Advising the Congress on Medicare issues

Reforming Medicare’s wage index systems

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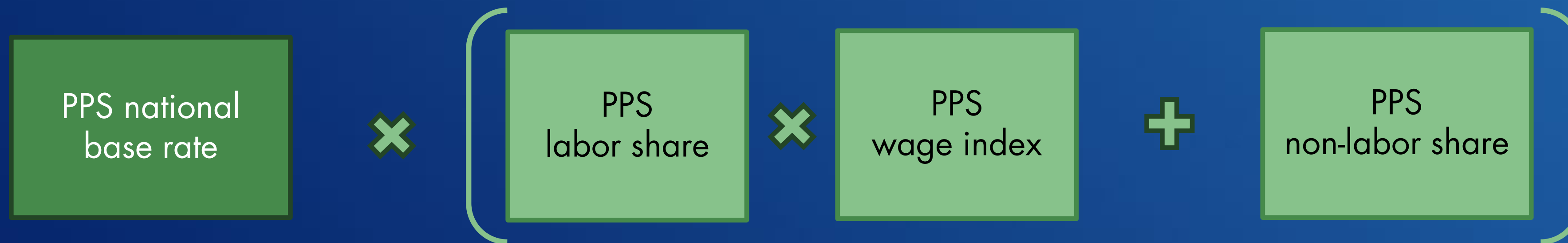
Roadmap

- Current Medicare wage index systems
- Concerns with current wage index systems
- Alternative wage index: Goals and principles
- Illustrative alternative wage index method, benefits, and effects
  - Acute care hospitals
  - Other sectors
- Discussion

Medicare's use of wage indexes

- Medicare's prospective payment systems (PPSs) use wage indexes to adjust Medicare base payment rates for geographic differences in labor costs



- For most provider types (e.g. post-acute care facilities), CMS uses one wage index based on acute care hospitals' cost reports
- For acute care hospitals, CMS applies many modifications to the initial wage index

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Current method: Initial wage index

- To calculate the initial wage index that is used in most Medicare PPSs, CMS:
  1. Calculates the aggregate average hourly wage (AHW) for acute care hospitals in each area;

$$AHW\ for\ hospitals\ in\ area = \frac{\sum Area\ wages}{\sum Area\ hours}$$

  2. Divides that area AHW by the national average

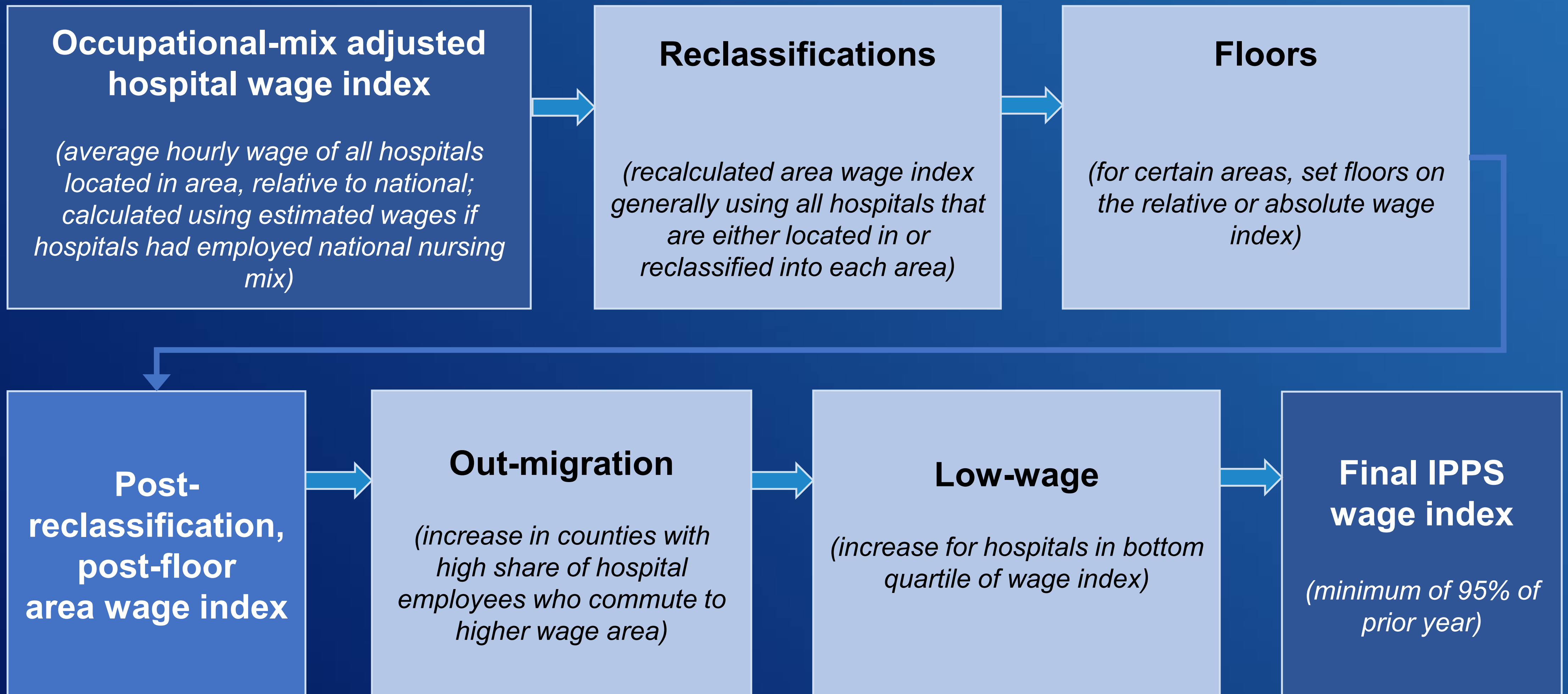
$$Wage\ index\ for\ area = \frac{Area\ AHW}{National\ AHW}$$

Current method: Initial wage index, FY 2022

- Based on wages and hours from about 3,200 acute care hospital reports that began in 2018
- Aggregated to 459 labor areas (411 MSAs and 47 rural areas)
- Most areas have wage index values slightly below 1, but a minority had much higher or lower values

Note: MSA (Metropolitan Statistical Area). CMS also uses metropolitan divisions. Not all states have a rural labor market area.
Source: MedPAC analysis of FY 2022 IPPS wage index files.

Current method: Acute care hospital wage index includes up to four types of exceptions



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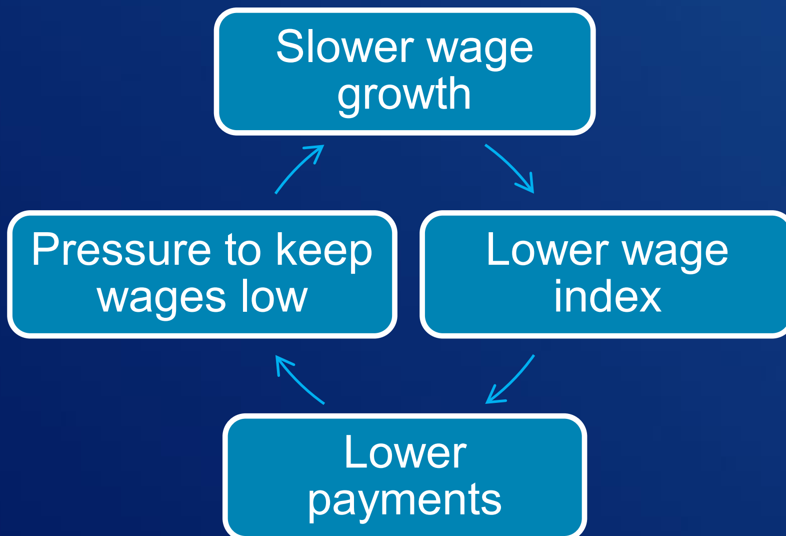
Concerns with current wage index systems: (1) Fails to isolate differences in labor costs

- The current wage index values reflect not only geographic differences in labor costs, but also:
  a. Hospitals' market power
  b. Hospitals' employment decisions
  c. Non-empirical wage index exceptions for acute care hospitals

Concerns with current wage index systems: (1.a) Circularity and market power

- ***Concern***: Using data from small number of hospitals can cause wage index to reflect hospitals' market power, e.g.,



- ***CMS response***: Added a temporary low-wage index policy in 2020, which increases wage index value of hospitals in bottom quartile
- However, policy is temporary, has no empirical support for magnitude of increase, and only addresses low-end circularity

Concerns with current wage index systems: (1.b) Limited accounting of occupational mix

- ***Concern***: Using aggregate average hourly wage across all occupations can cause wage index to reflect employment decisions, as
  - Providers can employ different mixes of occupations
  - Relative wages can vary across occupations

- ***Congressional response***: Occupational-mix adjustment in IPPS wage index
- However, CMS implements based on survey of only four nursing occupations, and only applies to IPPS

Concerns with current wage index systems: (1.c) Non-empirical exceptions decrease accuracy

- ***Concern:*** Acute care hospital wage index exceptions with no empirical basis erodes integrity of IPPS by creating large differences between wage index value and the area's relative labor costs
- Also contributes to variation in payments across settings

- ***Policy response***: Over time, some attempts have been made to remove some exceptions
- However, these have been unsuccessful, and more exceptions have been added

Concerns with current wage index systems: (2) Exceptions allow manipulation and add burden

- ***Concern:*** Wage index exceptions:
  - Create opportunities for wage index manipulation, of which hospitals have been increasingly taking advantage
  - Add administrative burden to Medicare

- ***CMS response***: Has tried to create policies to limit manipulation, but with limited success and added administrative burden

Concerns with current wage index systems: (2) Exceptions allow manipulation: Examples

- Rural reclassification to raise rural floor
  - Certain high-wage hospitals are reclassifying to rural areas, thereby raising the rural floor and increasing wages index values for urban hospitals in that state at the expense of all other states
- Timing of reclassification cancellation and reapplication
  - Certain low-wage hospitals are cancelling rural reclassification and then reapplying only once it is too late for CMS to include their data
- Dual reclassifications to gain non-wage-index benefits
  - Certain large urban hospitals are first reclassifying to rural areas and then reclassifying again, in the process gaining non-wage-index benefits

Concerns with current wage index systems: (2) Exceptions can result in substantial benefits

- In FY 2022, about 68 percent of acute care hospitals benefitted from at least one wage index exception
- These exceptions can result in substantial increases in payments for these hospitals, paid for by:
  - A relatively small decrease in payments to all hospitals (budget-neutral exceptions), or
  - Increase in Medicare program spending and beneficiary cost-sharing (for non-budget-neutral exceptions)

➔ Hospitals that benefit have strong incentives fight for their exceptions, others have smaller incentives to remove exceptions

Concerns with current wage index systems: (3) Masked variation and wage index cliffs

- ***Concern***: Use of MSAs and rural balance-of state without county-level smoothing can result in:
  - ***Masked variation***: One wage index value despite different relative wages
  - ***Cliffs***: Adjacent area with much higher wage index value
- ***Congressional response***: Reclassifications and other exceptions
- These can create domino effects and result in even greater masked variation and wage index cliffs

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Concerns with current wage index systems: (4) Use of initial wage index for other PPSs

- ***Concerns***: Current initial wage index may not accurately reflect relative labor costs faced by other providers because:
  - Relative wages of acute care hospitals may not accurately reflect relative wages of other health care providers
  - Mix of occupations employed by acute care hospitals may not reflect mix employed by other providers

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Alternative wage index: Goal and principles

- **Wage index goal**: accurately measure the labor costs of doing business that differ solely because of geography
- To meet goal, wage index method would ideally:
  1. Use cross-industry, occupation-level wage data, weighted by sector-specific occupational weights
  2. Account for county-level variation in relative wages and smooth wage indexes across adjacent counties
  3. Have no exceptions

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Illustrative alternative wage index for acute care hospitals: Method

- Calculate initial area wage index using (i) occupation-level, cross-industry average hourly wages (AHW) and (ii) national occupation weights for acute care hospitals

$$Wage\ index\ for\ area = \sum \frac{AHW\ for\ occupation\ in\ area}{AHW\ for\ occupation\ nationally} * occ\ weight$$

- Adjust area wage index for benefits' share of total compensation in that region
- Apply a county-level intra-area adjustment, up to +/-5%
- Smooth wage index across adjacent counties, such that maximum difference is 10%

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Illustrative alternative wage index for acute care hospitals: Benefits

Wage index feature	Current	Alternative
Isolates county-level differences in labor costs while limiting wage index cliffs	✗	✓
Minimizes opportunities for manipulation and reduces administrative burden on Medicare	✗	✓

➔ More accurately reflects geographic differences in labor costs at lower administrative cost than the current system

Illustrative alternative wage index for acute care hospitals: Redistribution of IPPS payments

- IPPS payments would increase for acute care hospitals:
  - With no current wage index exceptions
  - With a relatively low current wage index
  - In areas where acute care hospitals pay less than the usual premium above other employers’ wages for similar employees
  - In counties with higher wages relative to its parent area or adjacent to a county with a much higher wage index
- IPPS payments would change by more than +/- 5 percent for small minority of acute care hospitals once fully phased-in

Note: IPPS (inpatient prospective payment systems).

Illustrative alternative wage index for other PPSs: Method, benefits, and effects

- Method: Same method as for acute care hospitals, but using occupations and weights specific to that sector (e.g. IPF, IRF, SNF, HH)
- Benefits: Separate wage indexes more accurately reflect relative labor costs faced by providers in each sector
- Effects: PPS payments would shift towards certain providers, generally similar to results for acute care hospital
  - However, effects on individual providers would often be larger because these sectors have a higher labor share

Note: IPF (inpatient psychiatric facility); inpatient rehabilitation facility (IRF); SNF (skilled nursing facility); HH (home health); PPS (prospective payment system).

Results are preliminary and subject to change

Discussion

- Questions on current wage index systems?
- Agreement with concerns with current systems? Other concerns?
- Agreement with proposed alternative wage index goals and principles?
- Questions on alternative method or effects?

→ What additional information would Commissioners want to see in the Spring if interested in a recommendation to improve Medicare's wage index systems?