located.

B. Alternatively, CMS Should include in the Labor Component Only the Portion of Fringe Benefits, Nonmedical Professional Fees, and Other Labor Intensive Services That Are Wage-Related.

The application of the wage index to "nonmedical professional fees" and "labor intensive" costs is arbitrary also because only a portion of these costs are "wage or wage-related." For example, at present, the labor component includes landscaping services and auto repair services, 67 Fed. Reg. at 31,447, even though only a portion of those cost are attributable to labor. Even CMS recognizes that there is a nonlabor component of contract services, 67 Fed. Reg. 31,432–33, but it has not eliminated this portion of the charges from the labor component.

Alternatively, the definition of "wage and wage-related costs" should be limited to those costs for items or services that can be purchased only in the local labor market. MedPAC Report to Congress, *Medicare in Rural America,* at 79 (June 2001); see 67 Fed. Reg. 31,447. CMS's current definition of the labor component, however, includes any inputs with prices "influenced" by the local market, even if those inputs are purchased only in a national market, or if a portion of the inputs is purchased locally and the remainder is purchased regionally or nationally. *Id.*

IV. CONGRESS SHOULD ENSURE THAT THE WAGE INDEX REFLECTS THE FACT THAT MANY LABOR COSTS ARE INCURRED IN A NATIONAL MARKET.

A faulty premise underlying the wage index as it is now administered is that labor markets are entirely "local" markets. Right now, Alabama hospitals confront the migration of workers outside the state. Thus, Alabama hospitals should have PPS rates adjusted to reflect the wages that are paid to migrating workers by hospitals in other states.

The Association has monitored these migration patterns. Each year, for example, more than ten percent of the nurses in Alabama apply for license verifications to permit them to practice outside the State. Approximately 7,000 RNs, out of a total of 68,000, seek license verifications each year to be licensed to practice in another state. This exodus is not limited to RNs: other groups of medical professionals are regularly leaving Alabama, too.

The hospitals in Alabama clearly are competing with out-of-state hospitals for these nurses. These out-of-state hospitals with higher contract labor costs will be assigned an ever-increasing wage index; they will be paid higher DRG payments; and they can then better afford even more contract labor. Conversely, hospitals in low wage index areas like Alabama will confront steadily lower wage indices and will not be able to retain RNs and other specialized labor as salaried employees. Therefore, these national labor markets must be taken into account in calculating the wage indices of states like Alabama.

V. CONGRESS SHOULD ENSURE THAT CMS ADOPTS MORE REALISTIC STANDARDS FOR GEOGRAPHIC RECLASSIFICATIONS.

There is a mechanism for hospitals with unusually high labor costs to seek relief by applying to the Medicare Geographic Classification Review Board. However, the standards for reclassification are overly restrictive.

In general, an urban hospital qualifies for reclassification only if it is within 15 miles of the area to which it seeks reclassification. A rural hospital must be within 35 miles of the area to which it seeks reclassification. 42 C.F.R. § 412.230(a)(2). These mileage restrictions were arbitrarily established more than a decade ago, 55

Fed. Reg. 36,766 (Sept. 6, 1990), *as amended,* 56 Fed. Reg. 25,488 (June 4, 1991). The commuting patterns in Alabama and throughout the country have expanded so dramatically that the 15- and 35-mile proximity requirements are now outdated. These proximity requirements should reflect new commuting patterns so that either an urban or rural hospital may be reclassified if it is within 50 miles of the area to which it seeks reclassification. Also, to eliminate confusion, this mileage should be measured in air miles.

If a hospital does not meet the mileage requirements, it may be reclassified if, among other things, more than 50 percent of the hospital's employees live in the area to which it seeks reclassification. 42 C.F.R. § 412.230(b)(2). This is an unduly restrictive definition of the real labor market in which hospitals operate and in which employees commute. Congress should make three changes to these requirements.

First, reclassification should be permitted if as few as 10 percent of a hospital's employees live in the area to which the hospital seeks reclassification. Standard market definitions recognize that a single market exists if there is as little as 10 percent movement between the two areas. *See, e.g.* Horizontal Merger Guidelines (1997) (Department of Justice and FTC measurement for geographic market definition for antitrust cases).

Second, hospitals should be reclassified if a significant number of people in the area in which the hospital is located commute *to* the region to which the hospital seeks reclassification. Reclassification is possible only if the hospital in the low wage area draws a significant number of workers *from* the area that has the higher wage. 42 C.F.R. § 412.230(b)(2). By definition, in a fluid labor market the workers from the low wage area in which the hospital is located will commute *to* the hospitals that are located *in* the higher wage areas.

Third, reclassification should be permitted if a hospital competes for labor with facilities in two or more nearby geographic areas. Under 42 C.F.R. § 412.230(b)(2), reclassification currently is permitted only if the hospital draws at least 50 percent of its employees from the one area to which it seeks reclassification. This standard for reclassification is overly restrictive in that it focuses exclusively on the dynamics between two geographic areas. Some hospitals may draw employees from (or lose employees to) two or more different geographic areas. Therefore, Congress should modify this standard to allow reclassification whenever there is any significant in-migration or out-migration from the area in which the hospital is located, even if the workers commute to several nearby areas.

Finally, an urban hospital seeking reclassification must demonstrate that its wage levels are at least 108 percent of those of the hospitals in the area in which it is located, and at least 84 percent of the wages in the area to which it seeks to be reclassified. Similarly, a rural hospital seeking reclassification must demonstrate that its wage levels are at least than 106 percent of those in the area in which it is located and at least 82 percent of the wages in the area in which it seeks to be reclassified. These requirements are too stringent, and Congress should adopt more flexible standards.

CONCLUSION

Various factors affect the proper calculation of Medicare payments to hospitals. Apparently, the Subcommittee is concerned that the geographic areas used to calculate the wage indices may be arbitrary. The Association strongly suggests, however, that these more fundamental problems in the calculation of the wage index and the labor component must be corrected before the Subcommittee can evaluate the use of the geographic areas now specified by statute.

I look forward to the opportunity to testify in person on these issues and other matters the Subcommittee may address regarding the calculation of payments to hospitals under Medicare's Prospective Payment System.

Statement of the American Academy of Family Physicians, Leawood, Kansas

This statement is submitted to the House Ways and Means Subcommittee on Health on behalf of the 93,500 members of the American Academy of Family Physicians. Twenty-eight percent of the members of AAFP reside and practice in rural areas and are therefore disadvantaged by Medicare payment formulas that include geographic adjustment factors.

AAFP strongly supports the elimination of all geographic adjustment factors from the Medicare Fee Schedule except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). This long-

standing policy of the AAFP was first adopted in 1973, was reaffirmed in 1996 and remains current today.

Medicare payment formulas should accurately compensate physicians and providers who deliver high-quality, cost-effective services to Medicare beneficiaries in all areas of the country. However, the formulas used by the Medicare program to reimburse physicians and health care providers for beneficiaries' medical care are not accurately measuring the cost of providing services, and are reimbursing physicians and other health care providers in a manner that favors urban providers over rural providers. AAFP commends the chair for convening this hearing today and appreciates the efforts of the committee to promote fairness and equity in the Medicare program.

As stated above, Medicare payments to rural physicians and other health care providers are less than what their equivalent counterparts are paid in more densely populated areas, even though it costs as much and even more to provide medical services in rural areas.

Medicare payment policy with respect to physician services delivered in rural and underserved areas can be described as contradictory—paying bonuses to physicians for practicing in rural and underserved areas on the one hand while devaluing physician clinical decision-making and patient services in rural areas less, on the other. AAFP urges Congress to correct this mixed message by aligning the policies and ensuring that they consistently provide incentives to physicians to practice in rural and underserved areas.

The American Academy of Family Physicians has endorsed two pieces of legislation that would correct these inconsistencies: the "Rural Equity Payment Index Reform Act" (REPaIR, H.R. 3569), introduced by Representative Doug Bereuter (R–NE) and 60 bipartisan cosponsors, would phase-in a floor of 1.000 for the Medicare "physician work adjuster," thereby raising all localities with a work adjuster below 1.000 to that level. This proposed change would positively and substantially affect patients and physicians in 56 (63 percent) of the 89 geographic payment localities. A phase-in over four years would soften the budgetary ramifications of such a policy correction.

A second bill, the "Revitalizing Underserved Rural Areas and Localities Act" (RURAL, S. 2555), introduced by Senator Max Baucus (D–MT) would revise and improve the Medicare Incentive Payment Program (MIP) which exists for the purpose of encouraging physicians to practice in rural and underserved areas. The existence of MIP could be interpreted as a commitment of the Federal Government (and the Medicare program in particular) to help rural America attract and retain physicians. However, when MIP is combined with a geographic disparity represented by the devaluing of physician work in rural areas, the incentive makes Medicare appear contradictory. This contradiction sends a mixed message to physicians who would consider locating their practices in rural America.

The Medicare Incentive Payment Program (MIP)

Created in 1989, the MIP program provides bonus payments to physicians who practice in HPSAs in an effort to encourage more physicians to those areas. According to a Medicare Payment Advisory Commission (MedPAC) report dated June 2001, a recent decline in the bonus payments to physicians has caused concern that several aspects of the program design are compromising its effectiveness.

For example, currently the MIP ten-percent bonus is paid to physicians practicing in HPSAs only upon submission of the claim form along with a special coding modifier that is attached to each service. Since the bonus payment is predicated upon the use of this special coding modifier, and, due to the inherent instability of the HPSA designation, physicians cannot always be certain if they are practicing in a shortage area, the use of the MIP has been less than expected.

In 1996, 75 percent of participating rural physicians, or about 18,700 doctors, received less than $1,520 each in bonus payments for the year. In addition to the complexities described above, the low level of payments may be attributable to carriers being required to review claims of physicians who receive the largest bonus payments. A 1999 study by the Health Care Financing Administration (HCFA) suggested this policy may discourage physicians from applying for the MIP program. More importantly, a 1999 General Accounting Office (GAO) report suggested the ten-percent bonus payments may be insufficient to have a significant influence on recruitment or retention of primary care physicians.

The RURAL bill (S.2555) would make any physician practicing in a Health Professional Shortage Area (HPSA) automatically eligible for a ten-percent bonus. The bill would also charge the Secretary of Health and Human Services to conduct an ongoing program to provide education to physicians on the Medicare Incentive Payment (MIP) program. The Secretary would also be directed to conduct an ongoing study

of the MIP program, which would focus on whether such a program increases the access to physicians' services for those Medicare beneficiaries who reside in a HPSA.

Geographic Practice Cost Indices (GPCIs)

Payments for physicians' services under Medicare are made on the basis of a fee schedule. The fee schedule has three components: the relative value for the service; a geographic adjustment; and a national dollar conversion factor. The relative value for a service compares the relative physician work involved in performing one service with the work involved in providing other physician's services. It also reflects average practice expenses and malpractice expenses associated with the particular service. Each of the 7,500 physician service codes is assigned its own relative value. The relative value for each service is the sum of three components:

- physician work, which measures physician time, skill and intensity in providing a service;
- practice expense, which measures average practice expenses such as office rents and employee wages; and
- malpractice expense, which reflects average professional liability insurance costs.

A separate geographic adjustment is made for each of these three components. As stated earlier, Medicare payments to rural physicians and other health care providers are less than what their equivalent counterparts are paid in more densely populated areas even though it costs as much, and in some cases even more, to provide medical services in rural areas.

AAFP policy recommends that physician work should be valued equally, irrespective of the geographic location in which it is performed. Since it is probably not politically feasible to lower the work adjuster levels of health care providers in urban areas to correct this inequity, this change proposed in the "Rural Equity Payment Index Reform Act" (REPaIR, H.R. 3569) would be put in place without regard to the budget neutrality agreement in the present law. Thus, Congress would need to change the law in order to authorize an increase to establish a floor of 1.000 to all parts of the nation. The phase-in approach attempts to soften the budgetary ramifications by spreading it over a few years. HR 3569 will at least reduce the current inequity in payments.

Ratios of Physicians Practicing in Health Professional Shortage Areas

The number of Health Professional Shortage Areas (HPSAs) in the US indicates that these programs are not fully successful. (See Exhibit A, which indicates the current number of HPSAs in the US.)

Of 3142 counties in the United States, 1189 (63%) are designated full or partial county HPSAs meaning that the desired ratio of one primary care physician to 3500 people is not met. If family physicians are removed or choose to remove themselves from the system due to insufficient payment or other reasons, the large majority of US counties would become full or partial county HPSAs. (See Exhibit B, which indicates how many counties would become full or partial HPSA if family physicians were to be removed).

Indeed, family physicians are opting for less than full participation in the Medicare program at an unprecedented rate. Recent AAFP research reveals that 21.7 percent of AAFP members responding indicate they are not accepting new Medicare patients, compared with 17.0 percent just a year ago. This represents a 28 percent increase in the past 12 months.

More than 2,200 physicians are needed in non-metropolitan areas to remove all non-metropolitan health professional shortage area (HPSA) designations for primary care. More than twice that many are needed to achieve a 2,000-to-1 optimal ratio in those HPSAs. Congress needs to take steps to improve Medicare for rural and other non-metropolitan areas now. Increasing the supply of primary care providers in rural areas by lessening geographic differentials in physician income is an important step Congress can take right now.

Experience of a Rural Family Physician

Dr. Baretta Casey has done what the government wants many physicians to do: set up practice in an underserved area, taking care of many patients on Medicare and Medicaid. She came to medicine later in life than many do, as a wife with two children—three by the time she graduated. She wanted to become a family doctor and practice in her Appalachian hometown of Pikeville, Ky.

Her business background stood her in good stead. She bought an office building at an auction, rented out the top floor to offset the cost of her first-floor office, computerized her practice from the start and opened her doors as a solo practitioner eight years ago.

Thanks to the booming practice and conservative living, Casey significantly paid down her $145,000 in student loans her first full year. But that was as good as it got. Ensuing years didn't get better. In fact, they got worse.

On her computer Dr. Casey watched while medical expenses continued to grow but payment rates failed to keep pace. Dr. Casey says: "As a solo practitioner, I pay for everything. And the increase in expenses hasn't been the measly little percentage you hear forecasted by the government. I've tracked it on my computer. It has gone up 10 to 15 percent every year."

"It took about six years, but at the six-year mark, expenses and income literally met in the middle," she says. "This past year, they crossed over. And now, I have to dip into my savings to cover the extra expense. I'm basically subsidizing my own practice out of a savings account."

And now, in 2002, the worst blow of all—the 5.4 percent cut in the Medicare conversion factor. "I've had to make some decisions," Dr. Casey says. "I won't take any new Medicare patients or any new patients with any insurance company that follows suit and drops payment." And ultimately, she says, "If things don't change, I probably couldn't stay in practice any more than two more years."

Dr. Casey has a message for Washington:

"If our reimbursement rates continue to go down and our expenses continue to go up," she says, "you will see an exodus of physicians out of rural areas like Moses out of Egypt. It's not because doctors don't care about their patients. They do, tremendously."

"It's because nobody is going to continue in a field or in a business when they're losing 10 to 15 percent per year. The practice of medicine is like any other business: If you can't pay your bills, you can't survive."

Conclusion

Medicare payment rates, insufficient valuation of physician work performed in rural areas, and an ineffective Medicare Incentive Payment Program contribute to the problems experienced by Dr. Casey and many other family physicians across the country, particularly those who practice in rural and underserved areas.

AAFP calls upon Congress to take the necessary steps to remedy this failing system by: (1) permanently fixing the formula by which Medicare payment rates are determined; (2) eliminating the geographic disparity that devalues physician work performed in rural and underserved areas; (3) and revising the Medicare Incentive Payment Program to increase its effectiveness. These adjustments will create a more consistent Medicare policy and improve the likelihood that it will accomplish the intended policy objective: i.e., to attract physicians to rural and underserved areas.

Statement of the American Hospital Association

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health care systems, networks and other providers of care, we are pleased to submit the following statement for the record as the Subcommittee on Health discusses the critical issue of geographic cost adjustors for Medicare payment.

As rural hospitals must now compete in a national labor market for the same health care workers as urban hospitals, today's Medicare reimbursement policies hamper the ability of rural hospitals to close the expanding wage gap. As a result, many rural hospitals are paid too little to compete for personnel in an increasingly tight labor market.

These facilities and the men and women who work in them are an integral part of their communities, not only providing access to health care services but also serving as a hub for public health, wellness and social services. Because many are smaller facilities, these hospitals have difficulty absorbing changes in reimbursement and coverage policies, as well as government regulations. They are more severely affected by shifts in local demographics, health status, practice patterns and the loss of health care professionals. And, because there often are few or no reasonable alternatives to care, small or rural hospitals are usually the sole source of essential health care for their communities.

As rural hospitals struggle with continued Medicare and Medicaid payment reductions, mounting regulatory requirements and rising technology and blood expenses—all of which impose significant financial burdens on small rural hospitals—they must also confront a growing shortage of health care professionals. Because rural health care workers may earn less than their urban counterparts as a result of Medicare payment policies, these health care professionals may commute long distances or relocate to earn higher wages in urbanized areas. As a result, small or rural hospitals feel the financial pressure to compete with their urban neighbors for a dwindling pool of health care professionals.

America's 2,200 rural hospitals provide essential inpatient, outpatient and post-acute care, including skilled nursing, home health and rehabilitation services, to nearly 9 million Medicare beneficiaries. Rural hospitals rely heavily on Medicare payments, which can be 70 percent or more of their revenue, yet are less able to manage within a prospective payment system (PPS) because of low financial reserves, thinner margins and significant fluctuations in patient volume. These challenges, combined with their sparse populations and high levels of poverty, have significantly affected the ability of many rural hospitals to remain financially viable

under Medicare prospective payment policies. In fact, one out of every three rural hospitals is losing money, as reported by the Medicare Payment Advisory Committee (MedPAC) in their *2002 Report to Congress.*

To help hospitals in rural and smaller metropolitan areas attract and retain quality health care personnel, the AHA urges a comprehensive, national solution to this problem through passage of H.R. 1609, the Area Wage Index and Base Payment Improvement Act, introduced by Representatives Phil English (R–PA) and John Tanner (D–TN).

This bill specifically establishes a "floor" on the area wage index used to adjust Medicare hospital inpatient and outpatient prospective payments. By setting a floor of 0.925 on the area wage index, this proposal would bring Medicare payments in areas with the lowest wage index up to just below the national average. Another provision of the bill raises inpatient PPS base payment amounts for rural and smaller urban hospitals to match the "large urban" rate, which was included in the recently passed H.R. 4954, The Medicare Modernization and Prescription Drug Act, phased-in over two years.

Adequate government funding is essential to help hospitals attract and retain qualified personnel. Because overall hospital margins have been reduced, funds for increasing wages are not available from internal sources and must be added by all payers, including Medicare. With today's tight labor market, Congress should pass legislation creating a wage index floor and moving to one base payment amount. These two measures will help ensure that rural and smaller metropolitan hospitals have the necessary health care workers to continue providing the highest quality of care to our nation's elderly.

Statement of Dale E. Baker, Baker Healthcare Consulting, Inc., Indianapolis, Indiana

Baker Healthcare Consulting, Inc. is an Indianapolis based consulting firm that works with hospitals throughout the country on Medicare geographic classification matters and Medicare wage index matters. Our clients range from small rural hospitals to large urban metropolitan medical centers. We also work with leading hospital associations on wage index matters and prepare applications for geographic reclassification for groups as well as individual hospitals. Our comments are not prepared on behalf of any individual client of this firm but are submitted as an effort to focus the testimony of members of Congress and others on the prevalent technical issues that were being addressed (but not always enumerated) by members of Congress.

Most people think of Medicare geographic reclassification as a rural program, increasing payments primarily to rural hospitals. Statistics support this point of view, for FFY 2004 of 628 reclassified hospitals 82% or 515 were rural hospitals reclassified to nearby other areas (source: August 1, 2002 Federal Register, page 50280).

Surprising though, of the fifteen members of Congress on the tentative witness list, only five represented truly rural constituencies (Representatives Nussle, Aderholt, Moran, Peterson (PA) and Sandlin). Ten presenters represented mostly urban areas and in fact, five representers areas included in Consolidated Metropolitan Statistical Areas (CMSAs) which are areas with over one million population and generally sprawling areas surrounding major metropolitan areas with significant commuting patterns to and/or from major city. This includes Representatives Roukena, Visclosky, Shays, Hinchey and Kelly. These witnesses represent a very different constituency than a simple glance at the overall hospital reclassification statistics would suggest.

Defining the technical issues that the hospitals in these urban jurisdictions represent might assist the Subcommittee (and perhaps the administration) in defining solutions to the problems presented by members of Congress.

Group Reclassifications

The Medicare program allows for group reclassifications (countywide reclassifications or New England County Metropolitan Area (NECMAs) for areas that are included in CMSAs. The five presenters on this topic all represent Primary Metropolitan Statistical Areas (PMSAs, a designation within a CMSA) that were just outside the large urban areas, New York City and Chicago.

Hospitals in these outlying PMSAs are in competitive labor markets with the larger "core" areas such as New York City or Chicago. The size of the wage index "cliffs" at artificially designated county lines create enormous hardships on these outlying hospitals in attracting and retaining health professionals, whose mobility allow them to commute considerable distances, in many instances to earn significantly

higher wages. As savvy hospital human resource managers design worker friendly shifts (such as three twelve hour days rather than the standard five day work week) workers become ever more willing to commute greater distances for greater pay. Combine that with shortages of health professionals including RNs, pharmacists, and many others, and the need for geographic reclassification to hospitals in outlying PMSAs becomes obvious.

Hospitals in eligible outlying PMSAs can seek group reclassification if the group meets two key statistical criteria. First, the group average hourly wage must be at least 85% of the target PMSAs hourly wage. This criteria corresponds to an 84% criteria for an individual hospital reclassification. In the mid nineties the 85% criteria was reduced to 84% for individual urban hospitals seeking reclassification. In explicit idly, the group criteria were never changed.

For a group reclassification, hospitals must additionally meet a second criteria based on the groups average standardized cost per case. That criteria requires the standardized group cost per case to exceed a computed threshold amount to prove "comparable costs" to the target PMSA. The threshold amount is not based on the cost per case in the target PMSA but is based on the Medicare standardized payment rates computed as follows:(25% of the home PMSA Medicare standardized payment amount) plus (75% of the target PMSA Medicare standardized payment amount) equals the threshold amount.

For FFY 1995, there were twenty-three group reclassifications approved for a total of 119 hospitals. For FFY 2003, in an ever more competitive environment for scarce healthcare workers, only five group reclassification requests were approved for a total of sixteen hospitals, 13% of the hospitals approved in 1995. The attached exhibit summarizes the number of group reclassifications approved and the number of hospitals reclassified by year.

What happened? Hospital have greatly expanded outpatient units, opened and enlarged alternate sides of care including rehabilitation, psychiatric and long term care units to provide more expert cost effective patient care. The fixed overhead costs, which were formerly allocated largely into the inpatient acute care units, are now distributed to the other expanded units. Hospital groups can no longer meet the artificial cost per case criteria conceived before proliferation of alternative care sites. Note that these changes in health delivery are not unique to the outlying PMSAs but also apply to the New York City and Chicago hospitals as well. The criteria do not measure the relative urbanicity of these outlying areas as a true comparison of relative costs compared to the nearby city. The rate-based criteria is a "proxy" designed in 1989 that lacks relevance in today's environment and simply does not work right.

Modernizing the criteria, which were developed based on 1988 data, and eliminating the cost per case criteria (or modifying the criteria) would result in more appropriate reclassifications. Also, the wage index criteria should be set at 84%, the same as for individual urban hospitals.

Eliminating the standardized amount group criteria would result, based on our modeling in approximately twenty group reclassifications and shift approximately $132 million of inpatient operating payment to the newly reclassified hospitals. Total Medicare payments of $83.2 billion are budgeted for FFY 2003 (11,484,000 discharges times $7,247.2 per case payment per August 1, 2002 Federal Register). This budget neutral shift would reduce payment to other hospitals by only.0016 or $11.50 per discharge for inpatient operating payment. We would be please to work with staff to further refine these estimates. These criteria can fixed by regulation.

Dominant Hospital in Small MSA Issue

Two Congressmen, Representative Peterson (MN) and Smith represent urban districts with a dominant hospital that is unable to be reclassified. For an individual urban hospital to be reclassified for wage index purposes to a nearby urban area the applying hospital must generally meet three criteria as follows:

1. Proximity requirement—the hospital must be within fifteen miles of the target MSA to which it requests reclassification. A few formerly rural hospitals are exempt from this requirement.
2. The applying hospital must have an average hourly wage equal to or greater than 84% of its target MSA; and
3. The applying hospital's average hourly wage must be at least 108% of its home geographic area (including the applying hospital's wages).

The 108% criteria by definition prevents a hospital that is the only hospital in a small MSA from even qualifying for an individual hospital reclassification (unless the hospital is in a PMSA and can qualify under the aforementioned group criteria).

The issue also affects dominant hospitals where there may be two or three other hospitals in the MSA making it all but impossible for the dominant hospital to exceed the 108% criteria.

There are several technical solutions to fix this problem, including waiver of the 108% criteria where appropriate, or other criteria modification for small MSAs with dominant hospitals. Such a fix could be done by regulation or by statute. Approximately three years ago we estimated one possible fix to this issue might impact approximately twenty-six hospitals and shift $40 million in budget neutral payments. We will be pleased to work with staff to update this estimate based on various criteria that would alleviate this issue. These criteria can be fixed by regulation.

The Rural Issue

Several presenters (including Representatives Anderholt, Moran, Peterson (PA) and Sandlin) indicated that the same competitive pressures outlined in our PMSA discussion negatively impact rural hospitals. Various presenters endorsed the proposal for a.9250 wage index floor.

We agree that there are problems with the rural hospital payment level. We believe that there are an alternate technical approach to Congressional action on this issue that have several advantages compared to the floor proposal. We believe that the Subcommittee should consider "compression" as MedPAC has coined the term. CMS usually uses a Geographic Adjustment Factor (GAF) to modify inpatient capital payment. The GAF is the wage index taken to the power of.6848. The GAF is always closer to the mean of 1.0000 than the wage index. "Compression" would change all hospital wage indexes under some legislative threshold and result in a revised wage index that would be closer mean, resulting in wage indexes that are in the same order as the present wage index (i.e. the lowest wage index would still be the lowest).

If the Committee decides to grant rural and some urban hospitals wage index relief, a technique similar to the GAF would be an appropriate alternative to the floor. Such an approach would preserve existing incentives for rural hospitals to carefully collect and report wage index data. The floor might eliminate this incentive for many hospitals that have wage indexes well below the.925 proposed floor and result in distortion in the overall wage index. The formula could be applied, for example, to all hospitals with a wage index of less than 1.0000 thus giving more hospitals at least a small increase in payment. The.9250 floor rewards the lowest paying hospitals disproportionably, while denying rural hospitals in a state such as Vermont (with a wage index of.9345) any additional add on payment. We believe that Vermont hospitals face the same pressures as for example rural Alabama hospitals and therefore it seems appropriate that the rural Vermont hospitals should get some increase. "Compression" would achieve this objective. A factor such as the.6848 power used for the capital payment can be accurately crafted to increase payment according to a Congressional mandate.This change would require legislation.

Budget Neutrality

Traditionally, the members of Congress, the AHA and others have lamented the budget neutrality impacts of reclassification on other hospitals. The significant shift of funds in Budget Neutrality Adjustment occurred as of October 1, 1991, when the reclassification system first was implemented.

Since 1991, the only difference in budget neutrality is the annual incremental change of reclassifications; a very small number compared to total Medicare payments. If Congress is concerned about the impact on non-reclassified hospitals it could consider a proposal to "cap" the total rewards to reclassified hospitals in a separate pool of money to totally eliminate budget neutrality consideration. Such a pool could be enlarged from today's level if additional reclassifications are anticipated as a result of Congressional action to modernize the criteria as advocated in this paper. Such a pool could then be increased annually based on the rate of increase in the standardized amount, or some other objective methodology.

The above three issues address the vast majority of requests as presented by Congressional representatives at the July 23, 2002 hearing. There are other smaller reclassification issues, but fixing the above three issues would greatly improve the reclassification system.

We appreciate the opportunity to present our comments to the Subcommittee. Should you have further questions please do not hesitate to contact us.

MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

Group Reclassification Approvals Federal Fiscal Year 1995–2003

County Group	Target MSA	Number of Hospitals Reclassified [1]								
		1995	1996	1997	1998	1999	2000	2001	2002	2003
Atlantic County Hospital Group, NJ.	Philadelphia	3	3	3	3	3	3			3
Bergen County Hospital Group, NJ.	New York			6						
Boulder County Hospital Group, CO.	Denver	3	3					3	3	3
Butler County Hospital Group, OH.	Cincinnati	4	4	4	4				4	4
Cape May County Hospital Group, NJ.	Philadelphia	1	1	1	1		1			
Cumberland County Hospital Group, NJ.	Philadelphia	2	2	2		2				
Dade County Hospital Group, FL.	Ft. Lauderdale	8								
Hunterdon County Hospital Group, NJ.	Newark	1	1	1	1		1			
Kankakee County Hospital Group, IL.	Chicago		2							
Kenosha County Hospital Group, WI.	Chicago									2
Kitsap County Hospital Group, WA.	Tacoma	1	1	1						
Lake County Hospital Group, IN.	Chicago	8	8	8	8	8				
Mercer County Hospital Group, NJ.	Monmouth	5	5	5						
Middlesex County Hospital Group, NJ.	Newark/ Monmouth	4	4		4		4			
Monmouth County Hospital Group, NJ.	Middlesex	5	5	5						
Morris County Hospital Group, NJ.	Bergen-Passaic	4	4		4		4			
Ocean County Hospital Group, NJ.	Philadelphia	4		4						
Orange County Hospital Group, CA.	Los Angeles	33	33							
Orange County Hospital Group, NY.	Bergen-Passaic	6		6	6	6	6			
Passaic County Hospital Group, NJ.	Newark			6						
Pierce County Hospital Group, WA.	Seattle	5								
Portage County Hospital Group, OH.	Cleveland	1		1	1	1				
Racine County Hospital Group, WI.	Milwaukee	3	3	3	3				3	3
Santa Cruz County Hospital Group, CA.	San Francisco	3	3	3	3					
Somerset County Hospital Group, NJ.	Newark	2		2	2					
Summit County Hospital Group, OH.	Cleveland	5	5	5						
Union County Hospital Group, NJ.	Bergen-Passaic		5							
Ventura County Hospital Group, CA.	Los Angeles	8								
Total Group Reclassifications.		**23**	**17**	**18**	**10**	**5**	**5**	**2**	**4**	**5**

MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD—Continued

Group Reclassification Approvals Federal Fiscal Year 1995–2003

County Group	Target MSA	Number of Hospitals Reclassified [1]								
		1995	1996	1997	1998	1999	2000	2001	2002	2003
Total Hospitals Reclassified.		**119**	**88**	**66**	**35**	**20**	**15**	**7**	**13**	**16**

Source: Listings of MGCRB decisions analyzed by Baker Healthcare Consulting, Inc.

[1] The number of reclassified hospitals is from the CMS PPS Year 16 data file. No adjustments for new hospitals, closures, or mergers have been made.

Statement of the Boston Organization of Teaching Hospital Financial Officers, Boston, Massachussetts

The Boston Organization of Teaching Hospital Financial Officers is pleased to submit the following statement for the record as the Subcommittee on Health discusses the critical issue of geographic adjustors for Medicare payment. We thank Chairwoman Johnson, Ranking Member Stark and all Members of the Subcommittee for addressing this highly complex issue. The Boston Teaching Hospitals urge the Congress to take action to improve the current methodology for adjusting Medicare hospital payments based on area wage differences in a manner that will ensure the ability of hospitals to recruit and retain top-level personnel.

As currently constructed, the Medicare Area Wage Index (AWI) system is incapable of recognizing that multiple distinct labor markets can exist within a single MSA. We are encouraged by the acknowledgement of Chairwoman Johnson, MedPAC and GAO of this particular problem the Boston Teaching Hospitals (and others) face in Medicare's current determination of the AWI. To quote the statement given by Glenn Hackbarth of MedPAC at the July 23, 2002, hearing: "[M]arket areas as defined by MSAs and statewide rural areas can be too large, encompassing more than one distinct health care labor market." The most recent CMS hourly wage data illustrates the wide variation in hospital wages within the Boston MSA, which stretches from southern New Hampshire to southeastern Massachusetts. The average hourly wage for hospitals in the core central city of Boston (Suffolk County) exceeds the average hourly wage of the New Hampshire county within the MSA with the lowest wages by 25 percent and the hourly wage of the most distant Massachusetts county within the MSA by 12 percent.

Further, as a result of its reliance on averaging wage data across an entire MSA to determine the AWI adjustment, the current system disadvantages those facilities in higher cost labor markets. To illustrate, Boston hospitals' average hourly wage exceeds that of the entire MSA, on which their payment is based, by nearly 8 percent. This 8 percent variance results in an annual "transfer payment" of more than $20 million a year from the hospitals in Boston to the outlying counties. This in turn inhibits the ability of Boston hospitals to compete for the services of the most qualified patient care personnel in the local labor pool. While this problem is especially acute in Boston, it is by no means unique to that area, as indicated in the GAO's testimony before the Subcommittee. This annual loss of funding—at a time when MA hospitals continue to experience significant financial pressures at all levels—points out the weaknesses of the current system and the need for Congress to act. The Boston hospitals attempted to address this situation several years ago through the established administrative mechanism, the Geographic Reclassification Board, but were denied under jurisdictional grounds.

We recognize the responsibility of Congress to manage Medicare spending and thus, the pressure to implement program changes in a manner that adds no new costs. We are well aware of how difficult it will be to correct Medicare geographic adjustors in a budget neutral manner. Yet the system should be corrected to work as intended, even though some hospitals that have benefited from the current system will no doubt experience losses under a corrected system. (As CMS knows, there are mechanisms to soften these adjustments, including phase-ins.)

In fact, the Boston Teaching Hospitals (and all teaching hospitals) are currently in the midst of a Medicare payment system correction that is also having a re-distributive effect, in this case, redistributing payments from teaching hospitals to non-teaching hospitals. Until recently, the average hourly wage for each hospital included the wages pertaining to teaching programs. Since these wages were generally higher than the average hourly wage of the hospital as a whole, their inclusion increased the average hourly wage of teaching hospitals, the AWI of their areas and,

of course, their payments. Several years ago, CMS correctly concluded that the inclusion of these teaching wages in the AWI calculation was unfair, since these wages (and other teaching costs) were also reimbursed separately by payments for Graduate Medical Education. The phase-out of these teaching wages from the AWI calculation has decreased the AWI and, therefore, Medicare payments to the Boston Teaching Hospitals. Since the AWI calculation is budget neutral nationwide, our payment reductions (and those of other teaching hospitals) are redistributed to non-teaching hospitals. To be clear, this redistribution is of considerably less magnitude than that which may be required to correct Medicare's geographic adjustors. But in principle, correction of the AWI calculation is necessary and appropriate.

We urge the Subcommittee to continue this principle and correct Medicare's geographic adjustors to so that they ***accurately define labor markets and adjust national payment amounts to reflect the wages hospitals in each labor market must pay to attract and retain high quality personnel.***

The Boston Organization of Teaching Hospital Financial Officers thanks the Subcommittee for the opportunity to provide this written statement. We would be pleased to offer any assistance we can to help the Subcommittee in its efforts.

Statement of the Bridgeport Hospital, Bridgeport, Connecticut;
Danbury Hospital, Danbury, Connecticut;
Greenwich Hospital, Greenwich Connecticut;
Griffin Hospital, Derby, Connecticut;
Hospital of Saint Raphael, New Haven, Connecticut;
Midstate Medical Center, Meriden, Connecticut;
Milford Hospital, Milford, Connecticut;
Norwalk Hospital, Norwalk, Connecticut;
St. Mary's Hospital, Waterbury, Connecticut;
St. Vincent's Medical Center, Bridgeport, Connecticut;
The Stamford Hospital, Stamford, Connecticut;
Waterbury Hospital, Waterbury, Connecticut;
Yale-New Haven Hospital, New Haven, Connecticut

This statement is submitted on behalf of the thirteen hospitals listed above, which together comprise all of the Medicare-participating, general acute care hospitals in Fairfield and New Haven counties, Connecticut.

New Haven and Fairfield Counties

Fairfield and New Haven counties are located in southwestern Connecticut and in close proximity to New York and New York City. The two counties together form the New Haven-Bridgeport-Stamford-Waterbury-Danbury, Connecticut Metropolitan Statistical Area (the "New Haven MSA"). The New Haven MSA is a component of the New York-Northern New Jersey-Long Island Consolidated Metropolitan Statistical Area.

The Two Counties Are Integrated With the New York City Metropolitan Area

In many ways—economically, socially, and politically, for example—New Haven and Fairfield counties are highly integrated with the New York City metropolitan area. Fairfield County is adjacent to the New York MSA; several of the hospitals in Fairfield County are only a few miles from the New York border, and in close proximity with New York City. The Federal Reserve Bank of New York groups Fairfield County with New York for purposes of its statistical analyses, because "A significant portion of Fairfield County commutes to New York City where a significant portion of the county's income is earned," according to Rae Rosen of the Federal Reserve Bank of New York.

The same is true for hospital workers. The hospitals in Fairfield County compete with those in the New York MSA for staff, particularly clinical personnel. In the case of The Stamford Hospital, for example, fully 11 percent of the hospital's labor pool resides in New York. Despite having a wage index (1.2294 in 2002) that is 17 percent below the New York MSA wage index (1.4427 in 2002), the hospitals in Fairfield collectively pay wages that are only 10 percent below the wages paid by hospitals in the New York MSA (the combined average hourly wage of hospitals in Fairfield County is 89.83 percent of the combined average hourly wage of hospitals in the New York MSA). The New Haven hospitals share similar characteristics and issues. This significant reimbursement differential has made it difficult for these Connecticut hospitals to effectively retain and attract clinical personnel, a problem with particularly dire consequences in this time of nursing shortages.

The Medicare Methodology for Classifying and Grouping Hospitals is Flawed

The Medicare hospital prospective payment systems classify hospitals for purposes of the wage index based solely on location vis-à-vis county lines. One of the problems associated with grouping hospitals in this manner is that two hospitals may be less than one mile apart and have very similar labor cost experiences, but, because of their location in different counties, each would have a different wage index. For example, a hospital in Danbury would be classified in the New Haven MSA, whereas one in Putnam County, New York, while located only a few miles away, would be classified in the New York MSA. The average hourly wage of hospitals in Putnam County is 81 percent of the average hourly wage of hospitals in the New York MSA, of which they are a part, while the average hourly wage of hospitals in Fairfield County is 89 percent of the average hourly wage of hospitals in the New York MSA. Yet, the hospitals in Putnam are paid 17 percent more per case than hospitals in Fairfield. As a result, the hospitals in the New York MSA have a positive Medicare inpatient service margin of 1.93 percent; if none of the hospitals in the New Haven MSA qualify for reclassification, they would have a negative margin of 7.53 percent (based on the methodology used by the Medicare Payment Advisory Commission to calculate hospital Medicare inpatient service margins).

The Geographic Reclassification Process Can Resolve these Deficiencies

In an effort to address these situations, Congress established a geographic reclassification process in 1989. The geographic reclassification opportunity is worthwhile, and works effectively for more than 500 hospitals. However, it is not perfect, and does not work for the hospitals in Fairfield and New Haven counties.

Geographic Reclassification Improvements are Necessary

The Fairfield and New Haven hospitals are the type that Congress intended to help when it created the geographic reclassification process. However, most cannot qualify for geographic reclassification. Of the six hospitals within Fairfield County only four presently qualify for reclassification for purposes of the wage index: *i.e.,* Stamford, Greenwich, Danbury, and Norwalk. However, one—*i.e.,* Norwalk—likely will not qualify for reclassification in the next application cycle. Despite their close proximity to and integration with New York City, only three of these six hospitals expect to qualify for reclassification in the next application cycle. There are seven hospitals in New Haven County; none are able to qualify for geographic reclassification under current rules.

Most of the hospitals in New Haven and Fairfield counties cannot individually qualify for geographic reclassification because of the unrealistically restrictive proximity limitations. An urban hospital seeking reclassification to a nearby MSA must be within 15 miles of that MSA. In promulgating the original rules establishing the reclassification criteria, the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services instituted a mileage limitation as evidence of economic integration, and reasoned that economic integration is not likely present where an urban hospital is more than 15 miles from the target MSA. In most large urban areas, and particularly in the New York City metropolitan area, typical workplace commuting distances exceed 15 miles. In fact, some employees of Yale-New Haven Hospital commute 55 miles one-way from New York.

Likewise, the New Haven and Fairfield hospitals cannot qualify for reclassification as a group because they cannot satisfy the requirements for standardized amount reclassification. Whereas an individual hospital may seek to reclassify to a neighboring area for purposes of the wage index or standardized amount, or both, hospitals applying jointly may apply for geographic reclassification only for purposes of the wage index and standardized amount. Consequently, hospitals applying jointly must concurrently satisfy the criteria for standardized amount and wage index reclassification. For this reason, very few hospital groups qualify for geographic reclassification; few can meet the requirements for standardized amount reclassification. In the last five years, no more than five hospital-groups nationwide were able to satisfy the requirements for standardized amount reclassification and qualify for geographic reclassification; in 2001, only two groups qualified

There is no policy justification that credibly explains why hospitals seeking reclassification individually may seek to reclassify to a neighboring area for purposes of the wage index or standardized amount, while hospitals applying jointly may apply only for purposes of the wage index and standardized amount. This requirement for group reclassification is particularly inexplicable when the hospitals seeking geographic reclassification as a group are already located within a "large urban area" and the resulting reclassification therefore would not entitle the qualifying hospitals to a higher standardized amount. The hospitals in Fairfield and New Haven coun-

ties are in a "large urban area"; they would not receive a higher or even different standardized amount by reclassifying to the New York MSA, which also is a "large urban area."

Recomendations

Congress should permit hospitals seeking group reclassification to seek reclassification for purposes of the wage index, standardized amount, or both, just as individual hospitals may. Congress may have already taken steps in this direction. Legislation recently approved by the U.S. House of Representatives (H.R.4954, § 303) would eliminate the "other area" standardized amount, and provide that payments to all hospitals beginning in fiscal year 2004 be determined using the "large urban area" standardized amount. In other words, if enacted, there would be only one standardized amount. If so, there no longer would be a need for geographic reclassification for purposes of the standardized amount.

If this legislation is enacted, Congress should concurrently and expressly eliminate references in the geographic reclassification statute (§ 1886(d)(10) of the Social Security Act) to reclassifications for purposes of the standardized amount, thereby eliminating the availability of reclassification for this purpose. Congress likewise should establish that, in considering applications from hospital groups for reclassification for purposes of the wage index, the Secretary may not require such applicants to also satisfy existing criteria required of hospitals seeking reclassification for purposes of the standardized amount.

The hospitals in New Haven and Fairfield counties likely could qualify as a group for geographic reclassification for purposes of the wage index, if they also do not need to satisfy the criteria for standardized amount reclassification.

Children's National Medical Center
Washington, DC 20010
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515–6353

Dear Madam Chairman:

On behalf of Children's National Medical Center in Washington, DC, I am writing today to express our strong support of the testimony offered by both William J. Scanlon, Director, Health Financing and System Issues, U.S. General Accounting Office (GAO), and Glenn D. Hackbarth, Chairman, Medicare Payment Advisory Commission (MEDPAC), at the July 23rd Subcommittee on Health Hearing on Medicare's Geographic Cost Adjustments.

As referenced in Mr. Scanlon's testimony, the urban hospitals in the Washington, DC Metropolitan Statistical Area (MSA) have historically been disadvantaged by the current system to adjust payments to hospitals for geographic differences in labor costs, otherwise known as the Medicare wage index. The geographic area or MSA for which the wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify. The Washington, DC MSA currently encompasses the 10 urban hospitals in Washington, DC, 16 hospitals in Virginia, 12 hospitals in Maryland and 2 rural hospitals in West Virginia. This geographic region is hardly a representative of a uniform labor market that competes for the same pool of employees. Consequently, when the Medicare Wage Index factor is applied to modify 71 percent of Medicare payments to hospitals, the outlying Virginia and West Virginia hospitals in our MSA benefit greatly from the higher average hourly wage that District of Columbia hospitals require to attract employees, and the District of Columbia Hospitals are deprived of the financial support from Medicare that is truly representative of the labor market costs in an urban area.

Furthermore, in the Medicare Inpatient Prospective Payment System Final Rule released in August of 2001, in section 304(b) of Public Law106–554, a process was established under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index. The District of Columbia would be an excellent example of where this "statewide" designation should be applied and even the Virginia Hospital and Health Care Association submitted a letter of support of the District's effort to designate itself as such. However, the Centers for Medicare

and Medicaid Services (CMS) commented that they believed that "Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC."

We urge your subcommittee's support to review and update the current geographic classification system for purposes of the Medicare wage index and to support the findings and recommendations of the GAO and MEDPAC. It is a system that unfairly penalizes urban hospitals that fall into MSAs that are not representative of a single labor market. District of Columbia hospital, as all urban hospitals, continue to struggle financially due to rising health care costs and the provision of health care to the uninsured. Already two District hospitals have recently closed and half of the remaining hospitals operate in the red. The future of health care in the District of Columbia may be placed jeopardy if corrective action is not taken.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at (202) 884–2340.

Sincerely,

Greta Todd
Director, Government External Affairs

Statement of Monty E. McLaurin, Chief Executive Officer and President, Christus St. Joseph's Health System, Paris, Texas

CHRISTUS St. Joseph's Health System ("CSJHS") thanks the Subcommittee for conducting a hearing on the important issue of geographic cost adjusters used to determine Medicare payment to program participating hospitals, and for the opportunity to submit this statement. CSJHS is systematically undercompensated by the prevailing wage index used to adjust payments for inpatient and outpatient services furnished to program beneficiaries, and by its inability to qualify for geographic reclassification in 2002, and so welcomes this opportunity to share its concerns and suggestions with the Subcommittee.

CSJHS is a two-campus hospital licensed for 405 beds located in Paris, Texas. The Hospital is a Medicare designated Rural Referral Center ("RRC"), which offers state-of-the-art heart care, surgical, orthopedic, radiology, emergency and rehabilitation services, among others. CSJHS also operates four clinics that offer quality medical care in surrounding rural areas.

For purposes of Medicare payment, the Hospital is considered to be located in Rural Texas, although it is physically located approximately 30 miles from the Dallas Metropolitan Statistical Area ("MSA"). CSJHS has qualified for geographic reclassification for purposes of the wage index and standardized amount to the Dallas MSA in past years. Because of its proximity to Dallas, CSJHS competes with hospitals in these areas for personnel, particularly highly skilled personnel, such as nurses and technicians.

CSJHS failed to qualify for wage index reclassification for federal fiscal year ("FFY") 2002 in part because of shortcomings in the current reclassification process. In 1996, CSJHS had to make a significant downward adjustment to workers compensation reserves, which lowered its average hourly wage ("AHW") for 2001 considerably. Failure to qualify for geographic reclassification in this year is particularly devastating to the Hospital, since nearly 64 percent of its inpatient days are attributable to Medicare patients. In fact, the percentage of population 65 years or older in CSJHS's eight county primary service area is nearly twice the percentage in the remainder of the state. Specifically, CSJHS estimates that it will lose approximately ~~$3.1~~ 6.8 million in Medicare revenues in 2002 because it failed to qualify for geographic reclassification in this year. This foregone reimbursement, compounded with other Medicare reimbursement reductions in recent years, has forced CSJHS to discontinue services and close facilities, including a home health agency, an inpatient behavioral medicine unit and a hospice. Moreover, the Hospital has current plans to eliminate approximately 5% of its workforce.

In February 2000, CSJHS appealed the decision of the Medicare Geographic Classification Review Board ("MGCRB") to the Centers for Medicare and Medicaid Services ("CMS") Administrator. CSJHS argued that the Administrator should reverse the MGCRB's decision as a matter of fairness. Regrettably, the Administrator denied our appeal and upheld the MGCRB's decision.

We commend the Subcommittee for examining the deficiencies of the Medicare geographic reclassification process. The geographic reclassification process is good. It works for many hospitals. It should be maintained. However, it also should be fixed. There are numerous flaws, which Congress can and should address. We believe that had the MGCRB and CMS conducted a subjective, case-by-case evaluation in this

instance, as was initially envisioned by the reclassification statute, CSJHS would be reclassified for 2002.

Congress created the geographic reclassification process because it recognized that the system of assigning wage indices based solely on a hospital's physical location within a particular county does not always reflect true labor-market experience. In addition to the physical location of hospitals, Congress deemed it appropriate to take into account the location of hospitals relative to proximate urban areas, worker commuting patterns and other considerations when assigning wage indices.

Congress conferred upon the Secretary discretion to establish guidelines for determining whether and when hospitals would qualify for geographic reclassification, but intended for the Secretary to utilize the MGCRB as a tribunal, much like the Provider Reimbursement Review Board, that would hear and consider all relevant facts presented by an applicant hospital. The Medicare regulations reflect this original intent: "The MGCRB will issue a decision based upon all documents, data, and other written evidence and comments submitted timely to MGCRB by the parties." 42 C.F.R. § 412.254(a). The regulations further provide, "MGCRB's decision is based upon the evidence of record, including the hospital's application and other evidence obtained or received by MGCRB." 42 C.F.R. § 412.274(a).

In practice, however, the MGCRB evaluates applications under a series of bright-line objective criteria, without taking into account any additional evidence presented by the applicant. Moreover, the process is almost entirely staff-driven, and leaves virtually no role for Board members. Despite numerous requests each year from hospitals wanting to present additional relevant information to the MGCRB through its oral hearing process, it is our understanding that the Board has neither granted nor held an oral hearing since 1990. It is in part because of what the MGCRB has become that hospitals have been increasingly seeking relief from Congress.

Had the MGCRB and Administrator looked beyond the bright-line objective criteria at the additional evidence CSJHS presented, the reclassification may have been granted. CSJHS is the type of hospital that Congress intended to help when it created the opportunity for hospitals to apply for wage index geographic reclassification. CSJHS is located just a short distance from the Dallas MSA (approximately 30 miles). Moreover, the Hospital is an RRC, offering skilled services more akin to those offered in the Dallas MSA. Congress has repeatedly recognized the important role played by RRCs, and enacted legislation intended to buttress these hospitals. In fact, Congress has repeatedly expressed a desire that CMS make it easier for RRCs to qualify for geographic reclassification. Because of its proximity to the Dallas MSA, and comparability to the hospitals in Dallas in terms of services offered, CSJHS competes with hospitals in these neighboring urban areas for skilled clinical personnel. As a result, CSJHS's AHW is considerably higher (*i.e.,* 107 percent) than other hospitals located in rural Texas, and comparable to hospitals within the Dallas (*i.e.,* 81 percent) MSA. Moreover, CSJHS had qualified for wage index reclassification in past years. For these reasons, CSJHS should have been eligible for wage index geographic reclassification, even though it did not satisfy the wage comparison threshold required to qualify under the MGCRB's standard evaluation. CSJHS encourages Congress to improve the reclassification process by taking steps to restore the MGCRB to its original intended purpose.

Additionally, CSJHS encourages Congress to ensure that hospitals with labor cost aberrations are not precluded from reclassification. Congress significantly improved the geographic reclassification process in 2000 when it required that wage index reclassifications should be valid for three years. This change to some extent limited the in-one-year-out-the-next phenomenon that caused significant reimbursement fluctuations for hospitals and made it difficult for hospitals to budget from year-to-year. However, Congress should take additional steps to ensure that wage data aberrations, such as reporting errors or one-time labor cost spikes or dips, do not exclude a hospital from reclassification for a year.

Finally, CSJHS implores Congress to take action to restore the reimbursement funding lost by CJSHS in 2002 by requiring that the Hospital be deemed to be reclassified to the Dallas MSA for that year.

Community Memorial Hospital
Ventura, California 93003
July 22, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Johnson,

In 1995, Ventura County hospitals met the requirements of the Medicare Geographic Classification Review Board (MGCRB) for a countywide reclassification to the Los Angeles Primary Metropolitan Statistical Area (PMSA). Since then the Ventura County hospitals have not been able to meet the criteria for a countywide reclassification.

Competition with Los Angeles hospitals for scarce medical personnel has increased markedly since 1995 because of shortages in skilled positions such as registered nurses, pharmacists and radiation technologists. Our freeways promote commuting across county lines and the Ventura County hospitals must offer competitive wages to keep existing personnel and attract new employees in our mobile society.

The Ventura County hospitals have an average hourly wage that Is 93% of the Los Angeles MSA average hourly wage which easily exceeds the minimum criteria of 85% to allow for a wage index reclassification to LA. But the Centers for Medicare and Medicaid Services (CMS) require the Ventura County hospitals to meet a second criteria for the MGCRB to approve a group reclassification. This second criteria is designed to demonstrate comparability of the per discharge costs between the hospitals in the two counties. The formula mandated by CMS is out of date and frustrates Ventura and similarly situated counties throughout the country from receiving needed reclassifications.

In 1995, the peak year, twenty-three group reclassifications were approved by the MGCRB, reclassifying a total of 119 individual hospitals. For FFY 2003, only five groups were approved for reclassification affecting a total of sixteen hospitals. Only 13% of the hospitals in these large metropolitan areas that met the criteria in 1995 were able to meet these outdated criteria FFY 2003. This is not a result of less competition for scarce personnel now compared to 1995, it is clear evidence that the criteria no longer works as originally intended.

The flawed criteria computes the standardized cost per case for the group seeking reclassification (the Ventura County hospitals) and compares that amount to a computed threshold amount that is not based on the cost per case of LA hospitals. The cost per case must exceed that threshold for a group reclassification to be approved. The threshold amount is a Medicare payment rate based criteria (25% of the Medicare standard payment rate applicable to Ventura County plus the addition of 75% of the Medicare payment rate of LA hospitals). The criteria worked reasonably well when promulgated thirteen years ago in 1989. But since then hospitals have changed dramatically by increasing the types of procedures performed on an outpatient basis and changed the site of care to specialized units such as rehabilitation, psychiatric and skilled nursing. This has improved patient care and improved cost efficiency within the hospitals. These changes are not unique to Ventura County hospitals but are equally applicable to LA hospitals and hospitals throughout the country. Because overhead costs are now absorbed by these other expanded units, groups can no longer qualify.

We believe it is important to consider that Ventura County is an integral part of The Los Angeles Metropolitan area. The county meets every census bureau criteria to be a part of the Los Angeles MSA. This includes the minimum population requirements, the percentage urban population requirement and the requisite minimum commuting percentages between the counties. The only reason that Ventura County has been designated a Primary Metropolitan Statistical Area (PMSA)—which is a part of the large urban Los Angeles-Orange County-Riverside Consolidated Metropolitan Statistical Area (CMSA) is that "local opinion" was considered by the census bureau in establishing a PMSA designation. Without the PMSA designation, Ventura County would be a part of the Los Angeles MSA and share the same wage index with the Los Angeles county hospitals. Based on the "artificial" PMSA designation and the realities of the competitive marketplace, treating Ventura County hospitals as a separate wage index area and not approving a reclassification to Los Angeles penalizes these hospitals and puts them at a competitive disadvantage in recruiting and retaining needed health professionals.

We ask for short term legislation to grant Ventura County hospitals a needed reclassification and that the cost-per-case criteria be modernized or eliminated, or the

labor market areas for PMSAs be treated so as not to disadvantage hospitals located in a major metropolitan area solely as a result of a "local opinion" census standard.

David B. Glyer
Director, Financial Services

DC Partnership to Improve End-of-Life Care
Washington, DC 20005
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Dear Madam Chairman:

On behalf of the DC Partnership to Improve End-of-Life Care, I am writing today to express our strong support of the testimony offered by both William J. Scanlon, Director, Health Financing and System Issues, U.S. General Accounting Office (GAO), and Glenn D. Hackbarth, Chairman, Medicare Payment Advisory Commission (MEDPAC), at the July 23rd Subcommittee on Health Hearing on Medicare's Geographic Cost Adjustments.

As referenced in Mr. Scanlon's testimony, the urban hospitals in the Washington, DC Metropolitan Statistical Area (MSA) have historically been disadvantaged by the current system to adjust payments to hospitals for geographic differences in labor costs, otherwise known as the Medicare wage index. The geographic area or MSA for which the wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify. The Washington, DC MSA currently encompasses the 10 urban hospitals in Washington, DC, 16 hospitals in Virginia, 12 hospitals in Maryland and 2 rural hospitals in West Virginia. This geographic region is hardly a representative of a uniform labor market that competes for the same pool of employees. Consequently, when the Medicare Wage Index factor is applied to modify 71 percent of Medicare payments to hospitals, the outlying Virginia and West Virginia hospitals in our MSA benefit greatly from the higher average hourly wage that District of Columbia hospitals require to attract employees, and the District of Columbia Hospitals are deprived of the financial support from Medicare that is truly representative of the labor market costs in an urban area.

Furthermore, in the Medicare Inpatient Prospective Payment System Final Rule released in August of2001, in section 304(b) of Public Law 106–554, a process was established under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index. The District of Columbia would be an excellent example of where this "statewide" designation should be applied and even the Virginia Hospital and Health Care Association submitted a letter of support of the District's effort to designate itself as such. However, the Centers for Medicare and Medicaid Services (CMS) commented that they believed that "Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC."

We urge your subcommittee's support to review and update the current geographic classification system for purposes of the Medicare wage index and to support the findings and recommendations of the GAO and MEDPAC. It is a system that unfairly penalizes urban hospitals that fall into MSAs that are not representative of a single labor market. District of Columbia hospital, as all urban hospitals, continue to struggle financially due to rising health care costs and the provision of health care to the uninsured.

Already two District hospitals have recently closed and half of the remaining hospitals operate in the red. The future of health care in the District of Columbia may be placed jeopardy if corrective action is not taken.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me.

Sincerely,

Joan T. Panke
Executive Director

Statement of the Hon. Rosa L. DeLauro,
a Representative in Congress from the State of Connecticut

Madam Chairwoman and members of the Committee, thank you for the opportunity to testify on this important issue that affects our hospitals, skilled nursing facilities, home health agencies, and ultimately our seniors.

This issue is of particular concern in my home state of Connecticut. As a result of their proximity to New York City, fourteen hospitals in Fairfield and New Haven counties in Connecticut compete with hospitals there for staff, particularly clinical personnel. However, despite being close to the city, these hospitals are reimbursed significantly less for furnishing services to Medicare beneficiaries, because the wage index applicable in Fairfield and New Haven counties is seventeen percent lower than the wage index available to hospitals in the New York Metropolitan Statistical Area (MSA). This significant reimbursement differential has made it difficult for the Connecticut hospitals to effectively retain and attract clinical personnel, a problem with particularly dire consequences in this time of nursing shortages.

As you know, the Medicare hospital prospective payment systems classify hospitals for purposes of the wage index based solely on location vis-à-vis county lines. One of the problems associated with grouping hospitals in this manner is that two hospitals may be less than one mile apart and have very similar labor cost experience, but, because of their location in different counties, each would have a different wage index. For example, a hospital in Danbury would be in the New Haven MSA and have a much lower wage index than a hospital located only a few miles away in Putnam County, New York, which would be classified in the New York MSA. Consequently, the hospital in Putnam would receive millions more in Medicare reimbursements than a hospital of comparable size and case mix in Danbury, even though the hospital in Danbury may be as close to New York City and have comparable labor costs to the hospital in Putnam.

In an effort to address these situations, Congress established a geographic reclassification process in 1989. However, only two of these fourteen Connecticut hospitals are likely to qualify for geographic reclassification during the upcoming application review cycle.

The Fairfield and New Haven hospitals are the type of facilities that Congress intended to help when it created the geographic reclassification process. Fairfield and New Haven counties are proximate to the New York MSA and compete with hospitals there for staff, particularly clinical personnel. In fact, several hospitals in Fairfield are only a few miles from the New York MSA. The Fairfield and New Haven hospitals need to be on a level playing field with the New York hospitals to be able to attract and retain highly skilled clinical staff.

I understand there to be two reasonable solutions to this problem. One option is to expressly deem the hospitals in the New Haven-Bridgeport-Stamford-Waterbury-Danbury MSA to be located in the New York MSA for Medicare payment purposes. The other is legislation that would permit hospitals seeking "county-wide" reclassification to seek reclassification for purposes of the wage index, standardized amount, or both (at present, when an individual hospital seeks reclassification it can seek reclassification for purposes of the wage index, standardized amount, or both; however, when all hospitals within in a county join together to seek "county-wide" reclassification, they must seek and qualify for reclassification for purposes of both the wage index and standardized amount.) However, this latter option, if enacted, would benefit only the hospitals in Fairfield County; the hospitals in New Haven County would not qualify for reclassification for the wage index as a group.

Providing quality care to patients requires hiring the best qualified doctors and nurses. Without a change to the current system, hospitals in Connecticut will not have the resources to compete with other hospitals, in some cases only miles away. For the health of our seniors, I believe we must change the current system so that our hospitals can retain and attract doctors and nurses that will provide high quality health care.

I am hopeful that we can remedy this situation and enable the Fairfield and New Haven hospitals to qualify for reclassification, and I welcome any assistance the Committee can provide.

Thank you again for the opportunity to testify today. I look forward to working with you on this vital issue.

District of Columbia Hospital Association
Washington, DC 20005
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Dear Madam Chairman:

On behalf of the District of Columbia Hospital Association, I am writing today to express our strong support of the testimony offered by both William J. Scanlon, Director, Health Financing and System Issues, U.S. General Accounting Office (GAO), and Glenn D. Hackbarth, Chairman, Medicare PaymentAdvisory Commission (MEDPAC), at the July 23rd Subcommittee on Health Hearing on Medicare's Geographic Cost Adjustments.

As referenced in Mr. Scanlon's testimony, the urban hospitals in the Washington, DC Metropolitan Statistical Area (MSA) have historically been disadvantaged by the current system to adjust payments to hospitals for geographic differences in labor costs, otherwise known as the Medicare wage index. The geographic area or MSA for which the wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify. The Washington, DC MSA currently encompasses the 10 urban hospitals in Washington, DC, 16 hospitals in Virginia, 12 hospitals in Maryland and 2 rural hospitals in West Virginia. This geographic region is hardly a representative of a uniform labor market that competes for the same pool of employees. Consequently, when the Medicare Wage Index factor is applied to modify 71 percent of Medicare payments to hospitals, the outlying Virginia and West Virginia hospitals in our MSA benefit greatly from the higher average hourly wage that District of Columbia hospitals require to attract employees, and the District of Columbia Hospitals are deprived of the financial support from Medicare that is truly representative of the labor market costs in an urban area.

Furthermore, in the Medicare Inpatient Prospective Payment System Final Rule released in August of 2001, in section 304(b) of Public Law 106–554, a process was established under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index. The District of Columbia would be an excellent example of where this "statewide" designation should be applied and even the Virginia Hospital and Health Care Association submitted a letter of support of the District's effort to designate itself as such. However, the Centers for Medicare and Medicaid Services (CMS) commented that they believed that "Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC."

We urge your subcommittee's support to review and update the current geographic classification system for purposes of the Medicare wage index and to support the findings and recommendations of the GAO and MEDPAC. It is a system that unfairly penalizes urban hospitals that fall into MSAs that are not representative of a single labor market. District of Columbia hospitals, as all urban hospitals, continue to struggle financially due to rising health care costs and the provision of health care to the uninsured.

Already two District hospitals have recently closed and half of the remaining hospitals operate in the red. The future of health care in the District of Columbia may be placed jeopardy if corrective action is not taken.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at 202–289–4923.

Sincerely,

Joan H. Lewis
Senior Vice President

District of Columbia Hospital Association
Washington, DC 20005
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

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Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at (202) 289.4925.

Sincerely,

Tracy A. Thompson
Financial Analyst

District of Columbia Hospital Association
Washington, DC 20005
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
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Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at 202–682–1585.

Sincerely,

Machelle Yingling
Vice President, Information Services

Statement of the Hon. John J. Duncan, Jr.,
a Representative in Congress from the State of Tennessee

Madame Chairwoman and Members of the Committee, thank you for inviting me to appear before this Committee. I regret that, due to a scheduling conflict, I could not sit before you and share in person my thoughts on a topic that has such a vital

impact on the entire health care industry—Medicare's Geographic Cost Adjustment. Thank you for allowing my submitted testimony to the official hearing record.

Like so many areas of Medicare, the formula used to determine a hospital's standing on the wage index is quite complex. The wage index, as you know, is estimated by calculating an average hospital wage for each labor market area, and the average for that area is compared to the national average hospital wage. It is a system that I believe leaves way too much room for error and is not always interpreted fairly.

The hospitals in Knoxville, Tennessee, are suffering because of the downfalls of this current cost-adjusting system.

The wage index in the Knoxville Metropolitan Statistical Area (MSA) (Knox, Anderson, Blount, Loudon, Sevier and Union Counties) is well below the national average. It is also based on data from the Medicare Cost Report filed about four years earlier, which does not reflect issues like significantly higher wages paid to nurses because of the current shortage.

In 2001, nine hospitals in the Knoxville MSA lost between $14 million and $17 million in Medicare reimbursements because the MSA's 2000 area wage index was not appropriately adjusted.

The hospitals impacted are Blount Memorial, Baptist Health System of East Tennessee, University of Tennessee Memorial Hospital, St. Mary's and Covenant Health, which consists of Fort Sanders Loudon Medical Center, Fort Sanders Parkwest Medical Center, Fort Sanders Regional Medical Center, Fort Sanders Sevier Medical Center and Methodist Medical Center of Oak Ridge).

The problem is the result of errors made by the fiscal intermediary (Riverbend Government Services), the former Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS) and several Knoxville hospitals. However, there is incontrovertible evidence that the hospital data supports a substantially higher FY 2001 wage index than the one imposed.

Considering the financially stressed condition of Knoxville area hospitals—even with the relief received through congressional action last year—the loss of these funds is having a negative impact on hospital operations.

There was a dramatic reduction in the wage index between 2000 and 2001, as you can see from the following chart. When hospitals discovered this significant reduction last year, they worked diligently with expert help to determine the causes for the steep decline. However, by the time an analysis was completed, HCFA officials said it was too late to make any changes.

FY	Wage Index Based on Cost Report Year
1998	.88311994
1999	.89371995
2000	.91991996
2001	.83401997
2002	.89041998

These hospitals have all the detailed documentation necessary that supports a higher wage index in FY 2001. This information was provided to the fiscal intermediary as soon as the wage index reduction was discovered. The intermediary, Riverbend Government Services, recommended that the hospitals appeal directly to HCFA and the intermediary supported the hospitals' findings. An appeal was made and rejected.

If not corrected, the losses could compound as the government moves toward a three-year wage index averaging methodology. I believe CMS should have the authority to make these types of adjustments—regardless of who is at fault—when these errors are discovered. Otherwise, we are unfairly penalizing the patients who are served by these hospitals.

Should legislation be introduced, I believe it should include an adjustment for these Knoxville area hospitals that reflects the reality of the data for the 2001 program year. They must be made whole.

Thank you, Madame Chairwoman, for conducting this hearing on an issue of critical importance to our nation's health care system.

Statement of Tracy Warner, Vice President, Finance Policy, Iowa Hospital Association, Des Moines, Iowa

On behalf of Iowa's 116 community hospitals, the Iowa Hospital Association (IHA) appreciates the opportunity to provide comment to the House of Representatives

Committee on Ways and Means Subcommitte on Health for its hearing on assessing Medicare's geographic cost adjustors used for Medicare payment.

As indicated in the advisory announcing the hearing, the Medicare wage index is one of the most important determinants of Medicare payments to hospitals. In addition to determining over 71 percent of inpatient payment, the wage index is applied to 60 percent for outpatient payment, and just over 75 percent of the skilled nursing facility payment is adjusted by the hospital wage index. Medicare is profoundly important to Iowa hospitals given the fact that nearly half of Iowa hospitals' revenue comes from Medicare. This is due to the fact that as a percentage of its population, more citizens 85 years and older live in Iowa than any other state, and further, Iowa ranks fifth in the nation in the percent of residents over age 65. Yet Iowa hospital Medicare payments are among the lowest in the nation, and Iowa ranks last in the nation for Medicare payments per beneficiary at $3053 per enrollee. The national average per enrollee payment is $5490, or 45 percent more than what is paid in Iowa. Because of the heavy dependence on the Medicare and the low revenues received from the program, its not surprising to learn that the total Medicare margin for Iowa hospitals is −6.5%, among the worst in the nation. Further, Iowa hospitals lose $48 million a year on Medicare services.

One of the primary factors why Medicare payments to Iowa hospitals are among the lowest in the nation is because the wage index data used by Medicare locks Iowa into a historic inequity devised in 1983 when the Medicare inpatient prospective payment system (PPS) was developed. Although the Social Security Act requires that as part of the methodology for determining prospective payments to hospitals the Secretary must adjust the standardized national payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared with the national average hospital wage level, the reality is that wages necessary to attract and retain quality health care professionals are not really that much different in Iowa than the rest of the nation. But the Medicare wage index leaves hospitals in areas with historically lower labor costs at a critical disadvantage when it comes to recruiting and retaining personnel. Iowa hospitals are competing in a regional, interstate market and must pay as well as hospitals in Omaha, Nebraska; Rochester, Minnesota; La Crosse, Wisconsin; and Kansas City, Missouri. Yet every hospital in Iowa has a wage index below 1.00. For example, hospitals in northwestern Iowa with a wage index of.8147 must compete with the Mayo Clinic across the Minnesota state line with a wage index of 1.1462. In fact, the Minnesota facility buses nurses from the Decorah, Iowa community up to its hospital every day and nurses are more than willing to commute across the border for an additional $10 per hour. Similarly, hospitals is Red Oak, Atlantic and Harlan, Iowa with a wage index of.8147 must attempt to match wages in Omaha, Nebraska (wage index.9712) that is within 50 miles, a drivable commute in exchange for an enhanced salary. And with the continued shortage of health care professionals, qualified workers can and do make the choice to seek out positions that will pay them more. **The wage index should reflect market realities so hospitals can pay competive wages to attract and retain quality health care professionals and meet workforce challenges.**

This inequity is compounded even further because the Centers for Medicare & Medicaid Services (CMS) currently assumes that just over 71 percent of hospital costs included in the inpatient prospective payment system are labor-related while wages, salaries and benefits generally comprise a much lower percentage of costs for most hosptials—no more than 55 percent in Iowa. Yet CMS has recently proposed increasing the percentage to 72.5% in FY 2003 which is contrary to a recent study by the Medicare Payment Advisory Commission (MedPAC) indicating that the labor-related portion of the wage index that should be applied to the Medicare inpatient payment base rate should be reduced, rather than increased.

Furthermore, the wage index itself is flawed in that the current inpatient wage index often contains wage and salary data related to "overhead" for non-inpatient related health care personnel. For example, the lower wages of personnel in the general administration category, such as housekeepers and maintenance staff, cannot be adequately split between the time providing service in a hospital inpatient unit and hospital-based nursing facility. The affect of this flaw dilutes the facility's average hourly wage because of the portion of the salaries attributed to lower paid employees. This phenomenon is particularly true in Iowa and other rural states where it is fairly common for a rural hospital to operate an attached nursing facility.

In addition, the data used to construct the wage index is several years old, with the FY 2002 index based on cost data filed by hospitals in 1998. This timetable does not immediately recognize the increased costs of personnel in a dynamic health care environment driven today by workforce shortages. Furthermore, the data is audited by fiscal intermediaries with only general guidance from CMS. Therefore, various

interpretations result in inconsistent application of costs depending on the fiscal intermediary which can and does lead to lower wage indices in some locations.

Although there is an opportunity for hospitals to be geographically "reclassified" into a nearby labor market, only 12 hospitals (less than one percent of Iowa's facilities) meet the requirements that would allow them to receive the wage index of another area and thus, higher Medicare reimbursement.

Due to the dependence of Iowa hospitals on revenue from the Medicare program, IHA has placed high priority on equity issues that address the long-standing formula-driven Medicare payment problems. Among the ideas for fixing these problems include the creation of a wage index floor of.925 and adjusting the percentage of inpatient payment to which the wage index is applied. If enacted by Congress, either of these changes would have a positive impact on Iowa hospital payments and stabilize the precarious financial position in which many Iowa hospitals exist. Passage of the wage index floor would have a $179 million impact over five years for Iowa hospitals thus allowing our facilities to continue to provide high quality healthcare services to Medicare beneficiaries in rural communities and throughout the state of Iowa. But the Medicare equity issue is more than a hospital problem. To cope with the growing gap between Medicare reimbursements and actual costs, hospitals must transfer this deficit to the private sector. County hospitals are raising property taxes, and all hospitals are forced to raise charges. This situation threatens the very future of Iowa hospitals. Imagine the consequences for a community that loses its local hospital, not only in terms of access to health care, but in the local and regional loss of jobs, business partnerships, and economic stability.

In conclusion, IHA requests support from members of Congress to enact changes that would have a positive impact on hospitals in Iowa, as well as nationwide, and stabilize the precarious financial position in which many Iowa hospitals exist. Immediate action is needed to address payment inequities within the Medicare system that threaten access to quality healthcare services for Medicare beneficiaries.

Statement of the Iowa Medical Society, West Des Moines, Iowa

Congresswoman Johnson and members of Congress, thank you for the opportunity to submit testimony on the issue of Medicare's geographic cost adjustors used for Medicare payment. Medicare's application of geographic payment adjustors to the physician reimbursement formula has created a disparity in payments to Iowa and many other states and it is having a detrimental impact on our citizens, physicians, and our health care infrastructure. Fixing Medicare's payment disparity to Iowa is the number one priority of the Iowa Medical Society and our physician members.

8th Highest in Quality of Care

In 2000, the Health Care Financing Administration (HCFA) released a study ranking states on Medicare quality for six clinical areas including heart attacks, breast cancer, diabetes, heart failure, pneumonia and stroke. Measured according to quality indicators for each condition, Iowa's care of Medicare patients ranked 8th highest in quality among 52 states and territories. Yet of Medicare's 89 geographic payment localities, Iowa is the 80th lowest reimbursed locality. Iowa's poor reimbursement is due to the geographic adjustments made to the three Geographic Practice Cost Indices (GPCIs)—*physician work; practice expense and medical liability expense* under the Medicare Part B Resource Based Relative Value System (RBRVS). This unfair formula is at the root of Iowa's poor reimbursement.

Can you imagine if the geographic adjustments used to reimburse physicians were applied to Social Security benefit payments in such a way that, if you lived in Iowa, your benefits were reduced? What if United States Congressmen and women from California and New York were paid higher than Congressmen and women from Iowa and Kansas?

Both of those ideas are ludicrous, and if they were even *proposed*, they would be laughed out of the Capitol. But that is exactly how we reimburse for Medicare services in our country, and Iowa patients and the state's health care infrastructure are suffering as a result even though Iowans pay the same Medicare taxes.

The Impact of Medicare's Geographic Cost Adjustors on Iowa

The Federal Government's own data indicates that Iowa physicians provide high quality care and that our patients use health care more efficiently than recipients in other states. Iowa's reward for providing high quality care efficiently and appropriately is to receive much less for the same services as provided in other states.

The fact that Iowa physicians receive less reimbursement for the same procedure than their colleagues in other parts of the country is having a serious impact on

our citizens. The payment to Iowa physicians on ten common procedure codes currently shows Iowa ranks 80th for each procedure out of the 89 geographic payment localities across the nation.

Over the past two years, Katie Couric from the *Today Show*, has made a point of having a screening colonoscopy each year on national television. She lost her husband to colon cancer and wanted to stress the importance of screening colonoscopy, which might have saved her husband's life.

Today, in Des Moines, Iowa, in a very well-run, sophisticated practice, if you were to call to schedule a screening colonoscopy, it takes six months to get an appointment. In that same practice, if your primary care physician refers you to a gastroenterologist specialist (GI), it takes two weeks to get in, even if you are symptomatic and require a gastroenterologist consult.

Why is that the case? Is it because the GI specialists are lazy and want to get home by 5:30 every night? Not at all, they are currently working hours that few other professionals would endure because their commitment to this community is so great. But they have been trying to recruit a partner for several years, and they are competing with practices in states with much more generous Medicare reimbursement than Iowa. GI is a specialty that relies a great deal on Medicare and, therefore, the recruit has to choose between Iowa, where they will work considerably more hours for significantly less pay, and another location, for more pay, and a schedule that allows them to enjoy more time with their families. Consider that physicians coming out of residency today have between $85,000 and $115,000 in education debt, and you know what choice you would make if it were your decision.

For the first time in our state's history, a system in Northern Iowa laid off ten physicians. That means that patients who used to go to Dr. Jones can no longer see him, because he is out of a job. He is out of a job because the health system that formerly employed him can no longer afford him, due in large part to the Medicare crisis of underpayment. His patients will have to find another physician. If those patients were in the room today, they could explain in stark terms how this crisis affects quality of care.

Iowa physicians are also competing with surrounding markets for health care professionals including Chicago, Kansas City, and Minneapolis. But how can we compete when we are reimbursed less and when buses are being sent into Iowa to take nurses across the border where they can earn more?

We stress that this issue is not just about the bottom line suffering for physicians and hospitals. Iowa patients are also truly being shortchanged under the current system.

Medicare HMO's

Medicare's geographic payment disparities have also kept Iowa recipients from receiving benefits that recipients in other states with higher Medicare reimbursement receive. As reported in a July 7, 2002 *Washington Post Article,* "At a time when the government has been encouraging Medicare patients to find drug benefits by signing up for managed care, Iowa does not have a single Medicare HMO." In some areas of the country, reimbursement rates are high enough that Medicare HMOs can offer plans without a premium. Consequently, in those localities, a majority of Medicare patients are in managed care plans. Those Medicare recipients are, in some cases, receiving prescription drug coverage, vision and hearing services and a plethora of other benefits, sometimes for no annual premium and no co-payment. Iowa's low reimbursement has created an environment that penalizes Iowans by offering no Medicare HMO plan.

Iowa's Medicare Population

The impact of Medicare's poor reimbursement to Iowa is additionally magnified by the state's increasing proportion of people who are aged 65. Iowa's high percentage of Medicare eligibles translates into the reality that as Iowa physicians are being reimbursed less, they are also treating more Medicare patients. Iowa's practice environment is also more difficult because Iowa physicians are faced with treating Iowa's 80+ population which is its fastest growing age group. As you can imagine, the health care needs of the 80+ age group are more demanding and costly.

As a whole, Iowa's proportion of older adults in our population exceeds that of the United States as a whole. In fact, Iowa ranks second in the nation of percentage of persons aged 85 and older—2.2%; fourth in the nation of percentage of persons aged 75 and older—7.7%; fifth in the nation of percentage of persons aged 65 years old and older—14.9%; and fourth in the nation of percentage of persons aged 60 years and older—19.2%. As our population ages, these percentages will only increase. Iowa's current Medicare population is approximately 475,000 eligibles.

Iowa's Poor Medicare Reimbursement: Driving the Market

Our high percentage of Medicare enrollees is not the only reason Iowa physicians are beholden to our poor Medicare reimbursement rates. In Iowa, Medicare's reimbursement rate is driving all aspects of physician reimbursement. Iowa Medicaid reimbursement is tied to Medicare through Iowa law and private insurance payors are using Medicare to set their rates as well.

The Flawed Formula: Geographic Practice Costs Indexes

The Medicare Part B formula is fundamentally flawed, due to its use of geographic cost adjustors. The formula used to reimburse physicians is based on assumptions that it is cheaper to provide care in certain parts of the country than it is in others. However, the costs measured by GPCIs do not accurately represent all of the costs associated with practicing medicine. While the formula may be able to fairly measure the cost of rent, it cannot appropriately or accurately measure the cost of providing services.

Iowa physicians face additional costs of having to travel to satellite clinics sometimes as far away as 60 miles to treat patients. To perform the latest treatments, Iowa physicians must purchase the same equipment as their colleagues in New York and San Francisco, often at the same price. However, for the same surgical procedure the equipment is utilized for, they are reimbursed less. An ophthalmologist removing a cataract in Iowa is reimbursed 34% less than physicians in San Francisco for the same exact procedure.

Additionally, the GPCIs are only updated every three years, causing them to lag behind the costs being incurred in today's market. The professional liability insurance cost GPCI is a prime example. While this GPCI is measured accurately, the fluctuating market can endure sudden increases, making the three-year lag time unacceptable in setting reimbursement rates today.

Geographic Payment Coalition

Iowa providers are not alone in our outcry about the inequitable Medicare payment system. That is why this past June at the American Medical Association Annual Meeting, Iowa played a leading role in launching the Geographic Equity in Medicare (GEM) Coalition.

GEM is a coalition of medical organizations that agree that current physician reimbursement should be equitable across the country. The substantial degree of this geographic disparity in patient services and physician reimbursement levels in the Medicare Part B program is unjustified and inherently unfair—and is having an increasingly negative impact on patient care and access in many parts of the United States.

GEM's member organizations believe that federal policy makers must assign a high priority to eliminating Geographic Practice Costs Indices (GPCIs) and other components of the Medicare Part B program that result in inappropriate and inequitable reimbursement to tens of thousands of physicians across this country providing medical care to millions of Medicare beneficiaries.

The Solution

The Iowa Medical Society and GEM propose that GPCIs should be eliminated from the Medicare reimbursement formula, and as a result, the nation be put on a single national fee schedule for Medicare reimbursement of physician services.

While the goal of the Iowa Medical Society is to implement a national Medicare physician fee schedule, we are aware of the political impediments inherent to such a proposal. Given that incremental steps in public policy are most likely to be successful, we ask that you further legislative language that sets an absolute floor on all three GPCIs at 1.0.

Placing all physicians in the nation on the same fee schedule will not completely solve the Medicare problem. The government also needs to fully fund their obligation by raising Medicare reimbursement up to a level that at least fully covers the cost of treating our country's elderly population.

Iowa's physicians are deeply committed to doing the best job they can and remain committed to our Iowa Medicare patients. It is up to you and your colleagues to fix this program so that they can keep that commitment.

Statement of the Hon. Frank A. LoBiondo,
a Representative in Congress from the State of New Jersey

Chairman Johnson and Ranking Member Stark, I appreciate this opportunity to provide written comment on Medicare's Geographic Cost Adjusters as they pertain

to the State of New Jersey. The New Jersey delegation has had a longstanding commitment to rectifying the inequities in Medicare's geographic cost adjusters.

The Balanced Budget Act of 1997 imposed drastic cuts in Medicare's payments to healthcare providers. In New Jersey alone, our hospitals will experience over $2.5 billion in Medicare payment reductions through 2005.

Congress recognized that the BBA of 1997 went too far and thereby acted on two Medicare relief bills which were passed to lessen the reductions. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 provided relief to our hospitals valued at $110 million and $281 million, respectively. While helping to ease the burdens imposed by BBA, these relief measures combined to restore only 15 percent of the original reductions.

Going forward, the Congress must continue their efforts at ensuring fair and adequate Medicare payments to hospitals. The Medicare reform bill that was passed late last month contains three provisions that will benefit New Jersey hospitals by restoring almost $300 million in Medicare payments over a 10-year period.

Medicare recognizes that there are differences in market prices for labor and other inputs across the nation. To adjust for these differences, Medicare uses several geographic cost adjustment factors in its payment systems, including the area wage index in the hospital inpatient acute care PPS and the geographic practice cost indexes in the physician fee schedule.

For the hospital inpatient PPS, Medicare uses two separate operating base payments known as the standardized amounts. One standardized amount is for hospitals in large urban areas (defined as a metropolitan statistical area with a population of one million or more). The other standardized amount is for hospitals located in all other urban areas and rural areas.

Many of the hospitals in my district are designated as "other urban. I support the MedPAC recommendation that the differences between the two standardized amounts be eliminated, and that hospitals located in any urban area should be reimbursed using the "large urban" standardized amount as the base payment for Medicare operating payments.

The area wage index is another geographic adjuster used by Medicare to reflect differences in regional labor markets. With New Jersey sandwiched between New York City and Philadelphia, boasting the first and fifth highest rankings in city populations in the nation, we share the same labor markets. Although I represent a portion of the state that is currently satisfactory in its MSA designation, one of my counties, Cumberland County, would benefit from having the option of joining the Philadelphia MSA or joining with the Atlantic County MSA. Therefore, I would support the Federal Government's efforts of ensuring equity in the calculation of area wage indexes among hospitals in northern New Jersey and New York City as well as among southern New Jersey hospitals and the Philadelphia MSA.

Included in the Medicare reform bill, recently passed by the House, is a GAO study on this important issue and I believe this study will provide useful information to the Committee in the future.

I thank the Committee for their attention to the Medicare Geographic Cost Adjuster issue and for holding this important hearing.

Statement of the Marshfield Clinic, Marshfield, Wisconsin

The following testimony is submitted on behalf of the physicians and staff of Marshfield Clinic, who thank the Subcommittee for conducting this hearing and the opportunity to express concerns regarding the Medicare Physician Fee Schedule. We commend the Subcommittee for its leadership in the development of the Medicare Modernization Act of 2002 and for its continued efforts to improve the Medicare program.

Marshfield Clinic is a large private group medical practice in Wisconsin with 690 physicians, 5400 additional staff, and 1.6 million annual patient encounters. The Marshfield Clinic system includes a major diagnostic treatment center, a research facility, a reference laboratory and 42 regional centers located in northern, central and western Wisconsin. Approximately one-half of the Clinic physicians are in the city of Marshfield (population 19,000). Marshfield Clinic serves a disproportionately large socio-economically disadvantaged population. As a 501(c)(3) non-profit organization, Marshfield Clinic's assets are held in a charitable trust. Marshfield Clinic serves patients regardless of their ability to pay. The Clinic serves several federally designated Health Provider Shortage Areas (HPSAs). The Clinic also provides services in partnership with a federally funded Community Health Center at 13 locations in Wisconsin providing comprehensive integrated care to un- and under-insured residents of the community with incomes at or below 200% of the federal pov-

erty level. Security Health Plan of Wisconsin, a tax-exempt health maintenance organization, is a wholly owned subsidiary of Marshfield Clinic and provides financing for health care services for almost 120,000 members throughout northern, central and western Wisconsin. Security Health Plan initiated enrollment and marketing of Advocare, Marshfield's M+C product on July 22, 2002.

The mission of Marshfield Clinic is to serve patients through accessible high quality health care, research, and education. Marshfield Clinic is committed to improve the health of the patients and communities it serves. Marshfield Clinic concurs with and strives for the six aims articulated in *Crossing the Quality Chasm* by the Institute of Medicine (IOM) for a future health care system that is safe, effective, patient centered, timely, efficient and equitable. Marshfield Clinic continues to build the infrastructure necessary to support these six aims. Unfortunately, the current Medicare reimbursement system represents a major barrier, not only to achieving the future vision but also to preserving the rural health care delivery infrastructure Marshfield Clinic has painstakingly built and maintained over the last three decades. Simply stated, in our part of the country Medicare does not even pay close to the true costs of beneficiary health care, much less lend support for the infrastructure of population health initiatives such as disease state management programs.

While the Resource Based Relative Value Scale attempted to uniformly align payments with resource use across services, it did not address payment adequacy. Within the Marshfield Clinic system payments from all sources for covered services provided to Medicare beneficiaries is less than 70% of Medicare defined reasonable costs**,** which in turn are themselves not entirely "reasonable" in terms of actual costs of good quality care. Historically, the difference has been made up by charging other patients more. Marshfield Clinic no longer has the ability toshift the costs of Medicare underpayment to the private sector. It is critically important to our patients that steps are taken soon to assure that Medicare reimbursement more fairly approximates the cost of providing services.

We believe the best solution to this dilemma is to foster improvements in the quality and effectiveness of care, reinvesting savings (historic or otherwise) in the care system. Unfortunately, even where evidence exists that changing inputs in the care process within our clinic setting can generate significant system-wide savings for Medicare (through lower hospitalization) the existing reimbursement system will not support such changes. This has not allowed us to systematize pilot projects that have demonstrated utility.

In the absence of comprehensive payment reform that would support improvements in the care process and faced with an unsustainable erosion in the adequacy of Medicare payments, Marshfield Clinic is interested in any and all legislative initiatives that would either close the gap between payments or directly support activities that enhance quality and effectiveness of care.

While it is true that creating a floor for the geographic adjustment factor for physician work within the Medicare physician payment system is not likely to enter into the locational decisions of individual physicians, it does not follow that placing such a floor would not be helpful to physicians and health systems serving low payment localities. Marshfield Clinic urges the Subcommittee to support efforts to phase in a floor of 1.000 for the Medicare physician work adjuster, as articulated in H.R. 3569 introduced by Representative Doug Bereuter and S. 2555 introduced by Senator Max Baucus precisely because it would help to close the gap between Medicare payments and cost of providing Medicare services. It would also send a signal that there is an understanding of the problem faced by organizations like Marshfield Clinic and the will to take steps (however small) to address our legitimate concerns.

We believe, and hope that you would agree, that Medicare payments should closely match the necessary costs of high quality efficiently provided services. We would like to call your attention to several inter-related problems regarding Medicare Part B reimbursement that affect physicians throughout the country: 1) Medicare physician payment falls far short of meeting the Medicare allowable costs of delivering medical services to beneficiaries. 2) There are systemic flaws in the Medicare payment formula. The subject of this hearing, Medicare's geographic adjustment of the work element of physician fees, is an inherently flawed formula that exacerbates access problems in rural areas. 3) Medicare revenue shortfalls are offset by cost shifting to other sectors, resulting in a hidden tax principally on patients with employer-based insurance, and have had a determinative effect on commercial premium inflation throughout the country.

This testimony will expand upon the above issue through examples and research into the effects of Medicare underpayments on physician practices and the effect of cost-shifting on commercial health insurance premiums. We acknowledge that rising

healthcare costs are caused by many factors, only one of which is the Medicare underpayment.

At the same time, however, Medicare is Marshfield Clinic's largest payor and its systematic underpayments have a significant impact on our operations and potentially on our entire delivery system.

Medicare Reimbursement Falls Far Short Of The Cost Of Producing Physician Services

During 2001, Marshfield Clinic worked with the General Accounting Office to evaluate Medicare chemotherapy reimbursement and oncology practice expense payments. In conjunction with the evaluation, Marshfield Clinic also conducted an internal analysis utilizing generally accepted accounting principles to determine to what extent payment from all sources for covered services to Medicare beneficiaries covers the "Medicare allowable" costs of providing those services. The analysis indicates thatthe Clinic recovers approximately 70% of its costs in providing Part B Medicare services. The following chart also demonstrates an alarming trend. The gap between the cost to produce Medicare covered services and total payments for those services is growing.

Year	Medicare Revenue as a % of cost
2000	71.52
2001	70.59
2002	68.50

This study demonstrates that the Medicare reimbursement is significantly below Marshfield Clinic's Medicare allowable cost of providing services to Medicare beneficiaries, and that the situation is getting worse. It is our understanding that this result is similar for other group practices in our State.

The Medical Group Management Association (MGMA), a large association for physician clinics of all sizes, conducted a national practice cost study between 1992 and 2000. MGMA's study found that over this period, total operating costs per physician rose by 31.7%. During this same period of time, physician Medicare payment increased only 13%. If the MGMA estimate of changes in physician operating costs roughly approximates changes in the Medicare physician practice and malpractice expenses, it follows that there has been little or no increase during this nine-year period in nominal payments for physician work.

Physician reimbursement under the Medicare program is significantly different than other forms of Medicare reimbursement for hospitals, nursing homes and other health professionals. Inaccuracies in Medicare physician payment have created significant economic incentives to provide more care than is needed in some localities and have impeded access to services in other localities. These inaccuracies distort markets for delivery of health services and undermine the potential for federal reliance on competitive markets to reign in the cost of health care services. Markets adjust to the distortions of federal payment but they shift the costs to commercial purchasers of insurance and clinical services, most notably those employees who are already taxed to provide Medicare benefits. The inaccuracies of the traditional Medicare fee-for-service system have also been imported into and assimilated in the Medicare+Choice system and threaten the viability of M+C.

Though not the subject of this hearing, inaccuracies in the measurement of practice expense (overhead costs) lead to the misstatement of non-physician professional staff salaries, benefits (including health insurance), equipment expenses, and facility construction costs/rents. These errors affect the cost of services, the delivery of care, and the markets for services in widely diverse communities. In rural communities the additional expenses associated with establishing a regional system of care are spread across a disproportionately smaller and more aged population. This problem must be addressed immediately because it is fundamental to comprehensive Medicare reform. Congress must not wait for a system collapse to recognize that this problem affects all specialties, and is a significant source of payment disparity between Medicare and commercial purchasers of physician services.

Physician reimbursement is the only payment system under Medicare that is tied to the gross domestic product (GDP). The program utilizes a formula called the sustainable growth rate (SGR), which reduces fees to physicians as the volume of services increases. In 2002, the result of this formula was a decrease in payments to physicians of 5.4%. Physician payments for 2003 will be further reduced by 4.4% unless Congress acts to change the formula.

Under current law the Centers for Medicare and Medicaid Services (CMS) estimates the amount of total services to be paid for under Medicare Part B; as the volume and cost of Part B services increases, beyond target levels, Medicare law re-

quires that the reimbursement per unit of service must be reduced to achieve budget neutrality. The net effect is that the increasing volumes of services provided throughout the country lead to reduced payments for Medicare physician services without regard for those responsible for the volume increase. This zero-sum approach penalizes conservative medical practices. It also penalizes low payment areas because across-the-board reductions in the Medicare conversion factor represent larger percentage reductions in low payment areas relative to high payment areas.

While Medicare payments for physician services have increased in the aggregate as a result of increasing volume, population and benefits, Medicare payments for services have been substantially reduced since the fee schedule was implemented. The amount Medicare pays is now less than it costs to provide the service. In addition, the amount Medicare spends on its beneficiaries varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health status.

Since beneficiaries and others pay into the program on the basis of income and wages and beneficiaries pay the same premium for Part B services, this results in substantial cross subsidies from people living in low payment states with conservative practice styles or beneficiary preferences to people living in higher payment states with aggressive practice styles or beneficiary preferences.

A recent report prepared May 13, 2002 for the Medicare Payment Advisory Commission by David Glass compared the premium amounts that would be paid monthly by Medicare beneficiaries for Part B services if beneficiaries were to pay a premium that covers 25 percent of the spending for services provided in their state. Currently Medicare beneficiaries residing anywhere in the United States pay a premium of $54 per month for Part B coverage, that is set at this level to cover 25 percent of Part B spending for all aged beneficiaries. Some observers have suggested that it would be more fair for beneficiaries to pay a premium that covers 25 percent of the spending for the services provided in their state. If such a policy were implemented the highest premiums, $69 in Louisiana, $68 in Florida, $64 in New York, $64 in New Jersey, and $63 in California, reflect high use of services by the state's beneficiaries and relatively high payment rates paid to the state's providers. The lowest premiums, $38 in Minnesota, $39 in Hawaii, $39 in South Dakota, $40 in North Dakota, $40 in Wisconsin, $41 in Iowa, and $42 in Montana, Nebraska and Idaho reflect low service use and relatively low payment rates. There are a total of 36 states for which the premium would be less than $54 if this policy were implemented. The District of Columbia and 14 other States would have premiums greater that $54. It is unquestionable that Medicare's payment policies treat beneficiaries in high and low payment states inequitably.

It seems unfair that the cost of providing the service is increasing yet the government is decreasing the payment. This has caused a problem with access to care for the elderly, as many physician practices now limit the amount of Medicare services they provide in order to stay in business.

The Medicare Geographic Adjuster is an Inherently Flawed Formula

We do not believe that geographic adjustment favors rural areas. We would remind the committee that the Physician Payment Review Commission recommended in 1989 that there should be **no** geographic adjustment of payment for physician work, based on the judgment that physician compensation for providing a service should be the same regardless of the locality where the service was provided. The Physician Payment Review Commission in its 1989 Report to Congress recommended "the cost-of-practice index underlying the geographic multiplier (of the fee schedule) should reflect variation only in the prices of non-physician inputs."

In the Omnibus Budget Reconciliation Act of 1989 Congress overrode the recommendation of PPRC to recognize differences among geographic areas in the cost of living. While we recognize that there are differences in the cost of living, they **do not** affect the value of the work of physicians nor do they fundamentally relate to the supply and demand for physician services in any locality. In spite of higher measured cost of living, physicians are abundant in high payment localities, but in short supply in low payment localities. We question whether Congress intended this outcome! Many more services are also provided to Medicare beneficiaries in high payment localities than low payment localities. Compounding the difficulty is the phenomenon that many seniors are attracted to rural and other low cost areas concentrating the extra expenses incurred in serving Medicare populations in localities where physicians are scarce.

In Urban Institute testimony to the Committee, Stephen Zuckerman, an invited witness who co-directed the development of the practice cost adjusters that were adopted for use in the Fee Schedule, stated that the fundamental reason to allow for geographic variation in the costs of physicians' own time is to create fees that

compensate physicians at the same *real* rate in all areas of the country. He noted that a cost of living adjuster would over-adjust fees by not taking into account the impact of an area's amenities might have on compensation. To overcome this problem HCFA used hourly earnings of workers in professional occupations with five or more years of college education to derive a proxy for the physician work component of the geographic practice cost adjuster, in spite of the fact that there is no statistical data to demonstrate a work value relationship between physicians and the proxies selected. Zuckerman also made the theoretical observation that "Properly adjusted, Medicare physician payments should tend to promote an adequate supply of physicians in both urban and rural areas." We believe that **if** proper adjustment of physician work ever occurs, this may hold true.

The HHS Rural Task Force to the Secretary published its report "One Department Serving Rural America" on July 26, 2002 noting on page 6: "As of 2001, only 9 percent of the nation's physicians practiced in rural areas while roughly 20 percent of the nation's population lived in rural areas." Presently the validity of the Medicare geographic adjustment formula is in question because there is a measurable abundance of physicians in high payment localities and an undersupply of physicians leading to access problems in rural areas. In high payment localities that are geographically desirable there are surpluses of physicians who negotiate and accept lower salaries. Conversely in low payment localities that are geographically less desirable there are many physician vacancies reported and physicians negotiate and demand higher salaries.

The absence of a relationship between the Medicare payment and the reasonable cost of providing services is highlighted by the emergence of physician supply problems in many rural localities. Marshfield Clinic currently has 80 physician vacancies, and 317 staff vacancies "on hold" because the Clinic's budget for 2003 is facing multi-million dollar deficits. We presently have patients waiting three months for scheduled appointments and we are juggling the placement of new physicians and support staff to maintain the delicate balance of revenues and expenditures in an environment of large and increasing budget deficits. We recruit in local, regional, Midwestern, and national markets for all of these positions and track national wage and productivity data utilizing the best available resources to maintain the competitive position and professional environment of Marshfield Clinic.

Physician shortages are particularly troublesome to Marshfield Clinic in the following physician specialties: Anesthesiology, Dermatology, Gastroenterology, Radiology, and Urology. Robert Redling reports in the July 2002 MGMA Connexion that physician recruiters are reporting shortages in most subspecialties, with gastroenterology, cardiology and radiology the hardest subspecialties to recruit for. (page 35) MGMA reports that median compensation for these specialties increased substantially between 1999 and 2000. According to the MGMA Physician Compensation and Production Survey Median income for urologists increased 22.7% between 1999 and 2000. Median income for Anesthesiologists increased 19%, Cardiologists increased 18%, and Radiologists increased 11.6%. We do not believe that it is a coincidence that Marshfield Clinic is experiencing great difficulty in filling these positions.

The market for radiologists is unusual, but serves as a good example of the market basis for physician services, because salaries for radiologists recently hit a new peak this year after the term of radiology residencies was extended from four to five years last year creating a gap in the radiologist pipeline.

Staff shortages among physician support personnel are also particularly troublesome for Marshfield Clinic for nurse practitioners, CNRAs, and physician assistants. Marshfield Clinic recruits for these positions on a nationwide basis. Many positions go unfilled because payments, even in Health Professional Shortage Areas where Medicare contributes an additional 10 percent, are not adequate to sustain the staffing levels required to meet the service needs.

The breakdown in the relationship between Medicare payments and cost to provide Medicare services is exacerbated by the incongruous notion that the Medicare payment for physician work should be related to the reported earnings of proxy professionals (engineers, mathematicians, teachers, lawyers, nurses, and artists) identified as having similar tastes in amenities as physicians, because HCFA, now CMS believed that "the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary." (July 17, 2001 FR 44190) There is no mechanism in the CMS formula that takes into account the relative supply and demand of these proxy professionals nor is there a statistical basis to justify the use of the proxies to determine how physician work should be adjusted.

At the request of Marshfield Clinic, RSM McGladrey, of Minneapolis, MN, has provided to the Committee a nationwide sample of physician salaries demonstrating the salary expectations of physicians in all specialties. This data is utilized by orga-

nizations throughout the country to determine the appropriate salary ranges and productivity norms for the purposes of hiring physicians and establishing appropriate compensation for their services. Similar data is published annually by the Medical Group Management Association and the American Medical Group Association demonstrating that there is a national market for physicians' services.

In this day and age, when physicians and other professionals are exceedingly mobile, the choice of where one wants to live is a discretionary choice, like choice of automobile or securities broker. Medicare subsidies of individual physician choices about where they chose to live is not an appropriate use of taxpayer money. Physician salaries are determined by supply and demand. The supply and demand of positions and eligible candidates for the six proxies is unrelated to the supply and demand of physicians.

Simply stated, in our view the geographic adjuster has never made good sense from any perspective. We compete in national markets for our physicians and highly trained staff. We pay salaries and wages determined by national markets. We buy our equipment, medical supplies, computer ware, etc., in national markets. We borrow money at rates determined by national markets. We deliver medical care on the basis of the national and international literature. Our vendors, lenders, suppliers, and professional work force charge us no less because of geography. The only practical effects of a geographic adjuster on rural Wisconsin are to cost-shift to the private sector, increase insurance rates, compromise beneficiary access, and make it increasingly difficult for organizations with public service values to stay in business.

The Effect of Cost-Shifting on Commercial Health Insurance Premiums in Wisconsin

The crisis in Medicare reimbursement is becoming increasingly precipitous, as more and more seniors age into the Medicare program, overwhelming other sources of revenue. In a 20-county Marshfield Clinic service area, which covers more than one-third of the geography of the State of Wisconsin, the regional micro-economy is depressed because there are 3.04 workers for every Medicare beneficiary, a ratio not expected on a national basis by the Bipartisan Commission on Medicare Reform until 2017. In some counties in the Marshfield Clinic service area, the ratio is already below 2 to 1. Medicare fee-for-service payments in Wisconsin are among the lowest in the nation. Wisconsin's premiums for commercial insurance, according to *ModernHealthCare* Dec. 24, 2001 issue, are the 7th highest in the nation, and are ranked above Maryland and DC**.**

Payments by Medicare for healthcare services are not uniform across the country, or across types of providers. This results in very different and disparate levels of reimbursement based on location in the United States. In fact, Wisconsin ranks in the lowest quartile of states in payments for services to Medicare beneficiaries.

A secondary effect of low payments by Medicare, is that hospitals, physicians and other providers must charge private patients a much higher fee for the same service, resulting in higher costs and higher health insurance premiums. This is what is referred to as "cost-shifting."

The cost-shifting from underfunded government programs to private fee-for-service payers is causing businesses and individuals to pay higher premiums for their health insurance. The effect of the cost-shift from government-sponsored health care to the private pay patients has driven Wisconsin commercial health insurance premiums to some of the highest in the country. This problem is further magnified by the demographic shift in Wisconsin of a decrease in people age 20–40 and an increase in the population over 65.

Wisconsin has become unattractive for business to locate here or remain here for a couple reasons. First, we have high tax rates. Secondly, commercial health insurance premiums in Wisconsin are some of the highest in the United States. The following sources that have identified Wisconsin's commercial health premiums as some of the highest in the United States.

Kaiser Family Study

The first source is the Kaiser Family Study, which was conducted in 1999. This study, which compared the average annual cost of employment-based health insurance for single coverage, found that the nationwide average in 1999 was $2,325. Wisconsin ranked seventh from the top with an average annual cost of $2,502. States that border Wisconsin were slightly less, with Illinois at $2,403, Iowa at $2,241 and Minnesota at $2,198. None of them were in the top seven, but this demonstrates that Wisconsin's costs for commercial insurance is higher than the national average by a substantial amount and higher than our bordering states by a significant amount.

Mercer/Foster Higgins National Survey of Employer Sponsored Health Plans

The Mercer/Foster Higgins National Survey of Employer Sponsored Health Plans is a credible source to compare commercial health insurance premiums across the country. At the request of Marshfield Clinic Mercer/Foster Higgins arrayed their data to compare overall commercial premiums on a state-by-state basis. In 2001, the nationwide average cost for an employee per year was $5,100. Wisconsin's cost was approximately $5,500 per year, making it the fourth highest cost per employee in the country.

Milliman USA 2001 HMO Intercompany Rate Survey

The actuarial consulting firm of Milliman USA has conducted an HMO intercompany rate survey for the past 13 years. This survey allows health plans to submit their manual rates for a defined group with common age/sex and common set of benefits. Other surveys comparing Wisconsin do not standardize the benefits or the age/sex of the group and, thus, may tend to rate Wisconsin slightly higher based on our history of more liberal benefits. This Milliman study takes into account the standardized benefit and population.

Milliman arrayed their data on a state-by-state basis, having 28 states with credible data. Of the 28 states with credible data, the Intercompany Rate Survey found that Wisconsin had the second highest per member per month premium for this group. The only state that was higher than Wisconsin was North Carolina.

Further comparing Wisconsin to states with more substantial Medicare payments, such as Florida, found Wisconsin commercial rates to be 20.6% higher than the Florida commercial premium. Comparing to Louisiana, Wisconsin's commercial premium was 31.5% higher. In comparing with California, which has some of the highest Medicare reimbursement, Wisconsin's commercial health insurance rates are 44.2% higher, based on the Milliman survey. We believe there is a strong correlation between the level of Medicare underpayment and higher commercial health insurance rates.

The Problem is Going to Get Worse

The problem is going to get worse, unless change is imminent. Rural areas are especially hard hit by the demographic shift that is occurring in the Medicare population. 77 million baby boomers are about to enter Medicare. Between 2000 and the year 2020, the number of Medicare beneficiaries will increase from 40 million to 61 million, or a 50% increase. At the same time, the number of workers per retiree to fund Medicare is decreasing. There will be fewer workers to support each Medicare beneficiary. Medicare and Social Security are pay-as-you-go programs and by almost all accounts and estimates, Medicare costs exceed revenues near the year 2025. In the year 1960, there were 4.5 workers per retiree. By the year 2000, this had decreased to 3.9 workers per retiree. In the year 2020, it is estimated that the number of workers per retiree in the United States will be 2.8.

In 1999, Wisconsin was at 3.69 workers per retiree, which was below the 2000 estimate for the country. Rural Wisconsin is in much worse shape than the rest of the country or the rest of Wisconsin. Many counties in northern Wisconsin have ratios between 2.0 and 3.0 laborers per Medicare beneficiary. In other words, Wisconsin's rural areas are already at the point where it is estimated that the Medicare program is no longer sustainable.

CONCLUSIONS

In summary, we believe that there are emergent access, cost, and quality-of-care concerns for the Medicare program that must be addressed immediately. Congress must take several steps to address the misalignment of incentives in Medicare reimbursement, and the mal-distribution of payments across different localities.

We commend you for developing provisions in the Medicare Modernization Act of 2002 that would forestall the projected 20% reductions in Medicare physician payment that the Centers for Medicare and Medicaid Services (CMS) would impose over the next three years. We also commend you for calling upon the General Accounting Office study to determine whether the CMS is using accurate information to adjust the physician work component of the RBRVS.

These are short-term steps, however, which do not address the immediate crisis regarding payment for physicians under the Medicare program. Medicare payments to rural physicians must be addressed immediately if Congress is going to avert the crisis in rural health care delivery and the related crisis in commercial premium increases.

We believe that the Medicare payment mechanisms that reduce physician payments in areas where physicians, and the professional staff they employ are in scant supply is bad public policy. We strongly support efforts to phase-in a floor of 1.000

for the Medicare physician work adjuster, as articulated in HR 3569 introduced by Rep. Doug Bereuter, and S. 2555 introduced by Senator Max Baucus that would raise all localities with a work adjuster below 1.000 to 1.000. A similar mechanism establishing a floor for the practice expense GPCI should also be implemented.

We will support your efforts to develop better information by which to address this problem. We believe that the Medicare Payment Advisory Commission should be instructed to study the adequacy of payment to physicians in much more depth than has been done to date, with the aim of developing a process to be used by the government to use cost information related to physicians in determining the adequacy of physician payments and examine the issue of cost variability among physician practice structures.

CMS should be engaged in this effort through research demonstrations structured to examine health delivery factors that encourage the delivery of improved quality in patient care as recommended in S. 2752 introduced by Senator Jeffords.

We believe that immediate changes are needed to assure the adequacy of Medicare payment for physician services. Medicare physician payments must be improved to match the costs of producing efficiently provided services. Consequently we support your efforts to improve reimbursement for physicians as one small step in the larger scheme of necessary modernizations of the Medicare program. We urge you to continue your efforts to bring about comprehensive Medicare reform.

Thank you for considering our views.

Statement of the Hon. Mike McIntyre, a Representative in Congress from the State of North Carolina

As Co-Chairman of the Rural Health Care Coalition in the House of Representatives, I am concerned that Medicare reimbursements create few incentives for physicians, nurses, and other health care professionals to practice in rural areas. Instead, dramatic disincentives exist that reduce access to quality health care for rural Americans. As the number of Medicare eligible citizens increases over the next two to three decades, this crisis will become acute in rural America.

The calculation of the physician fee schedule creates one such disincentive. Currently, the physician fee schedule uses three geographically adjusted variables to determine reimbursements. Two variables deal with the cost of a practice facility and malpractice insurance. The third, "physician work,"is the amount of time, skill, and intensity a physician puts into a patient visit. Rural areas and states have a lower physician work component index number. Because this number is used to determine the physician fee schedule in conjunction with the other variables, rural physicians are reimbursed less per patient than their urban counterparts. I have seen no evidence to suggest that rural physicians spend less time on patients, possess less skill than urban physicians, or pay less attention to their procedures. Physicians and other health care providers in rural areas put in as much time, skill, and intensity into a patient visit as do physicians in other areas. Yet, under the Medicare program, rural physicians are paid less for their work than those who practice in urban areas.

As you know, many rural communities have great difficulty retaining physicians and other skilled health care professionals.Recruitment difficulties for primary and tertiary care remain more severe in areas with lower cost of living indices. As it stands today, the fee schedule creates a barrier to physician recruitment—specifically specialists. Why would a new physician, saddled with student loans, practice in rural America if he or she will not be properly compensated for treating a higher number of Medicare patients?

Rural hospitals also suffer from Medicare's use of Geographic Adjustors. The Wage Index and the Base Payment Amount for Inpatient and Outpatient Discharges are examples of metrics that are used to approximate costs that are based in part on geography. The logic is that it costs less to provide services in rural areas because labor costs are lower. Therefore, Medicare reimbursements should be lower.

There are three primary problems with this logic:

First, it is not true that wages for hospital personnel are the same as in the general labor market. Certainly, clerical services or computer programmers should be accounted for using the labor market as a whole. But hospital personnel—nurses, physicians, radiology technicians, physical therapists, and others—are not accurately reflected in the market basket. MedPac suggested changes in the market basket for this very reason. In fact, to create the proper financial incentives for health care personnel to locate in rural areas, perhaps we should compensate rural hospitals more for providing services. In any case, the market basket does not accurately reflect the actual costs of competing in the health care labor market.

Second, a rural hospital operates with high fixed costs but a lower volume of total patients than its urban counterparts. Simply put, a heart monitor costs nearly the same in Lumberton, NC as it does in Washington, DC. However, it takes more time for a sufficient number of Medicare patients to cycle through rural Southeast Regional Hospital in Lumberton to pay for the same piece of equipment. In addition, it takes more Medicare patients to pay for the heart monitor because Medicare reimburses Southeast Regional Hospital less for each patient discharge.

Third, and related to the second, rural hospitals treat a larger proportion of Medicare patients as a percentage of total discharges than urban and suburban hospitals. Therefore, rural hospitals are more adversely affected by lower Medicare payments than other hospitals because Medicare provides a higher percentage of revenues. Generally, excluding Critical Access Hospitals, the smaller, more rural the hospital, the more financial trouble it has. Studies have shown that the Prospective Payment System has a deleterious effect on the financial health of rural hospitals because it reimburses them significantly less for providing the same services as other hospitals. Over time, Medicare revenue has declined setting off a chain reaction of unintended consequences for rural hospitals: a reduction in hospital services; reduced investment in hospital infrastructure and equipment; aging facilities and technology; limited ability to compete in a tight health care labor market; less demand for inferior service; and increased hospital closures. If the Wage Index and the Base Payment were adjusted to reflect this economic reality, rural hospital solvency would improve.

At a time when rural hospitals are having significant problems keeping their doors open—I have two hospitals in my district that operate in the red and 9 out of 10 that are not meeting their budget for this fiscal year—the Federal Government must be proactive and address these geographic disparities. If there are no rural hospitals, there will be no rural health care. We need to create the proper economic incentives for physicians to practice in rural areas. We need to create the proper economic incentives for physicians to take more Medicare patients. We need to end the perverse logic that says that just because janitorial services cost less in rural America, it must cost less to perform bi-pass surgery.

Rural Americans deserve equal access to quality care. Geographic discrimination—as it exists today—denies them this equality.

Statement of the Hon. Michael R. McNulty,
a Representative in Congress from the State of New York

Chairwoman Johnson, Ranking Member Stark, and members of the Subcommittee, thank you for holding this hearing, and thank you for allowing me the opportunity to share with you my concerns about Medicare's Geographic Cost Adjustors.

The Medicare program's approach to determining the relative differences in area wage costs is both inequitable and flawed. The current approach harms areas with historically lower wages. To compound this problem, Medicare's definition of labor markets is antiquated and inaccurate.

Over the last twenty years, health care providers in the Capital Region of New York State, my Congressional District, have successfully contained the rising cost of health care. The Federal Government, the community, and businesses have benefited from these efforts. Unfortunately, given the inherent flaws in Medicare's approach to paying for health care, "doing the right thing" now jeopardizes the future of health care services in the Capital Region. Many of the hospitals in my district teeter on the brink of financial collapse. During the last two years, the region's hospitals have combined losses of nearly $32 million.

Medicare bases an area's geographic cost adjustor, commonly called the wage index, entirely on historical data. Relying entirely on historical data confines some counties to perpetual low wage index values and lower Medicare payments. It creates an unavoidable cycle of decline—without additional payments from programs like Medicare, hospitals are unable to pay wages comparable to those in areas with historically higher labor costs. As a result, their future wage index values decline even further.

This problem is readily apparent when we compare wage levels for all workers (health care and non-health care workers) in the Capital Region to wages nationally and regionally. According to the Federal Government, wages in the Capital Region are between one and two percent greater than the U.S. average. Total wages in the Capital Region are five to six percent greater than wages in nearby and adjacent Berkshire County, Massachusetts.

Yet the Medicare program sees a very different picture when it looks at health care wages. According to Medicare, health care wages in the Capital Region are 15% less than the national average and 30% less than the health care wages in nearby Berkshire County. As a result, the Medicare program pays hospitals in nearby Berkshire County almost 25 percent more than it pays hospitals in Capital Region (see attached chart).

The differences in wages have a real impact on the workforce. Non-health care workers from surrounding counties travel to the Capital Region for employment. Health care workers leave the Capital Region for employment.

The Medicare program's definition of discrete labor markets is simplistic and distorted. Medicare uses a "bright line approach" to define labor markets. It is not uncommon for a hospital on one side of a bright line to receive 50% more in Medicare payments for the same types of patients than a hospital five miles away on the other side of this bright line. Labor markets are no longer discrete. Given the shortage of health care workers, health care labor markets have become both regional and to some extent national. Health care workers frequently relocate for better wages and, like any other part of the labor force, they do not hesitate to travel for better wages and working conditions.

What does this mean for my hospitals and my community? Emergency room nurses, critical care nurses, operating room nurses, respiratory therapists, radiology technicians, and even clerical staff can travel to hospitals in Massachusetts or to counties south of my area and earn 30 to 40 percent more. As a result, in the Capital Region, these positions go unfilled for weeks and sometimes months. Patients must wait in emergency rooms for hours or even days before a bed becomes available because hospitals don't have adequate staff. Necessary medical care is put on hold and patients "queue" and wait their turn.

Hospitals across the country are often told that these "wage index problems" can be fixed by applying for relief to the Medicare Geographic Reclassification Review Board. While the Board is able to address some problems, it is still bound by the two fundamental flaws in the current approach to computing wage index values—relying exclusively on historical costs and the bright line approach to defining labor markets.

Given the mobility of our work force and the regionalization/nationalization of the labor market, any new approach for defining the differences in wage costs between areas cannot rely on historical data or on the misguided notion that labor markets are discrete and have fixed boundaries.

I offer three recommendations. First, no more than 50% of the wage index should be Metropolitan Statistical Area (MSA) or county specific. The remainder should be national and/or regional, i.e. reflective of the broader labor market.

Second, the Congress should immediately develop a meaningful appeals process—a process reflecting the realities of the health care labor marketplace. Labor markets are very complex and it is unlikely that a single national model can adequately reflect the vagaries and complexities in every area. As a result, we need a qualitative—not a quantitative, appeals process.

Third, the Congress should authorize demonstration projects designed to test new "wage index values." Given the complexity of this problem, we cannot abandon the future of the nation's health care system to untested computer models that may or may not work.

I recognize that defining labor markets and relative wage indices is a very difficult task. Yet the present system is distorted. It brings some hospitals to financial ruin, undermines the quality of patent care and, in some communities, threatens the future of health care. At the same time, it rewards other hospitals without merit simply because they fall into the right Medicare "wage index area."

In conclusion, I hope we can rectify this serious problem and I look forward to working with this Subcommittee to reach an agreeable solution. Specifically, I ask this Subcommittee to keep under consideration the grave situation in my Congressional District. I very much appreciate Chairwoman Johnson and Ranking Member Stark offering me the opportunity to share my views.

MEDICARE WAGE INDEX vs. HOUSEHOLD AND FAMILY INCOME

Metropolitan Statistical Area	Wage Index (FY2002)	Median Household Income (1999)[1]	Est. Median Family Income (FY2001)[2]
Albany-Schenectady-Troy, NY	**0.8547**	**$43,250**	**$53,000**
Pittsfield, MA	1.1454	$38,515	$49,600

MEDICARE WAGE INDEX vs. HOUSEHOLD AND FAMILY INCOME—Continued

Metropolitan Statistical Area	Wage Index (FY2002)	Median House hold Income (1999)[1]	Est. Median Family Income (FY2001)[2]
Syracuse, NY	0.9621	$39,750	$47,900
Rochester, NY	0.9347	$43,955	$52,900
Buffalo-Niagara Falls, NY	0.9459	$38,488	$48,400
Dayton-Springfield, OH	0.9225	$41,550	$56,900
Columbus, OH	0.9565	$44,782	$59,900
Altoona, PA	0.9126	$32,861	$39,500
Harrisburg-Lebanon-Carlisle, PA	0.9425	$43,022	$52,400
Allentown-Bethlehem-Easton, PA	1.0077	$43,098	$52,000
Greensboro-Winston-Salem-High Point, NC	0.9539	$40,913	$53,100
Spokane, WA	1.0668	$37,308	$45,800
Columbia, SC	0.9492	$41,677	$53,200
Bangor, ME	0.9593	$35,837	$42,500
Charleston, WV	0.9264	$35,418	$44,100
Albany, GA	1.0640	$34,829	$43,300
Atlantic-Cape May, NJ	1.1293	$43,109	$49,800
Flint, MI	1.0913	$41,951	$52,700
Muncie, IN	0.9939	$34,659	$47,900
Pocatello, ID	0.9448	$36,683	$45,000
Salem, OR	1.0033	$40,665	$45,600
United States	.....	$41,994	$52,500

[1] Source: U.S. Bureau of the Census, Census 2000
[2] Source: U.S. Department of Housing and Urban Development

Statement of Douglas W. McNeill, President and Chief Executive Officer, Middletown Regional Health System, Middletown Ohio,

Fort Hamilton Hospital 36–0132,
McCullough Hyde Hospital 36–0046,
Mercy Hospital of Hamilton/Fairfield 36–0056,
Middletown Regional Hospital 36–0076

The above-referenced hospitals are in my Congressional district and benefited greatly from the Section 152 of BBRA—1999 countywide reclassification to the Cincinnati Primary Metropolitan Statistical Area (PMSA). Butler County is a PMSA that is an integral part of the Cincinnati-Hamilton Consolidated Metropolitan Statistical Area (CMSA).

The Butler County hospitals compete with Cincinnati hospitals for the same labor market of skilled hospital professional employees. The four Butler County hospitals easily exceed the 85% criteria for geographic reclassification to Cincinnati, but for the last two years the four hospitals have met the also required standardized amount cost per case criteria by less than 1%. In fact, for the FFY 2002 reclassification the Medicare Geographic Classification Review Board (MGCRB) did not reclassify these hospitals because their computations indicated that the hospitals did not meet the cost per case criteria. CMS's Office of Attorney Advisor recomputed the MGCRB data, found that the hospitals met the criteria and overturned the MGCRB decision and reclassified the group. The threshold amount was set by regulation in 1989 and never modified. It is outdated and works to prevent hospital groups in PMSAs from receiving a needed wage index reclassification to another PMSA which is a part of the same CMSA.

For FFY 2003, the cost per case exceeded the threshold amount by a razor thin margin of.01562% (.0001562) for a standardized amount reclassification. These hospitals are clearly in a competitive labor market with Cincinnati, but the out of date cost per case criteria almost prevented a standardized amount reclassification for the last two years in a row.

If the Congress approves statutory reclassifications, we believe that Butler County's request should be approved as it was in the BBRA.

A review of hospital margins supports the need for such a reclassification. The attached schedules, prepared by Baker Healthcare Consulting, Inc., indicate that the county hospitals experienced a negative Medicare margin of 6.82%, a negative operating margin of 8.75%, and total margin of a negative 4.81% for the FFY 1999 data (the most recent data currently available from CMS). The investment income

incurred in 1999 assisted in reducing the loss from operations. Such investment income is unlikely to be realized in FFY 2002.

Please carefully consider a statutory reclassification for the Butler County hospitals.

Mercy Hospital of Hamilton/Fairfield
Provider No. 36–0056
Restated Margin Data for Year Ended December 31, 1999
(Without Wage Index Reclassification for FFY 2000)
Per July 30, 1999 Federal Register

Hamilton average hourly wage (AHW)		$18.9474
National AHW	÷	21.1800
Computed wage index		.8949
Cincinnati reclassified wage index		.9434
Increase in wage index		.0485
Labor related standardized amount as a percent of total	×	.711
Increase in payment (annualized)		.0345
Percent of year effective (October 1–December 31)	×	25%
		.0086
Mercy inpatient Medicare payment		×105,785,491
Reduction in revenues and profits		$909,755
Total revenue per cost report		109,217,543
Revised total inpatient Medicare revenue		$108,307,788
Net patient revenue per cost report		105,785,491
Revised net patient revenue		104,875,736
Net loss per cost report		(8,066,009)
Revised net income		(8,975,764)
Net operating margin computed from cost report		(11,498,061)
Revised operating margin		(12,407,816)
Medicare margin computed from cost report		(1,329,765)
Revised Medicare margin		(2,239,520)

North Mississippi Medical Center
Tupelo, Mississippi 38801
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515–6353

Re: Comment of Medicare's Geographic Cost Adjusters by North Mississippi Medical Center—Medicare Provider Number 25–0004

Madam Chairwoman and Members of the Subcommittee:

On Tuesday, July 23, 2002, the Subcommittee on Health of the Committee of Ways and Means held a hearing to assess the geographic cost adjustments to Medicare payment. Congresswoman Nancy L. Johnson, Chairwoman, invited individuals and organizations not scheduled for an oral appearance to submit a written statement for consideration by the Committee. Please accept the following as the comment of North Mississippi Medical Center (the "Medical Center"), Medicare Provider Number 25–0004.

The Medical Center supports continuation of the Medicare geographic reclassification program for the following reasons:

The Medical Center is a tertiary care regional referral center.

A not-for-profit, acute care hospital licensed for 650 beds, the Medical Center is the largest hospital in Mississippi as well as the largest rural hospital in the United States. The Medical Center, a major regional hospital, provides a full range of serv-

ices and programs consistent with its role as provider of primary, secondary and tertiary care for its service area residents in Tupelo and Lee County, 21 additional Mississippi counties, several counties in northwest Alabama and several counties in southwest Tennessee. The Medical Center's medical staff includes approximately 250 multi-specialty physicians. As of January 2002, the Medical Center employs 2,678 full time employees and 464 part-time employees, making it the largest employer in northeast Mississippi.

Significantly, the Medical Center is not supported by any public appropriations, unlike many Mississippi community hospitals owned by a governmental entity.

The Medical Center is also a regional referral center, providing sophisticated health care services and technology comparable only to that available in metropolitan areas such as Memphis, Tennessee; Birmingham, Alabama and Jackson, Mississippi. As the next closest rural referral center is at least 50 miles distant, the Medical Center is the predominant provider of services to Medicare and Medicaid beneficiaries in northeast Mississippi.

The Medical Center currently qualifies for reclassification to the Memphis, TN–AR–MS MSA (the "Memphis MSA") for purposes of calculating its wage index and has done so ever since the inception of the reclassification program. *See* MGCRB Case Nos. 90C0618, 91C0380, 92C0037, 93C0033, 94C0031, 95C0023, 96C0019, 97C0022, 98C0029, 99C0008, 00C0029.

Through Reclassification, the Medical Center Receives a More Appropriate Labor Cost Adjustment.

Geographic reclassification allows the Medical Center to receive a more appropriate labor cost adjustment. Average wages for the Medical Center tend to be higher than in other non-metropolitan areas within Mississippi. Surrounding the Medical Center are much smaller, rural hospitals lacking the tertiary services that the Medical Center provides including Aberdeen-Monroe County Hospital (49 licensed beds), Trace Regional Hospital (84 licensed beds), Okolona Community Hospital (10 licensed beds), Hillcrest Hospital (30 licensed beds), Pontotoc Hospital (58 licensed beds), Baptist Memorial Hospital-Booneville (114 licensed beds), Baptist Memorial Hospital-Union County (153 licensed beds), Gilmore Memorial Hospital (95 licensed beds), Iuka Hospital (48 licensed beds), Tippah County Hospital (70 licensed beds), and Clay County Medical Center (60 licensed beds). Because the labor cost adjustment does not take this kind of systematic variation into account, the adjustment sometimes does not appropriately reflect the average wages that hospitals such as the Medical Center pay.

Unlike surrounding hospitals, the Medical Center competes in its health care professional recruitment efforts with and has labor costs similar to major tertiary care hospitals in Memphis, Birmingham, and Jackson. To recruit and retain qualified, highly-skilled health care professionals in competition with hospitals in these metropolitan localities, the Medical Center must pay comparable wages. Thus, the Medical Center's costs reflect the average wage hospitals in these metropolitan areas face in their labor market area. To compete with these hospitals, the Medical Center must be reimbursed on the same level.

The geographic reclassification process recognizes the similar labor costs between the Medical Center and its counterparts in metropolitan areas. In allowing the Medical Center to receive a more appropriate labor cost adjustment, geographic reclassification ensures that the Medical Center is compensated fairly for these costs and can compete with similar hospitals in the labor market.

The Ability to Pay Higher Wages Is Critical to the Medical Center.

The Medical Center's ability to pay higher wages helps ensure that Medicare beneficiaries residing in the Medical Center's service area have adequate access to critical inpatient hospital services and other health care. One of Congress' primary goals in enacting the geographic reclassification program was adequate compensation of rural hospitals, thereby assuring that patient populations, predominantly Medicare and Medicaid patients, would continue to receive appropriate medical services.

As a regional referral center, the Medical Center more often than not is the only provider of tertiary care available to Medicare beneficiaries. Few hospitals in Mississippi provide the broad range of services available at the Medical Center, including services provided in a state-of-the-art cancer center, comprehensive cardiac care services, inpatient dialysis facilities, a specialty hospital for women, a sleep disorder center, a diabetes treatment center, a 30-bed rehabilitation institute and a behavioral health center. The cardiac care services include open heart surgery and a Heart Institute comprised of a complete cardiology center offering diagnostic, medical and surgical care which was recognized in 2001 as one of the top 100 hospitals

in the nation in successful treatment of heart disease. The NICU is one of five Level II NICUs in Mississippi and one of five which has three neonatologists on staff. The diabetes treatment center is one of only three American Diabetes Association-recognized centers within Mississippi. Faced with the closure of many rural hospitals, Mississippi must maintain the caliber of hospitals such as the Medical Center. Elderly and/or disabled, Medicare beneficiaries, for whom travel is often very difficult, receive at the Medical Center the highly specialized treatment ordinarily found only in large metropolitan areas.

While the Medical Center provides highly specialized treatments, its patients are sicker than area hospitals. The severity of the illnesses of Medical Center patients is reflected in its case mix index of 1.6867. In fact, the Medical Center's case mix is comparable to the average case mix index of hospitals in metropolitan areas. In contrast, area hospitals provide fewer high tech health care services and treat less severely ill patients as evidenced by their average case mix indices.

The Medical Center is also a provider of care for a significant percentage of elderly and/or disabled patients. During fiscal year 2001, the Medical Center had 11,812 Medicare discharges, more than one-third of its total admissions, and qualified as a Medicare disproportionate share hospital. In fiscal year 2001, the Medical Center derived approximately 66% of its revenue from the treatment of Medicare and Medicaid beneficiaries.

Maintenance of the Medical Center's regional medical leadership, not to mention increased growth, requires consistent funding. Medicare funding is critical to the Medical Center and its geographic reclassification revenues constitute a significant part of the Medical Center's bottom line.

The lack of a geographic adjustment factor over time could reduce the quantity of services the Medical Center provides, compromise its exceptional quality of medical care or, quite possibly, even jeopardize its financial stability and ability to continue serving Medicare patients. Loss of reclassification would significantly hamper the Medical Center's physician recruitment efforts. On the patient level, the people affected most will be those who can afford it least—the elderly, working poor and home-bound patients. Reduction in the Medical Center's services due to lack of funding would necessitate travel by Medicare beneficiaries to either Memphis, Birmingham or Jackson to obtain medical services formerly available at the Medical Center. To continue providing its current level of tertiary services to Medicare beneficiaries and to retain its status as a regional referral center, the Medical Center needs to be reimbursed at the same level as its regional competitors.

On behalf of the Medical Center and other rural hospitals whose geographic cost adjustments are essential to ensure adequate access to appropriate medical services for Medicare beneficiaries in rural areas, I would like to thank the Subcommittee on Health for the opportunity to submit this comment. Geographic reclassification is an effective mechanism to address the financial pressure faced by the Medical Center and other rural hospitals that pay wages higher than the average in their area. Recognizing the need to support those hospitals such as the Medical Center which provide tertiary care in isolated rural areas, the process provides equitable and reasonable Medicare reimbursement levels for rural hospitals competing with their metropolitan counterparts.

Sincerely,

Gerald D. Wages
Treasurer

Providence Hospital
Washington, DC 20017
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515–6353

Dear Madam Chair:

On behalf of Providence Hospital, I am writing today to express our strong support of the testimony offered by both William J. Scanlon, Director, Health Financing and System Issues, U.S. General Accounting Office (GAO), and Glenn D. Hackbarth, Chairman, Medicare Payment Advisory Commission (MEDPAC), at the July 23rd Subcommittee on Health Hearing on Medicare's Geographic Cost Adjustments.

As referenced in Mr. Scanlon's testimony, the urban hospitals in the Washington, DC Metropolitan Statistical Area (MSA) have historically been disadvantaged by the

current system to adjust payments to hospitals for geographic differences in labor costs, otherwise known as the Medicare wage index. The geographic area or MSA for which the wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify. The Washington, DC MSA currently encompasses the 10 urban hospitals in Washington, DC, 16 hospitals in Virginia, 12 hospitals in Maryland and 2 rural hospitals in West Virginia. This geographic region is hardly a representative of a uniform labor market that competes for the same pool of employees. Consequently, when the Medicare Wage Index factor is applied to modify 71 percent of Medicare payments to hospitals, the outlying Virginia and West Virginia hospitals in our MSA benefit greatly from the higher average hourly wage that District of Columbia hospitals require to attract employees, and the District of Columbia Hospitals are deprived of the financial support from Medicare that is truly representative of the labor market costs in an urban area.

Furthermore, in the Medicare Inpatient Prospective Payment System Final Rule released in August of 2001, in section 304(b) of Public Law 106–554, a process was established under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index. The District of Columbia would be an excellent example of where this "statewide" designation should be applied and even the Virginia Hospital and Health Care Association submitted a letter of support of the District's effort to designate itself as such. However, the Centers for Medicare and Medicaid Services (CMS) commented that they believed that "Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC."

We urge your subcommittee's support to review and update the current geographic classification system for purposes of the Medicare wage index and to support the findings and recommendations of the GAO and MEDPAC. It is a system that unfairly penalizes urban hospitals that fall into MSAs that are not representative of a single labor market. District of Columbia hospital, as all urban hospitals, continue to struggle financially due to rising health care costs and the provision of health care to the uninsured. Already two District hospitals have recently closed and half of the remaining hospitals operate in the red. The future of health care in the District of Columbia may be placed jeopardy if corrective action is not taken.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at 202 269–7131.

Sincerely,

Diana McDowell

Providence Hospital
Washington, DC 20017
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515–6353

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Providence Hospital, located in northeast Washington, DC, is a 300+ bed community provider with a high portion of its care that it provides dedicated to Medicare and Medicaid beneficiaries. As costs, such as nursing salaries and pharmaceuticals, have escalated rapidly in the last 5 years, the reductions in Medicare are eroding hospital's mission to serve the elderly and the poor. The reductions in our wage index only serve to exacerbate the problem. Any assistance would be greatly appreciated.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at 202–269–7131.

Sincerely,

David Sparks
Senior Vice President—Finance

Statement of the Rural Referral Center/Sole Community Hospital Coalition

The Rural Referral Center/Sole Community Hospital Coalition (the "Coalition") appreciates the opportunity to submit testimony to the Ways and Means Subcommittee on Health regarding Medicare geographic cost adjusters, and particularly on Medicare geographic reclassification.

Formed in 1986, the Coalition is comprised of approximately sixty large rural hospitals that have either or both the rural referral center ("RRC") or sole community hospital ("SCH") designations under Medicare (See Attachment A for a listing of Coalition Hospitals). These hospitals provide rural populations with local access to a wide range of health care services. In so doing, these facilities localize care and minimize the need for referrals and travel to urban areas. Coalition hospitals have as their common goal assuring that federal hospital payment laws and policies take into account their unique nature and role. A significant number of Coalition hospitals apply and qualify for Medicare wage index geographic reclassification, and so the issue of geographic reclassification is exceedingly important to Coalition hospitals. The Coalition urges the Subcommittee to correct a technical inconsistency in the reclassification system.

Medicare reimburses hospitals for providing *inpatient* services to Medicare beneficiaries using a prospective payment system ("PPS"). Payments to hospitals under the PPS are geographically adjusted by a factor known as the "wage index," which is intended to reflect the cost of labor in the area in which the hospital is located.

Congress recognized that the system of assigning wage indices based solely on a hospital's physical location within a particular county is highly objective and crude and requires some degree of subjectivity. Therefore, in the *Omnibus Budget Reconciliation Act of 1989,* Congress created the geographic reclassification process and the Medicare Geographic Classification Review Board ("MGCRB") for the purpose of, among other things, considering requests from hospitals that wish to reclassify from

the area in which they are physically located to another nearby area, to receive the higher wage index available in that other area.

However, statutorily speaking, the opportunity for hospitals to seek wage index geographic reclassification presently applies only to hospital *inpatient* services. When Congress established the reclassification opportunity in 1989, hospital inpatient services were the only services reimbursed under a PPS, and the only services where payment amounts were geographically adjusted using a wage index. As such, the opportunity for hospitals to seek wage index geographic reclassification applied only to hospital inpatient services. Now, most hospital-based services are reimbursed under some form of a PPS, and geographically adjusted using a wage index. In fact, the Centers for Medicare and Medicaid Services ("CMS") uses the same inpatient service wage index for virtually all services paid on a prospective basis. Yet, CMS has extended reclassification only to hospital outpatient services.

While CMS has exercised discretion to extend a hospital's reclassified wage index to hospital outpatient services, it has refused to use reclassified wage indices to adjust payments for other hospital-based services. As such, a rural hospital that qualifies for reclassification to an urban area would have an urban wage index used to adjust payments for inpatient and outpatient services, but still would have a rural wage index used to adjust payments for most other services provided by that hospital, such as skilled nursing, and inpatient rehabilitation services. This inconsistency means that Medicare pays one wage rate on one floor of a hospital and another wage rate on another floor. This inconsistency cannot be justified and places rural hospitals at a disadvantage when trying to recruit health professionals.

The same rationale that Congress applied in justifying reclassification for inpatient service wage indices now applies in the other contexts where a wage index is used to geographically adjust payments. A hospital provides inpatient and outpatient services within the same building. Similarly, skilled nursing services, inpatient rehabilitation services, and others are often located in the same building, or at least on the same campus as the acute care hospital. In these situations, the hospital's provider-based entities are therefore just as proximate to the MSA, and just as likely to incur the same labor cost experience, as the hospital's inpatient component.

Senator Michael Crapo and Representative Bart Stupak and 15 other Senators and 19 other Representatives recognize this disparity and have stepped forward with a solution. Messrs. Crapo and Stupak are seeking to advance a legislative remedy, the *Medicare Geographic Adjustment Fairness Act* (S. 659/ H.R. 1375), that would require CMS to deem hospitals that have been geographically reclassified for purposes of their *inpatient* wage index to be considered reclassified for purposes of other services (1) which are provider-based and (2) for which payments for those services are geographically adjusted using a wage index.

The Lewin Group, a prestigious Washington-based health care policy consulting firm, studied the *Medicare Geographic Adjustment Fairness Act.* The Lewin Group study revealed that nearly 400 hospitals would benefit from this proposal, and that approximately 90% of the hospitals that would benefit are rural hospitals (See Attachment B for a state-by-state breakdown of rural hospitals that would benefit). Additionally, S. 659 and H.R. 1375 would have no budget impact. Moreover, the Lewin Group predicts that $70 million would be redistributed by this bill and that the gain that eligible hospitals would receive represents less than.06% percent of total Medicare payment to all hospitals. Therefore, the redistrubutive effect of this proposal is negligible.

The Coalition urges the Subcommittee to embrace the legislative remedies outlined in S. 659/H.R. 1375 as it considers Medicare's geographic cost adjusters.

White River Medical Center, Inc., Batesville, Arkansas	**ALABAMA**
St. Bernard's Regional Medical Center, Jonesboro, Arkansas	Boaz Albertville Medical Center
Baxter County Regional Hospital, Inc., Mountain Home, Arkansas	Cherokee Baptist Medical Center
St. Mary's Hospital and Medical Center, Inc., Grand Junction, Colorado	East Alabama Medical Center
Hamilton Medical Center, Dalton, Georgia	Cullman Regional Medical Center
John D. Archbold Memorial Hospital, Thomasville, Georgia	Andalusia Regional Hospital
Kootenai Medical Center, Coeur D'Alene, Idaho	Chilton Medical Center
St. Joseph's Regional Medical Center, Lewiston, Idaho	Selma Baptist Hospital

Provena United Samaritans Medical Center, Danville, Illinois
Freeport Health Network, Freeport, Illinois
Galesburg Cottage Hospital, Galesburg, Illinois
Sarah Bush Lincoln Health Center, Mattoon, Illinois
CGH Medical Center, Sterling, Illinois
Columbus Regional Hospital, Columbus, Indiana
Marion General Hospital, Marion, Indiana
North Iowa Mercy Health Center, Mason City, Iowa
Hays Medical Center, Hays, Kansas
Hutchinson Hospital Corporation, Hutchinson, Kansas
Salina Regional Health Center, Inc, Salina, Kansas
Trover Regional Medical Center, Madisonville, Kentucky

Cape Cod Healthcare, Hyannis, Massachusetts
Gratiot Community Hospital, Alma, Michigan
Alpena General Hospital, Alpena, Michigan

Marquette General Hospital, Marquette, Michigan
Northern Michigan Hospital, Petoskey, Michigan
Munson Healthcare, Traverse City, Michigan
Heartland Health, St. Joseph, Missouri
Kalispell Regional Medical Center, Kalispell, Montana
St. Francis Medical Center, Grand Island, Nebraska
Mary Lanning Memorial Hospital, Hastings, Nebraska
Good Samaritan Hospital, Kearney, Nebraska
Regional West Medical Center, Scottsbluff, Nebraska
Cheshire Medical Center, Keene, New Hampshire
Lakes Region General Hospital, Laconia, New Hampshire
Mary Hitchcock Memorial Hospital, Lebanon, New Hampshire
Watauga Medical Center, Boone, North Carolina
Southeastern Regional Medical Center, Lumberton, North Carolina
Craven Regional Medical Center, New Bern, North Carolina
Columbus County Hospital,Inc., Whiteville, North Carolina
Wilson Memorial Hospital, Wilson, North Carolina
Jackson County Memorial Hospital, Altus, Oklahoma
Grady Memorial Hospital, Chickasha, Oklahoma
Valley View Regional Hospital, Ada, Oklahoma
St. Charles Medical Center, Bend, Oregon
Bay Area Hospital, Coos Bay, Oregon
Evangelical Community Hospital, Lewisburg, Pennsylvania
Avera St. Luke's, Aberdeen, South Dakota
Avera Queen of Peace, Mitchell, South Dakota

Avera Sacred Heart Hospital, Yankton, South Dakota
Maury Regional Hospital, Columbia, Tennessee

CHRISTUS St. Joseph's Hospital & Health Center, Paris, Texas
Memorial Health System of East Texas, Lufkin, Texas
Dixie Regional Medical Center, St. George, Utah
Rutland Regional Medical Center, Rutland, Vermont
Halifax Regional Hospital, South Boston, Virginia
St. Agnes Hospital, Fond Du Lac, Wisconsin
St. Joseph's Hospital, Marshfield, Wisconsin

IDAHO
Magic Valley Regional Medical Center
Gritman Medical Center
Eastern Idaho Regional Medical Center
Kootenai Medical Center
Vaughn Regional Medical Center, Inc.
Edge Regional Medical Center
L.V. Stabler Memorial Hospital

ARIZONA
Verde Valley Medical Center
Payson Regional Medical Center
Sierra Vista Community Hospital

ARKANSAS
Central Arkansas Hospital
St. Bernards Regional Medical Center
St. Joseph's Regional Health Center
Baxter County Regional Hospital
Baptist Health Med. Ctr.—Arkadelphia
Hot Spring County Medical Center
National Park Medical Center
Harris Hospital
Medical Center of South Arkansas
Medical Park Hospital
DeQueen Regional Medical Center
White River Medical Center
Advance Care Hospital

COLORADO
Mercy Medical Center
St. Mary's Hospital & Medical Center
Boulder Community Hospital
Yampa Valley Medical Center

Valley View Hospital

Sterling Regional Medical Center

Vail Valley Medical Center
Avista Hospital

GEORGIA
Hamilton Medical Center
Upson Regional Medical Center
Satilla Regional Medical Center

Gordon Hospital
Southeast Georgia Reg. Medical Center
Northeast Georgia Medical Center
John D. Archbold Memorial Hospital
Murray Medical Center

Bulloch Memorial Hospital
Mitchell County Hospital
South Georgia Medical Center
Redmond Park Hospital
Chestatee Regional Hospital
Lanier Park Hospital
Fannin Regional Hospital
North Georgia Medical Center

ILLINOIS
Katherine Shaw Bethea Hospital
Eureka Hospital

Wood River Medical Center

IOWA

Marshalltown Medical & Surgical Center
Boone County Hospital

Mary Greeley Medical Center
Floyd County Memorial Hospital

Great River Medical Center
Mercy Medical Center—North Iowa
Mercy Medical Center—Clinton
Story County Hospital
Waverly Municipal Hospital

Fort Madison Community Hospital

KANSAS

Newman Memorial County Hospital

Mercy Health System of Kansas, Inc.
Hays Medical Center
Hutchinson Hospital Corporation
Atchinson Hospital Association
St. Catherine Hospital
St. Luke Hospital
Mercy Health System of Kansas, Inc.
Stevens County Hospital
Norton County Hospital
Western Plains Regional Hospital

MAINE

Central Maine Medical Center
St. Mary's Hospital

MINNESOTA

Glencoe Area Health Center

Northfield Hospital
Community Hospital & Health Care Ctr.
Itasca Medical Center

International Falls Memorial Hospital
St. Joseph's Medical Center
Rice Memorial Hospital

Cannon Falls Community Hospital
Cook County North Shore Hospital
Mercy Hospital
Mille Lacs Hospital
Long Prairie Memorial Hospital
Kanabec Hospital

MISSOURI

Bothwell Regional Health Center

St. Mary's Health Center
Phelps County Regional Medical Center

Northeast Regional Health System
Hannibal Regional Hospital

Blessing Hospital
St. Anthony's Memorial Hospital
Galesburg Cottage Hospital
CGH Medical Center
Good Samaritan Regional Health Center
Passavant Area Hospital
Provena United Samaritan Medical Ctr.
Community Hospital of Ottawa
Freeport Memorial Hospital
Memorial Hospital of Carbondale
Marion General Hospital
St. Anthony Hospital & Health Centers
White County Memorial Hospital
Decatur County Memorial Hospital
Memorial Hospital
Saint Joseph's RMC—Plymouth Campus
Vencor Hosp.—LaGrange
Wabash County Hospital
Columbus Regional Hospital
Kosciusko Community Hospital

KENTUCKY

Highlands Regional Medical Center
Marymount Medical Center, Inc.
The Medical Center
Jewish Hospital Shelbyville
St. Claire Medical Center
McDowell Appalachian Regional Hospital
ARH Regional Medical Center
Pikeville Methodist Hospital
Ephraim McDowell Regional Medical Ctr.
Logan Memorial Hospital
Williamson Appalachian Regional Hosp

MICHIGAN

Community Health Care Ctr. of Branch
Gratiot Community Hospital
Marquette General Hospital
Central Michigan Community Hospital
Sturgis Hospital
Munson Medical Center
Northern Michigan Hospital

MISSISSIPPI

North Mississippi Medical Center
Magnolia Hospital
Baptist Memorial Hospital—North MS
Northwest Mississippi Regional Med.
Riley Memorial Hospital
Field Memorial Community Hospital
Wesley Medical Center
Southwest Mississippi Regional Med. Ctr.

Capital Region Medical Center

Audrain Medical Center
Moberly Regional Medical Center
Skaggs Community Health Center
Southeast Missouri Hospital Assoc.
Mineral Area Regional Medical Center
Three Rivers Doctors RMC
Lucy Lee Hospital
Pike County Memorial Hospital

MONTANA

Holy Rosary Hospital
St. Peters Community Hospital
Central Montana Medical Center
St. James Community Hospital

Kalispell Regional Medical Center
Bozeman Deaconess Hospital

NEW HAMPSHIRE

Mary Hitchcock Memorial Hospital

Lakes Region General Hospital
Cheshire Medical Center

NORTH CAROLINA

Northern Hospital of Surry County
Scotland Memorial Hospital
Rutherford Hospital
Park Ridge Hospital
Lenoir Memorial Hospital
Iredell Memorial Hospital, Inc.
Southeastern Regional Medical Center
Watauga Medical Center
Davie County Hospital
Wilkes Regional Medical Center
Transylvania Community Hospital
FirstHealth Moore Regional Hospital
Lake Norman Regional Medical Center
Craven Regional Medical Center
Catawba Memorial Hospital
Davis Medical Center
Nash General Hospital

OKLAHOMA

Baptist Regional Health Center

St. Joseph RMC of Northern OK, Inc.

Medical Center of Southeast Oklahoma
Jane Phillips Memorial Medical Center, Inc.
Jackson County Memorial Hospital
Duncan Regional Hospital

Muskogee Regional Medical Center
McAlester Regional Health Center

Mercy Memorial Health Center

McCurtain Memorial Hospital

Stillwater Medical Center
Grady Memorial Hospital

Baptist Memorial Hosp.—Golden Triangle
Anderson Regional Medical Center
Natchez Community Hospital
North Oak Regional Medical Center

MISSOURI

Callaway Community Hospital
Saint Francis Medical Center
Lake Regional Health System

NEBRASKA

Good Samaritan Hospital
Saint Francis Medical Center
Mary Lanning Memorial Hospital
Beatrice Community Hosp. & Health Center
Memorial Hospital
Regional West Medical Center
Great Plains Regional Medical Center
Fremont Area Medical Center
Columbus Community Hospital, Inc.

NEW MEXICO

San Juan Regional Medical Center
Eastern New Mexico Medical Center
Espanola Hospital
Holy Cross Hospital
Carlsbad Medical Center
Lea Regional Medical Center

NORTH DAKOTA

St. Ansgar's Health Center
Jamestown Hospital

OHIO

Southern Ohio Medical Center
Union Hospital
Marion General Hospital
O'Bleness Memorial Hospital
Providence Hospital, Inc.
Firelands Community Hospital
Wooster Community Hospital
St. Vincent Charity Hospital
Genesis HealthCare System
McCullough-Hyde Memorial Hospital, Inc.
Mercy Hospital of Hamilton/Fairfield
Fisher-Titus Memorial Hospital
Middletown Regional Hospital
Aultman Hospital
Mercy Memorial Hospital Memorial Hospital
Blanchard Valley Hospital
Coshocton County Memorial Hospital
Community Hospitals of Williams County
Fort Hamilton-Hughes Memorial Hosp.
South Pointe Hospital
Adena Regional Medical Center

Haskell County Hospital
Sayre Memorial Hospital
Elkview General Hospital

PENNSYLVANIA
Geisinger Medical Center
Evangelical Community Hospital
Lewistown Hospital
Clearfield Hospital
Robert Packer Hospital
Northwest Medical Center
Clarion Hospital
Conemaugh Valley Memorial Hospital
Meadville Medical Center
Waynesboro Hospital
Greene County Memorial Hospital
Chambersburg Hospital
Shamokin Area Community Hospital
Pocono Medical Center

SOUTH DAKOTA
Northern Hills General Hospital
Brookings Hospital
Sacred Heart Health Services
Avera Queen of Peace Hospital
Avera St. Luke's
St. Mary's Healthcare Center
Sturgis Community Health Center
Gregory Healthcare Center
Lookout Memorial Hospital
Siouxland Surgery Center

TEXAS
Memorial Medical Center
Graham General Hospital
East Texas Medical Center—Pittsburgh
Pampa Regional Medical Center
Crane Memorial Hospital
Permian General Hospital
Hansford County Hospital District
Spohn Klenberg Memorial Hospital
Pecos County Memorial Hospital
Hill Regional Hospital
East Texas Medical Center—Jacksonville
Memorial Medical Center of East Texas
Gulf Coast Medical Center
Presbyterian Medical Center at Winnsboro
Harris Methodist Erath County

Alice Regional Hospital
East Texas Medical Center—Mt. Vernon
Memorial Medical Center—Livingston
Parkview Regional Hospital
Colorado—Fayette Medical Center
Navarro Regional Hospital
Glen Rose Medical Center
Nacogdoches Memorial Hospital
Northeast Medical Center
Jackson County Hospital
Scenic Mountain Medical Center

Nacogdoches Medical Center
El Campo Memorial Hospital
Trinity Valley Medical Center
Covenant Hospital—Levelland
Clinton Memorial Hospital
Mary Rutan Hospital

OREGON
Mid-Columbia Medical Center
Three Rivers Community Hospital
Mercy Medical Center
St. Charles Medical Center
Merle West Medical Center
Lower Umpqua Hospital
Tillamook County General Hospital
North Lincoln Hospital
Valley Community Hospital
Bay Area Hospital

SOUTH CAROLINA
Georgetown Memorial Hospital
Springs Memorial Hospital
The RMC of Orangeburg & Calhoun Co.
Tuomey Regional Medical Center
Self Memorial Hospital

TENNESEE
Hillside Hospital
Bradley County Memorial Hospital
Southern Tennessee Medical Center
Cookeville Regional Medical Center
Lakeway Regional Hospital
Athens Regional Medical Center
Maury Regional Hospital
Baptist DeKalb Hospital
Crockett Hospital
Jellico Community Hospital
Smith County Memorial Hospital
Livingston Regional Hospital
White County Community Hospital

UTAH
Dixie Regional Medical Center
Delta Community Medical Center
Central Valley Medical Center
Heber Valley Medical Center
Bear River Valley Hospital

VERMONT
Central Vermont Medical Center
Brattleboro Memorial Hospital
Southwestern Vermont Medical Center

WASHINTON
Saint Mary Medical Center
Affiliated Health Services
Island Health Northwest
Central Washington Hospital
St. John Medical Center
Olympic Memorial Hospital

WEST VIRGINIA
West Virginia University Hospitals, Inc.
Greenbrier Valley Medical Center
United Hospital Center
Princeton Community Hospital
Fairmont General Hospital, Inc.

Golden Plains Community Hospital

WISCONSIN

St. Michael's Hospital
Memorial Hospital of Taylor County
Amery Regional Medical Center
The Monroe Clinic
St. Joseph's Hospital
Memorial Hospital of Burlington
Mercy Health System
Beaver Dam Community Hospital
Columbus Community Hospital
St. Agnes Hosp.
Howard Young Medical Center, Inc.
St. Luke's Memorial Hospital
St. Mary's Medical Center
Holy Family Memorial, Inc.
Bay Area Medical Center, Inc.
Memorial Medical Center—Ashland
Beckley Appalachian Regional Hospital
Raleigh General Hospital

WYOMING

Ivinson Memorial Hospital
Evanston Regional Hospital

Statement of the Hon. Jim Saxton, a Representative in Congress from the State of New Jersey

Chairman Johnson and Ranking Member Stark, I thank you for allowing me to provide written comment on Medicare's Geographic Cost Adjusters as they pertain to the State of New Jersey. The New Jersey delegation has worked to address the fiscal health of our hospitals over the last several years, and has specifically concentrated on rectifying the inequities in Medicare's geographic cost adjusters.

To preserve Medicare for the next ten years, the Balanced Budget Act of 1997 (BBA) slowed the rate of growth in payments to hospitals, physicians, and other providers; and established new payment systems for skilled nursing facilities and home health agencies. At the time of enactment, it was estimated that this would result in a savings of $116.4 billion over five years, $1.8 billion of which New Jersey hospitals were expected to shoulder.

Since that time, the actual Medicare payment reductions resulting from the BBA have been much larger than originally intended. As a result, beneficiary access to health care has suffered as the health care facilities have been faced with deep cuts in payments.

To remedy this situation and help improve the fiscal health of many Medicare providers, Congress passed the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to help restore funding to hospitals and other critical providers. Unfortunately, New Jersey hospitals received only a small fraction of the givebacks. This was due in large part to the fact New Jersey hospitals did not qualify for many of the major provisions in each bill, including aid to rural hospitals. In fact, N.J. hospitals only received $110 million over five years in BBRA and $281 million over five years from BIPA.

Most recently, I was pleased to see the House pass the Medicare reform bill in June 2002 because it will benefit New Jersey hospitals by restoring almost $300 million in Medicare payments over a 10-year period. Looking in the future, the Congress must continue their efforts at ensuring fair and adequate Medicare payments to hospitals.

However, aside from the Medicare provider restoration efforts, the New Jersey delegation has been examining other fundamental payment problems within the Medicare program, including the area wage index—a geographic adjuster used by Medicare to reflect differences in regional labor markets. New Jersey is unique from the rest of the country in that it is bordered by the first and fifth largest cities in the United States. Many New Jersey residents commute into these metropolitan hubs for employment and recreational purposes. New Jersey hospitals and other healthcare facilities have been and continue to be forced to compete for labor resources and patients in each of these markets. As a result, the largest and fastest growing cost of providing health care in New Jersey is not building new facilities or developing new technology, but workers' salaries.

Yet, while New Jersey hospitals compete for the same workers and patients in these areas, they have significantly lower Medicare wage indexes. This means that New Jersey hospitals receive hundreds of millions of dollars less in Medicare reimbursement than hospitals in the New York and Philadelphia metropolitan statistical areas (MSAs). For example, hospitals in Bergen County, New Jersey, some of which are only a few miles from New York City, receive $25 million less annually than hospitals in the New York MSA.

New Jersey hospitals simply cannot continue to compete with two of the nation's largest cities while facing the strains of an unprecedented workforce shortage. They need increased wages to retain nurses and other healthcare professionals. More than 40 percent of New Jersey hospitals ended 2000 in the red, and with $21 billion in looming budget cuts already set in law, the financial condition of this critical industry will only become bleaker.

While part of my district is currently satisfied with its MSA designation, Ocean County would benefit tremendously if given the opportunity to join the New York City MSA. In fact, as a whole, if hospitals in New Jersey were given the opportunity to reclassify into the New York City MSA as many as 60 hospitals in New Jersey would garner $241 million in additional wage-adjusted payments. Therefore, I would support the Federal Government's efforts of ensuring equity in the calculation of area wage indexes among hospitals in northern New Jersey and New York City as well as among southern New Jersey hospitals and the Philadelphia MSA.

I was extremely pleased to see the inclusion of a GAO study on improvements that can be made in the measurement of regional differences in hospital wages in H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002. Specifically, the study would examine the use of MSAs for purposes of computing and applying the wage index and whether the boundaries of such areas accurately reflect local labor markets. The study would also examine whether regional inequities are created as a result of infrequent updates of such boundaries.

This study is a critical step in the right direction, and I thank the leadership for working with the New Jersey delegation to address the critical fiscal problems faced by the New Jersey hospitals.

Once again, I appreciate having the opportunity to provide written testimony on this issue and thank the Committee for their attention to the Medicare Geographic Cost Adjuster issue and for holding this important hearing.

Sibley Memorial Hospital
Washington, DC 20016
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515–6353

Dear Madam Chairman:

On behalf of Sibley Memorial Hospital, I am writing today to express our strong support of the testimony offered by both William J. Scanlon, Director, Health Financing and System Issues, U.S. General Accounting Office (GAO), and Glenn D. Hackbarth, Chairman, Medicare Payment Advisory Commission (MEDPAC), at the July 23rd Subcommittee on Health Hearing on Medicare's Geographic Cost Adjustments.

As referenced in Mr. Scanlon's testimony, the urban hospitals in the Washington, DC Metropolitan Statistical Area (MSA) have historically been disadvantaged by the current system to adjust payments to hospitals for geographic differences in labor costs, otherwise known as the Medicare wage index. The geographic area or MSA for which the wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify. The Washington, DC MSA currently encompasses the 10 urban hospitals in Washington, DC, 16 hospitals in Virginia, 12 hospitals in Maryland and 2 rural hospitals in West Virginia. This geographic region is hardly a representative of a uniform labor market that competes for the same pool of employees. Consequently, when the Medicare Wage Index factor is applied to modify 71 percent of Medicare payments to hospitals, the outlying Virginia and West Virginia hospitals in our MSA benefit greatly from the higher average hourly wage that District of Columbia hospitals require to attract employees, and the District of Columbia Hos-

pitals are deprived of the financial support from Medicare that is truly representative of the labor market costs in an urban area.

Furthermore, in the Medicare Inpatient Prospective Payment System Final Rule released in August of 2001, in section 304(b) of Public Law 106–554, a process was established under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index. The District of Columbia would be an excellent example of where this "statewide" designation should be applied and even the Virginia Hospital and Health Care Association submitted a letter of support of the District's effort to designate itself as such. However, the Centers for Medicare and Medicaid Services (CMS) commented that they believed that "Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC."

We urge your subcommittee's support to review and update the current geographic classification system for purposes of the Medicare wage index and to support the findings and recommendations of the GAO and MEDPAC. It is a system that unfairly penalizes urban hospitals that fall into MSAs that are not representative of a single labor market. District of Columbia hospitals, as all urban hospitals, continue to struggle financially due to rising health care costs and the provision of health care to the uninsured. Already two District hospitals have recently closed and half of the remaining hospitals operate in the red. The future of health care in the District of Columbia may be placed jeopardy if corrective action is not taken.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at 202–364–7609.

Sincerely,

Chuck Crickenberger
Director, Contracts and Reimbursement

Statement of the Hon. Christopher H. Smith,
a Representative in Congress from the State of New Jersey

I'd like to thank and commend the Chairman and the committee for holding this very important hearing on Medicare's Geographic Cost Adjustors, an issue of national importance. I'd also like to thank my New Jersey colleague, Congresswoman Marge Roukema, for her very excellent and comprehensive statement on the Medicare wage index and its impact on northern and central New Jersey hospitals. I'd like to add my full support for, and endorsement of, her testimony.

I think one of the best case studies clearly demonstrating the need to reform Medicare's Geographic Cost Adjustor can be found by examining New Jersey's hospitals. Our state's hospitals have been in a terrible financial condition for several years in a row. If something is not done very soon, many of them will run their bond ratings into the ground, run out of cash, and go bankrupt. Approximately one third of our state's acute care hospitals are running in the red. According to data recently published by the American Hospital Association (AHA), New Jersey's average Medicare margin is **negative 8.1 percent**, and has been negative for several years. This means that on average, every time a hospital treats a Medicare patient, the hospital will get back less than its actual cost of providing care. Mr. Chairman, no hospital on the planet can lose money year in and year out and operate indefinitely. Statewide, our hospitals are losing $300 million a year in treating Medicare patients.

Several explanations have been offered to explain New Jersey's hospital crisis. However, none of the traditional explanations really account for it. Some have argued that New Jersey has too many hospitals and overcapacity leads to unused beds, high overhead costs, and red balance sheets. That might be true in individual hospitals, but there's no statistical evidence showing New Jersey suffers from system-wide overcapacity or underutilization problems. New Jersey's hospital beds per 1000 persons is tied for 23rd among 50 states, according to the 2000 American Hospital Association Annual Survey. The national average is 3.0 beds per 1000 persons. New Jersey has 3.1 beds per 1000 people. This is not abnormally high. As far as utilization is concerned, New Jersey's admissions per 1000 persons is tied for 17th out of 50 states, and total admissions are *higher* than the national average, not lower (130 in NJ vs. 120 nationwide). Obviously, overcapacity and underutilization cannot explain New Jersey's hospital financial crisis.

The other "usual suspect" is the average length of stay (ALOS) for our state's inpatient hospitals. Here again, while New Jersey's average length of stay is 7.5 days, according to CMS data for FY 2000, and higher than the national average of 6.0 days, it cannot fully explain New Jersey's negative Medicare margins. New York has

an average length of stay of 8.3 days, higher than both New Jersey and the national average, but yet their hospitals' Medicare margins are substantially better than New Jersey's (negative 8.1%) at positive 2.1%, according to AHA's latest data. If higher-than-average length of stay were the main variable driving New Jersey's sharply negative Medicare margins, shouldn't New York also have negative Medicare margins? One would expect to see that, yet the evidence is not there. Again, it is clear ALOS is not the key to understanding why New Jersey's hospitals are in a financial crisis.

Mr. Chairman, our delegation has studied this issue very closely for the better part of a decade, trying to figure out why our hospitals are consistently financially underperforming compared to their neighbors in Pennsylvania and New York. We have concluded that the one factor seeming to explain the vast majority of this difference relates to a huge gap in the wage adjustment factor.

Under current law, hospitals in nearby New York City receive a 44% add-on for every labor-related dollar of payment received from Medicare. New Jersey's hospitals, on the other hand, receive a wage adjustor of just four to 18 percent. In many cases, New Jersey hospitals in Bergen, Middlesex, Monmouth, and Union Counties are far closer to New York City and Staten Island than hospitals actually included in Medicare's New York City Metropolitan Statistical Area (MSA), which include hospitals as far away as Westchester and Orange Counties. By almost any measure, New Jersey's hospitals are competing for the same labor pool as the hospitals in the greater New York City MSA.

I cannot emphasize enough that many of New Jersey's hospitals suffer significant financial inequities due to Medicare's cost adjustment factors and those inequities have a severe negative impact on the hospitals' financial condition. In fact, if hospitals in northern and central New Jersey received the same labor adjustment as its close neighbors in New York, it would dramatically improve New Jersey's Medicare margins. According to estimates prepared by the New Jersey Hospital Association, our state's overall loss of $300 million due to negative Medicare margins would be reduced by nearly $244 million. The correlation between the two variables is an incredibly high.81. This means 81% of New Jersey's problem of low Medicare margins can be explained by just this one variable—the Geographic Cost Adjustor.

As the Chairman knows, to account for differences in market prices for labor and other inputs across the nation, Medicare uses several geographic cost adjustment factors in its payment systems, including the area wage index for the hospital inpatient acute care prospective payment system (PPS). For the hospital PPS, Medicare uses two separate operating base payments known as the "standardized amounts." One standardized amount is for hospitals in large urban areas, defined as a metropolitan statistical area with a population of one million or more. The other standardized amount is for hospitals located in all "other urban areas and rural areas."

Many of the hospitals in my district are designated as "other urban." I support MedPAC's recommendation that differences between the two standardized amounts be eliminated, and that hospitals located in any urban area should be reimbursed using the "large urban" standardized amount as the base payment for Medicare operating payments.

Another adjustment factor Medicare uses to reflect differences in labor markets is the area wage index. New Jersey's wage index is lower than neighboring areas, even though it must compete with hospitals in these nearby localities for labor. With New Jersey geographically positioned between New York City and Philadelphia, cities which boast the first and fifth highest rankings in city populations in the country, significant parts of the State share the same labor markets with these metropolitan areas. If you examine actual commuting patterns, you will see the labor markets in New Jersey and in the Philadelphia and New York markets are essentially two big markets that stretch across state lines.

In late 1999, the Metropolitan Area Standards Review Committee recognized that the settlement and commuting patterns of the mid-Atlantic region constituted larger entities, and formally suggested that a larger "megapolitan" area for New York and New Jersey exists. Sadly, when the MASRC proposed formally merging New Jersey's MSAs into one big megapolitan area, the New Jersey Chamber of Commerce opposed the move, arguing it would hurt its efforts to market New Jersey as a place to do business. Personally, I believe their opposition was baseless and foolish in the extreme. In the end, the Chamber's opposition caused the MASRC to reverse course, and leave the MSA borders as is. As a result, New Jersey lost out on hundreds of millions of dollars each year that our hospitals desperately need to operate. The fact that political opposition scuttled the proposal does not mean the MSARC was wrong. On the contrary, I believe the experts were correct all along.

It is commendable that the Medicare Modernization and Prescription Drug Act, as passed by the House, includes a provision my fellow New Jersey colleagues and

I requested. The requested provision directs the General Accounting Office to conduct a study of the Medicare wage index. The study would specifically examine the use of metropolitan statistical areas for purposes of computing and applying the wage index and whether the boundaries of such areas accurately reflect local labor markets. The study also would examine whether regional inequities are created as a result of infrequent updates to such boundaries. Additionally, the study would examine the portions of hospital cost reports relating to wages, and methods for improving the accuracy of the wage data and for reducing inequities resulting from differences among hospitals in the reporting of wage data. It is important that GAO examine both the use of MSAs and the consistency and equity of wage data.

The current Medicare wage index for Trenton, New Jersey—within my district—is 1.0419, as compared to the New York City index of 1.4427. As a result, for every $1 in Medicare services used, $1.04 will be paid to one of my Trenton hospitals, but $1.44 will be paid to a hospital in New York City. When a Trenton hospital tries to hire a nurse who lives in Hamilton, New Jersey, the Trenton hospital will have substantially less resources at their disposal to offer. Given the national shortage of nurses, the massive wage index disparity puts Trenton hospitals at a major disadvantage vis-a-vis their competitor hospitals in New York.

Even though Medicare's wage index is patently unfair, if you look hard enough, there is evidence that the labor market for health care workers is one and the same in New Jersey and New York. According to data collected and reported by the Bureaus of Labor Statistics (2000 Occupational Employment Statistics), the mean annual salary for the standard classification for "healthcare practitioners and technical occupations" across all standard industrial classifications (SICs) is $58,770 for the Trenton Primary Metropolitan Statistical Area (PMSA), while it is $55,760 for the NY, NY PMSA. I do not draw conclusions from this snapshot of BLS data for all SICs, but it does reinforce the need to examine the Medicare hospital wage index as far as its current ability to reflect the relative cost of labor.

The Medicare Modernization and Prescription Drug Act, passed by the House last month, provides significant assistance to our nation's hospitals, and will benefit New Jersey hospitals by restoring almost $300 million in Medicare payments over a 10-year period. I greatly appreciate the efforts of this committee to help our nation's hospitals, but Congress must continue and reinforce efforts at ensuring fair and adequate Medicare payments to hospitals.

I thank the Chairman for her interest in this important issue.

South Central Regional Medical Center
Laurel, Mississippi 39440
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515–6353

Re: Comment on Medicare's Geographic Cost Adjusters by South Central Regional Medical Center—Medicare Provider Number 25–0058

Madam Chairwoman and Members of the Subcommittee:

On Tuesday, July 23, 2002, the Subcommittee on Health of the Committee of Ways and Means held a hearing to assess geographic cost adjusters used for Medicare payment. Congresswoman Nancy L. Johnson, Chairwoman, invited individuals and organizations not scheduled for an oral appearance to submit a written statement for consideration by the Committee. Please accept the following as the comment of South Central Regional Medical Center, Medicare Provider Number 25–0058.

South Central Regional Medical Center supports the continuation of the Medicare geographic reclassification program.

South Central Regional Medical Center ("South Central") is a 285-bed Medicare-designated sole community hospital and rural referral center located in Laurel, Jones County, Mississippi. South Central's nearest competitors offering comparable services are located approximately 30 miles from South Central. South Central provides vital health care services that residents of Jones County and the surrounding areas otherwise would receive from hospitals in larger medical communities many miles distant. These services include emergency services, a women's center, rehabilitation services, a wellness center, surgical services, diagnostic and imaging services,

cardiac services, outpatient services, a nursing home, home health services and hospice services.

South Central supports continuation of the Medicare geographic reclassification program. Through this program, South Central and other rural hospitals receive Medicare payment in amounts comparable to payment received by competitor urban hospitals located across county lines.

Until fiscal year 1995, South Central was periodically reclassified to the Jackson, Mississippi Metropolitan Statistical Area (MSA) and received a substantial benefit from reclassification. Reclassification allowed South Central to compete, not only with nearby urban hospitals, but also with nearby rural hospitals that reclassified to the Jackson MSA and the Biloxi-Gulfport-Pascagoula MSA.

For example, in fiscal year 1993, South Central's wage index increased from the rural floor of .6963 to .7740 as a result of reclassification. This adjustment increased the amount of South Central's payment per discharge by $234.25 allowing South Central to provide an increased number of health care services to residents in central Mississippi.

Additional payment from geographic reclassification also allowed South Central to participate in many community activities. For example, South Central initiated a project known as ALIVE Jones County to develop a community health improvement plan focusing on four critical issues facing Jones County: breakdown of the family, teenage pregnancy, health care access and poor nutrition and exercise. South Central also serves as a training site for many area schools, universities and organizations, and provides a variety of community education programs, including a diabetes education and support group. South Central's Women's Life Center offers a health library complete with video tapes, books and pamphlets, as well as classes such as the Prepared Childbirth, Sibling Preparation and Safe Sitter classes. In addition, the Women's Life Center offers a monthly luncheon program called "Speaking of Women" and an annual Women's Life Conference which is Mississippi's premier women's health and wellness event. In addition to these activities, South Central sponsors Health Break, a weekly television program which features physicians and other health professionals discussing topics of interest to the community relating to health and well-being. Thus, Medicare geographic reclassification has benefitted not only South Central, but all residents of Jones County and the surrounding areas.

Problems with the Medicare geographic reclassification program jeopardizing South Central's continued viability.

Although South Central supports the continued existence of the Medicare geographic reclassification program, there are serious problems with the system that currently threaten South Central's continued viability as a provider of health care services in central Mississippi.

Formation of new MSAs may unexpectedly cause rural hospitals located near the MSA to lose their ability to compete.

In fiscal year 1995, the Hattiesburg, Mississippi MSA was formed, comprised of Forrest and Lamar counties. The Hattiesburg MSA borders Jones County, where South Central is located. In fiscal year 2002, all of the hospitals located within the Hattiesburg MSA reclassified for wage index purposes to the next closest MSA, the Biloxi-Gulfport-Pascagoula MSA. This reclassification resulted in significant increased Medicare payments to these hospitals. However, it left the Hattiesburg MSA empty with a wage index equal to the Mississippi rural wage index. Suddenly, through no action of its own and no shift in the labor market, South Central's ability to compete with other hospitals in the area was drastically reduced. South Central now may apply for reclassification to the Hattiesburg MSA but, unlike each of its competitors, receives no benefit from such reclassification.

Since fiscal year 1995, the MGCRB has reclassified most Mississippi rural referral centers, including South Central's competitors, to MSAs with a higher wage index. South Central's competitors include rural referral centers in Meridian, Mississippi (58 miles distant) and in Hattiesburg, Mississippi (23 miles distant). These hospitals each reclassified to the Jackson MSA and the Biloxi-Gulfport-Pascagoula MSA. As a result of its reclassification to the empty Hattiesburg, Mississippi MSA and its inability to reclassify to any other urban area, South Central receives a lower wage index than any other rural referral center in Mississippi meeting the reclassification criteria.

This situation places South Central in the position of reclassifying to the Hattiesburg MSA, which receives the rural floor wage index (.7680), while its nearest competitors qualify for reclassification to the Biloxi-Gulfport-Pascagoula MSA or the Jackson MSA, each of which receive a much higher reclassified wage index (.8667 and.8368, respectively). Based on fiscal year 2003 PPS rates, South Central will re-

ceive an estimated $362.21 less per Medicare discharge in fiscal year 2004 than it would have received had it reclassified to the Jackson MSA, and an estimated $268.83 less per Medicare discharge than it would have received had it reclassified to the Biloxi-Gulfport-Pascagoula MSA. Furthermore, South Central receives an estimated $359.20 less per Medicare discharge than it would receive if it were located across the county line in the Hattiesburg MSA, due to the increase in the DSH adjustment for an urban area. South Central's payment from Medicare on a per discharge basis is lower than that of any of its competitor hospitals in Hattiesburg, Meridian, Jackson and the Mississippi Gulf Coast and than any other reclassification-qualifying rural referral center in Mississippi.[1]

In fiscal year 2002, South Central was the only rural referral center in Mississippi that qualified for reclassification, but did not receive a benefit from such reclassification. South Central competes with reclassified hospitals for labor from the same labor pool, buys supplies and equipment from the same suppliers and has costs comparable to the competing hospitals. As a rural referral center, South Central must comply (as must other referral centers) with federal statutes, such as the Emergency Medical Treatment and Active Labor Act, that restrict activities of rural referral centers and impose upon South Central expensive administrative and clinical burdens. Yet South Central receives lower Medicare payments per discharge than any of its competitors.

The reduction in Medicare payment to South Central may cause serious detrimental effects to Jones County and the surrounding areas.

According to the U. S. Census Bureau, in 2000, 14.2% of the 64,536 residents of Jones County (over 9,000 people) were over the age of 65. Obviously, South Central's ability to provide services to Medicare recipients is vital to the residents of Jones County. However, the drastic reduction in Medicare payment that South Central experiences as a result of the formation of the Hattiesburg MSA threatens South Central's ability to provide services to these individuals.

Additionally, like many hospitals, South Central's ability to remain viable as a provider of health care services in central Mississippi is largely dependent upon Medicare revenues. Therefore, the reduction in Medicare payment to South Central that results from its inability to gain a benefit from reclassification to an urban area affects not only the health care services that it provides to Medicare beneficiaries, but its overall ability to provide quality health care services at prices comparable to its competitors. South Central's inability to compete with nearby hospitals for labor threatens its very existence.

In addition to providing health care services and as noted above, South Central participates actively in many community activities, including ALIVE Jones County, the diabetes education and support group, Health Break and activities sponsored by the Women's Life Center. The reduction in funds that South Central receives threatens its ability to participate in such outside activities. Thus, Jones County is threatened in its ability to obtain not only health care services, but many community services as well.

There are several possible ways to correct these inequities suffered by South Central and other rural hospitals that may reclassify only to an empty MSA. The wage index rules could be revised to provide that when all hospitals within an MSA (the "home MSA") qualify to receive payment rates of another MSA (the "reclassified MSA"), the home MSA will be assigned the same wage index as the reclassified MSA. Alternatively, the geographic reclassification rules could be revised to state that if all urban hospitals within an MSA are reclassified to a reclassified MSA, rural hospitals otherwise seeking reclassification to the home MSA will be exempt from proximity criteria and will be reclassified to the reclassified MSA. Finally, a grandfather clause could be added to the rules for rural hospitals that are detrimentally affected by the formation of a new MSA, which would allow a rural hospital to continue to reclassify to the previous MSA to which it was reclassified before the formation of the new MSA.

On behalf of South Central and other rural hospitals experiencing similar problems as a result of reclassification to an empty MSA, I would like to thank the Subcommittee on Health for the opportunity to submit this comment.

Sincerely,

Dinetia M. Newman

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[1] Assuming that South Central has 4,350 discharges in FY 2003 (a number comparable to previous year), South Central's total Medicare payment for FY 2003 will be $1,575,618.28 less than it would be if South Central were reclassified to the Jackson MSA, $1,169,390.92 less than it would be if South Central were reclassified to the Biloxi-Gulfport-Pascagoula MSA, and $1,562,514.34 less than it would be if South Central were located within the Hattiesburg MSA.

Statement of Sutter Health, Sacramento, California

Chairman Johnson and members of the committee, we appreciate the opportunity to present this written statement on the geographic practice costs adjustment in the Medicare Physician Fee Schedule. Because Sutter Health serves more than twenty Northern California counties and has care centers in more than 100 communities, we feel we are in a unique situation to provide insights into the practical impact of the fee schedule.

We would like to focus on a particularly troubling provision of the physician fee schedule that unfairly impacts physicians practicing in certain areas. The problem stems from the methodology used in 1997 to create new payment "localities." Each locality includes one or more counties within a state. Under the physician fee schedule each locality has a unique geographic adjustment factor that reflects the relative resource cost differences among all localities. This factor is applied to the base rate to determine the adjusted rate to be paid to physicians in the respective locality.

The 1997 methodology established unique localities with costs that were at least 5 percent higher than the combined average costs of all lower-cost localities in the state. The rest of the localities, i.e., those with cost equal to or less than the 5 percent threshold, within the state were combined into a single rest-of-state locality, because, it was assumed, their costs were relatively homogenous. These rest-of-state localities are called "Locality 99."

The major flaw in this methodology is that Medicare did not start in 1997 by looking at the relative cost difference of each county, instead it used the localities established in 1967 for Medicare's reasonable charge based physician payment system. The current localities in all states were established under the 5 percent threshold noted above by comparing the then existing locality costs, not by comparing individual county costs. That is, the "charge based localities" were not broken down into their county components.

The result is, at least in California, that the state's Locality 99 includes four counties with cost differences exceeding 5 percent. In other words, if Medicare had used individual counties instead of the "charge based localities," the counties of Santa Cruz, Sonoma, Santa Barbara and San Diego would be grouped in more appropriate localities or new unique localities. And, they would not be grouped in Locality 99.

For example, under the "charge based localities," Santa Cruz County was in a locality with San Benito and Monterey counties. The costs for this locality reflected the weighted average costs among these counties. Two other counties, Santa Barbara and Sonoma were also so grouped with lower cost counties. Since the average county costs with these "charge based localities" did not exceed the average costs of localities with lower values by at least 5 percent, these localities were combined with California's rest-of-state locality, i.e., "Locality 99."

If instead of using the "cost based localities" to establish the new localities for the physician fee schedule, Medicare had started on a county-by-county assessment (and retained the same 5 percent threshold), Santa Cruz, Sonoma, Santa Barbara and San Diego counties would be classified as a unique California localities with adjustment factors ranging from about 4 percent to 6.5 percent above their current level.

When confronted with this arbitrary inequity, Medicare officials, while acknowledging the validity of the argument, impose essentially non-scaleable barriers to making the fair correction.

Medicare essentially requires that the physicians in the area from which the respective county would like to leave must agree to the change. And, if the county would be assigned to a more appropriate adjacent locality with a higher adjustment factor, the physicians in that locality would also have to support the change. Frankly, this is not going to happen. Under the budget neutrality provisions of the enabling physician fee schedule statute, the lost of the higher cost county would lower the adjustment rate for the remaining physicians in Locality 99 and the adjustment factor in the locality to which the county could be assigned would likely be reduced. The economic imperatives of this situation will always trump equity. The irony of this situation is that it is a problem caused by Medicare, not by the physicians in the higher cost counties. If Medicare had initially established the 1997 localities in a fair and equitable manner, we wouldn't, by definition, have the current inequity. But Medicare is implicitly saying it's the physicians' problem not Medicare's.

We recommend that Congress establish a Medicare physician fee schedule payment locality reclassification option similar to the option available to hospitals under Medicare. In this case, however, the reclassification option would apply to counties. Under this option, Congress would adopt certain standards and, if met by a county, the respective county would be

deemed to have met the criteria. The petitioning county would then be reassigned to a more appropriate locality or assigned to a new unique locality.

As an alternative, Congress could, for purposes of such reclassifications, suspend the budget neutrality requirements. We believe the former option is attractive due to its objectivity and fairness. It would mute the affects of the economic consequences in the decision making process. The criteria would be straightforward and known to all. The use of the "deemed" status would speed the decision making process. The latter option, while offering a simplified approach, would have budget consequences for Medicare. Having observed the geographic reclassification process for hospitals, we feel the former option is compelling. And certainly has a precedent. In closing, we invite and urge your close attention to this matter. And, we stand ready to assist in any way possible. The issue is simple equity.

Washington Hospital Center
Washington, DC 20005
August 6, 2002

House Committee on Ways and Means
The Honorable Nancy L. Johnson, Chairman
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Dear Madam Chairman:

On behalf of The Washington Hospital Center, I am writing today to express our strong support of the testimony offered by both William J. Scanlon, Director, Health Financing and System Issues, U.S. General Accounting Office (GAO), and Glenn D. Hackbarth, Chairman, Medicare Payment Advisory Commission (MEDPAC), at the July 23rd Subcommittee on Health Hearing on Medicare's Geographic Cost Adjustments.

As referenced in Mr. Scanlon's testimony, the urban hospitals in the Washington, DC Metropolitan Statistical Area (MSA) have historically been disadvantaged by the current system to adjust payments to hospitals for geographic differences in labor costs, otherwise known as the Medicare wage index. The geographic area or MSA for which the wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify. The Washington, DC MSA currently encompasses the 10 urban hospitals in Washington, DC, 16 hospitals in Virginia, 12 hospitals in Maryland and 2 rural hospitals in West Virginia. This geographic region is hardly a representative of a uniform labor market that competes for the same pool of employees. Consequently, when the Medicare Wage Index factor is applied to modify 71 percent of Medicare payments to hospitals, the outlying Virginia and West Virginia hospitals in our MSA benefit greatly from the higher average hourly wage that District of Columbia hospitals require to attract employees, and the District of Columbia Hospitals are deprived of the financial support from Medicare that is truly representative of the labor market costs in an urban area.

Furthermore, in the Medicare Inpatient Prospective Payment System Final Rule released in August of 2001, in section 304(b) of Public Law106–554, a process was established under which an appropriate statewide entity may apply to have all the geographic areas in the State treated as a single geographic area for purposes of computing and applying the area wage index. The District of Columbia would be an excellent example of where this "statewide" designation should be applied and even the Virginia Hospital and Health Care Association submitted a letter of support of the District's effort to designate itself as such. However, the Centers for Medicare and Medicaid Services (CMS) commented that they believed that "Congress did not intend for section 304(b) to address the type of situation presented by Washington, DC."

We urge your subcommittee's support to review and update the current geographic classification system for purposes of the Medicare wage index and to support the findings and recommendations of the GAO and MEDPAC. It is a system that unfairly penalizes urban hospitals that fall into MSAs that are not representative of a single labor market. District of Columbia hospitals, as all urban hospitals, continue to struggle financially due to rising health care costs and the provision of health care to the uninsured. Already, two District hospitals have recently closed and half of the remaining hospitals operate in the red. The future of health care in the District of Columbia may be placed jeopardy if corrective action is not taken.

Thank you for your consideration. If you have any further questions, please do not hesitate to contact me at (202) 877–6225.

Sincerely,

Sean B. Gallagher

Statement of the Hon. Jerry Weller, a Representative in Congress from the State of Illinois

Chairwoman Johnson, I appreciate the opportunity to submit testimony for the record regarding Medicare's Geographic Cost Adjustors.

My home state of Illinois has 77 hospitals located in rural areas, nearly 34% of total hospitals in the state. These rural hospitals are more likely to serve large Medicare populations. In addition, rural residents in Illinois have higher rates of hospitalization than their urban counterparts. Illinois' rural hospitals depend on government payments as the government is the primary payor for care. Fifty-nine percent of Illinois rural hospitals' gross patient revenue was derived from government sources in the year 2000. It is important to note that Medicare contributed 48.4% of rural hospitals' gross revenue while 55% of discharges from rural hospitals were Medicare patients.

Illinois has many hospitals that are negatively affected by the Medicare Wage Index and their Metropolitan Statistical Area (MSA) classification. In my district, there are multiple rural hospitals which must compete with the nearby Chicago MSA for labor including nurses and other medical personnel. Community Hospital of Ottawa (in LaSalle County), and Riverside Medical Center (in Kankakee County) as well as nearby St. Margaret's Hospital in Spring Valley, Illinois are among those most affected. These rural hospitals have problems attracting and maintaining staff because of the higher wage rates paid in the nearby urban area. For example, Community Hospital of Ottawa is just eight miles away from the Chicago MSA border and has problems attracting nurses and other medical personnel because of higher wage rates paid in the nearby urban area. When hospitals receive higher reimbursement, they can pay higher salaries, creating an unfair advantage for certain hospitals over others.

Congress recognized this problem in its creation of the Medicare Geographic Classification Review Board to reclassify hospitals if they met eligibility requirements as determined by CMS. In determining the eligibility criteria for a wage index reclassification, several tests are applied. One of these tests to obtain a wage index reclassification is that a rural hospital must have an average hourly wage of at least 82% of its target MSA. However, rural hospitals often compete with close by urban areas for labor but cannot afford to have the same mix of professionals as the urban hospitals due to their lower Medicare reimbursement. This "labor substitution" often causes the rural hospital to "fail" the 82% test. An alternative to the 82% test is the 90% occupational mix criteria for hospitals unable to meet the average hourly wage criteria. The 90% occupational mix criteria determined if a hospital's pay rates are at least 90% of the target MSA pay rates for similar positions.

However, the data used to calculate this 90% occupational mix has not been maintained regularly since the 1990s. Several of my district hospitals including Ottawa Community Hospital in my district and St. Margaret's Hospital near my district have continued to seek a solution through CMS, but have as yet been able to obtain relief. Although it has been demonstrated that the occupational mix changes very slowly and that data from years past is still accurate, CMS has refused to allow this data to be used for the 90% occupational mix criteria. This leaves a few hospitals with no regulatory solution and no relief but still in a position where they cannot compete effectively with their nearby hospital counterparts for labor. Occupational mix data will be available within two years since OBRA 2000 requires CMS to capture this data.

Along with Community Hospital of Ottawa, Riverside Medical Center has also struggled with the Medicare Geographic Wage Index Reclassification issue. Riverside does not currently qualify for an administrative reclassification due to the statistical complications of having only two hospitals in its MSA. Riverside has lost the opportunity to completely recruit over 100 nurse applicants because of the higher wage index in the nearby Chicago MSA. In total, Riverside currently has 143 positions unfilled. Likewise, Community Hospital of Ottawa competes with hospitals just a few miles away in the Chicago MSA and attracted only one candidate out of nursing school this year due to wage differentials.

Kankakee and LaSalle counties' proximity to the Chicago MSA means that there are higher wage paying opportunities at other hospitals, leaving many vacancies in

my district hospitals. This year, the rural hospitals in my district have a wage index of.816—30 percent less than the Chicago MSA. This problem with vacancies will only grow worse for rural hospitals in my district as these gaps in the wage index continue to grow.

Kankakee County is a Primary Metropolitan Statistical Area (PMSA) and is part of the Chicago-Gary-Kenosha Consolidated Metropolitan Statistical Area (CMSA). As such, the county is eligible for a group reclassification. Like nearby Gary, Indiana, the Kankakee hospitals are unable to meet the cost per case criteria to qualify for a group reclassification. Kankakee County's wage index is scheduled to drop to.9591 while the Chicago wage index is proposed to rise to 1.1088 in 2003.

If the Congress grants reclassification to specific hospitals I ask that Community Hospital of Ottawa and St. Margaret's Hospital, Spring Valley receive temporary reclassifications. Both of these hospitals have submitted applications to the MGCRB demonstrating that the two hospitals meet the 90% occupational mix criteria and therefore are deserving of reclassification. I would ask additionally that relief be granted to Kankakee hospitals, which are comparable to Gary hospitals.

In addition, I believe the Committee should take a serious look at H.R. 1609, legislation to establish a floor for rural hospital payments at.925. This would bring many of Illinois' rural hospitals closer to a reasonable reimbursement rate and would help some of the specific hospitals that are compete directly with the Chicago MSA which is proposed to receive a rate of 1.1088 in 2003. Other Illinois hospitals in or near the 11th Congressional district that would benefit from this legislation include Mendota Community Hospital, Perry Memorial, Provena St. Joseph, St. Mary's in Streator, Illinois, Bromenn Regional Medical Center, and Illinois Valley in Peru.

The Medicare Geographic Wage Index has clearly created wage problems for areas such as I represent. These are areas that transition from urban to rural, but are close enough to urban centers to make competition for labor a serious issue for community hospitals. Several rural hospitals are faced with the additional burden of being able to recruit and maintain staff because higher paying jobs can be found often within an equal distance. I commend the Subcommittee for holding this hearing and look forward to working with you to reach a solution to this problem.