

CHAPTER

9

**Reforming Medicare's
wage index systems**

R E C O M M E N D A T I O N

- 9** The Congress should repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:
- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
 - reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
 - smooth wage index differences across adjacent local areas.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Reforming Medicare's wage index systems

Chapter summary

Medicare's prospective payment systems (PPSs) use wage indexes to adjust Medicare base payment rates for geographic differences in labor costs. For the inpatient prospective payment systems (IPPS), the Congress initially specified that the wage index should reflect the labor costs of hospitals in a geographic area relative to the national average hospital level. For other PPSs (such as those for skilled nursing facilities (SNFs)), the Congress granted CMS the authority to determine how to adjust Medicare PPS base rates for geographic differences in labor costs, and CMS has chosen to use a version of the IPPS hospital wage index. However, because of the limited data sources used, the use of broad labor market areas, and the number of wage index exceptions that the Congress and CMS have added over time to the IPPS wage index, Medicare's wage indexes are inaccurate and inequitable.

In 2007, the Commission recommended an alternative wage index method that would more accurately reflect differences in labor costs across geographic areas and be more equitable across providers. However, the Commission's recommendations were not implemented. Since then, the inaccuracies and inequities have grown, in part because the Congress and CMS have made additional exceptions to the already byzantine IPPS wage index. In 2022, about two-thirds of IPPS hospitals' wage index values

In this chapter

- Concerns with Medicare's current wage index systems
- An improved approach for Medicare's wage index systems and resulting impacts
- Moving to better wage index systems
- Appendix: Current IPPS wage index exceptions

were affected by exceptions, and, because most of the exceptions are budget neutral, payments to all hospitals—including those not benefiting from any exceptions—were reduced by 2.2 percent to compensate. This chapter updates the Commission’s 2007 work.

To accurately reflect geographic differences in labor costs among IPPS hospitals and other types of providers and to be more equitable across providers, the Commission recommends that Medicare’s wage index systems:

- use all-payer, occupation-level wage data with different occupation weights for the wage index of each type of provider;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas;
- cap wage index differences across adjacent local areas; and
- have no exceptions.

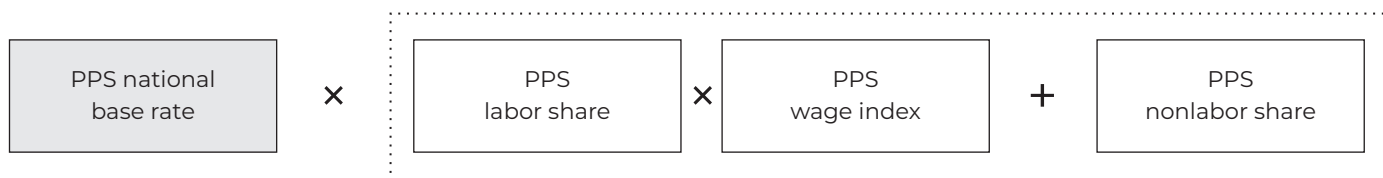
This wage index approach would be applied to all PPSs, including those for IPPS hospitals and post-acute care providers such as SNFs. To illustrate how this approach would improve the accuracy and equity of Medicare payments, we developed illustrative IPPS and SNF PPS wage indexes. Using data from all employers in a labor market area instead of just IPPS hospitals would establish a more robust basis for Medicare’s wage indexes and mitigate circularity issues that result in the current wage indexes reflecting hospitals’ historical advantages and disadvantages, such as relative market power. Incorporating local (e.g., county) wage data would allow the wage indexes to recognize differences in labor costs within a broader labor market area and allow for a smoother and more equitable distribution of wage index values across adjacent local areas. Furthermore, eliminating all wage index exceptions would remove hospitals’ opportunities for wage index manipulation.

Because of the large inaccuracies in the current wage index systems, implementing the Commission’s recommended changes would have a material effect on many providers. Based on our illustrative models, we estimate that, once the changes were fully phased in, IPPS payments would fall by more than 5 percent for about 10 percent of hospitals and rise by more than 5 percent for 18 percent of hospitals. We estimate that SNF PPS payments would decrease by more than 5 percent for 11 percent of SNFs and increase by more than 5 percent for 27 percent of SNFs. (In response to court cases, CMS has proposed wage index policy changes starting in fiscal year 2024 regarding the treatment of data from hospitals that reclassify to rural areas. If implemented,

these changes would alter the specific results in this chapter but not our conclusions.) Because of the significant redistributive effects, implementation of these changes would need to be phased in over multiple years or managed through a stop-loss policy so that no provider experienced increases or decreases in Medicare payments of more than a specified percentage in any one year due to the transition to the new wage index system. Once fully implemented, wage index systems such as the ones we modeled would result in more equitable payments across regions and across types of providers. To the extent that policymakers are concerned about certain providers—in particular, providers that are important for access and vulnerable to closure—any additional support should be targeted specifically to those providers to achieve defined and relevant policy goals and not made inefficiently through unrelated policies such as the wage index. ■

FIGURE 9-1

Medicare's prospective payment systems use a wage index to adjust national base rates for differences in labor costs



Note: PPS (prospective payment system). In several PPSs, the nonlabor share is multiplied by a cost-of-living adjustment for providers in Alaska and Hawaii. The inpatient capital PPS adjusts the base rate by the wage index raised to a fractional power.

Source: MedPAC analysis of CMS final rules.

Background

Medicare's prospective payment systems (PPSs) use wage indexes to adjust national base payment rates for differences in labor costs across labor market areas (Figure 9-1). The portion of the base payment rate that is adjusted by the wage index is determined by an estimate of the labor portion of that provider type's facility costs. The labor share for inpatient prospective payment systems (IPPS) hospitals is about two-thirds.¹ (For more on how the wage index is used in each PPS, see the Commission's *Payment Basics* series at <https://www.medpac.gov/document-type/payment-basic/>.) Physician and other clinician services paid under the Medicare physician fee schedule—including those provided in hospitals—have a different geographic adjustment to payments, which is beyond the scope of this chapter.

Most Medicare PPSs use a version of the IPPS hospital wage index (Table 9-1, p. 380). For the IPPS, the Congress initially specified that the wage index should reflect the labor-related costs of hospitals in a geographic area relative to the national average. Over time, however, the Congress and CMS have made numerous exceptions to this initial wage index calculation for IPPS hospitals. For other Medicare PPSs, the Congress granted CMS the authority to determine how to adjust national base rates for geographic differences in labor costs, and CMS has chosen to use a version of the IPPS hospital wage index (often with no exceptions).

Hospital wage index for each labor market area is based on hospital-reported data

To construct the hospital wage index, CMS collects labor cost data from IPPS hospitals' cost reports, which includes their reported labor costs—salaries and wage-related costs, such as pension and other deferred compensation costs, collectively referred to as wages—and hours, across all employees.² CMS excludes wages and hours for services not paid under the IPPS (such as services provided by physicians or other clinicians, or in non-acute inpatient components of the hospital) and excludes data for hospitals with missing or aberrant data.³

To define the labor market areas at which the wage index is calculated, CMS uses metropolitan statistical areas (MSAs) (an MSA is defined as a city with a population of at least 50,000 and its surrounding counties that have strong commuting ties to that city) and a residual called the statewide rural area (which includes all counties in the state that are not in MSAs).⁴

CMS calculates the initial hospital wage index (also referred to as the "unadjusted hospital wage index") for each labor market area as the ratio of the area's aggregate average hourly wage to that of the national average:

$$\text{Average hourly wage (AHW) for hospitals in area} = \frac{\sum \text{area wages}}{\sum \text{area hours}}$$

$$\text{Initial hospital wage index value for area} = \frac{\text{Area AHW}}{\text{National AHW}}$$

**TABLE
9-1**

Wage indexes used in Medicare's prospective payment systems

Prospective payment system	Wage index used
Inpatient	Initial hospital wage index with numerous exceptions
Outpatient*	
Skilled nursing facilities	Initial hospital wage index
Long-term care hospitals	
Inpatient rehabilitation facilities	
Home health	
Inpatient psychiatric facilities	
Ambulatory surgical centers	
End-stage renal disease	Initial hospital wage index + national floor
Hospice	Initial hospital wage index + low-wage adjustment

Note: Starting in 2023, CMS added a permanent policy to cap the maximum annual decrease in a provider's wage index at 5 percent, regardless of the reason. (In prior years, CMS episodically included other wage index transition policies.)

*For the outpatient prospective payment system, Medicare uses the inpatient prospective payment systems (IPPS) wage index when the services are provided in IPPS hospitals and uses the initial hospital wage index when provided in other facilities.

Source: MedPAC summary of CMS rules and regulations.

By construction, geographic areas with an average hourly wage less than the national average have wage index values of less than 1.0, while those areas with an average hourly wage greater than the national average have wage index values greater than 1.0. By statute, the initial hospital wage index is updated annually and implemented in a budget-neutral manner.⁵

In fiscal year 2022, CMS calculated the initial hospital wage index based on data from 3,182 hospital cost reports that began in 2018.⁶ CMS then aggregated the data across 459 labor market areas—411 urban areas and 47 rural areas—and nationally.⁷ The median wage index value was 0.9 and ranged from 0.3 (30 percent of the national average hourly wage of \$46.52, in Aguadilla, Puerto Rico) to 1.9 (nearly double the national average hourly wage in San Jose, CA) (Figure 9-2).

IPPS hospital wage index adjusted to reflect national average nursing mix

To make the IPPS hospital wage index more accurately reflect relative labor costs and not hospitals'

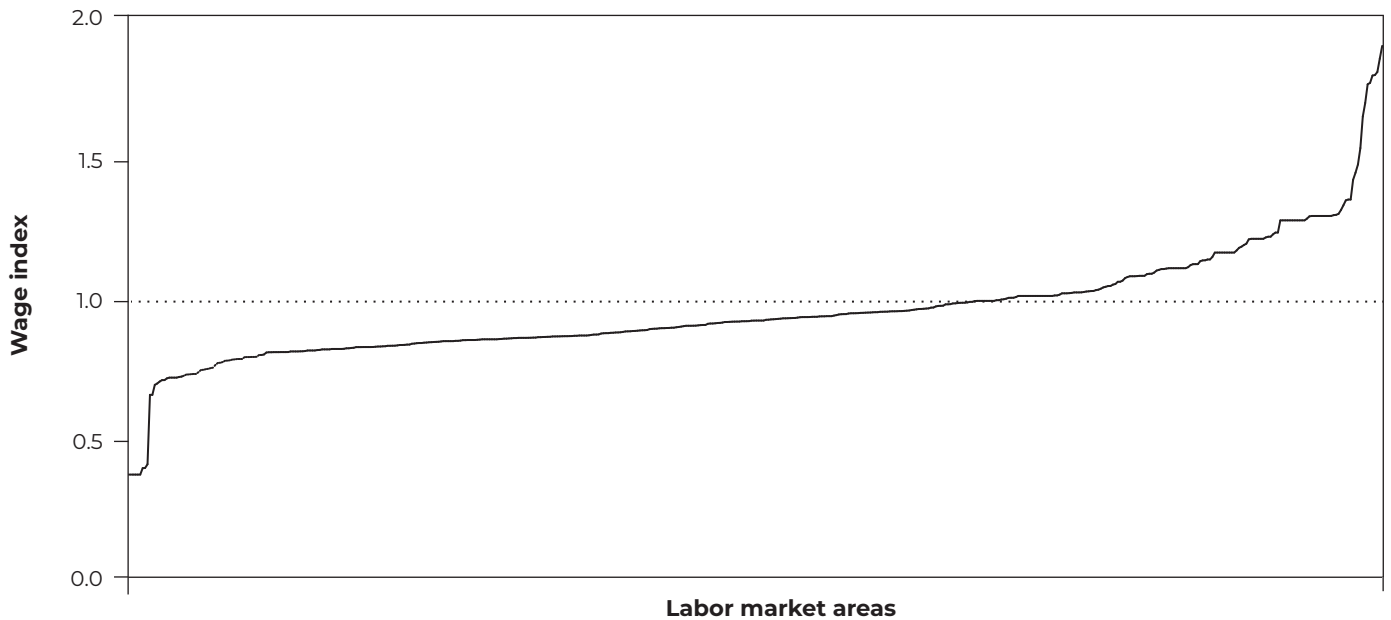
employment decisions, the Congress required CMS to add an occupational-mix adjustment to the initial hospital wage index when used in the IPPS.⁸ Because hospital cost reports do not collect occupation-level data, to make this adjustment, CMS fields a separate survey of IPPS hospitals on their occupation-level wages and hours for selected occupations. The current categories are registered nurses (RNs), licensed practical nurses and surgical technologists, nursing assistants (NAs) and orderlies, medical assistants, and a single category for all other occupations.

Using these survey data, CMS calculates an occupational mix-adjusted wage index for each labor market area based on the estimates of what each hospital's labor costs would have been if they had employed the four types of nursing occupations proportional to the national average nursing mix, and then CMS applies a budget-neutrality adjustment.⁹

The magnitude of this occupational-mix adjustment is relatively small. In fiscal year 2022, for almost all areas,

**FIGURE
9-2**

Most labor market areas had an initial hospital wage index value slightly below 1, but a minority had much lower or higher values, 2022



Note: Labor market areas are metropolitan statistical areas and statewide rural areas.

Source: MedPAC analysis of fiscal year 2022 wage index files.

the occupational-mix adjustment changed the wage index value by less than 2 percent.

IPPS wage index includes many exceptions

In response to various stakeholder concerns, the Congress and CMS have added four categories of wage index exceptions, some of which are applied at the labor market area level and some to individual hospitals (Figure 9-3, p. 382).¹⁰ (These are summarized below; more details are in the appendix. In response to court cases, CMS has proposed wage index policy changes starting in fiscal year 2024 regarding the treatment of data from hospitals that reclassify to rural areas; this chapter does not reflect those proposals.)

These four categories of exceptions are explained below.

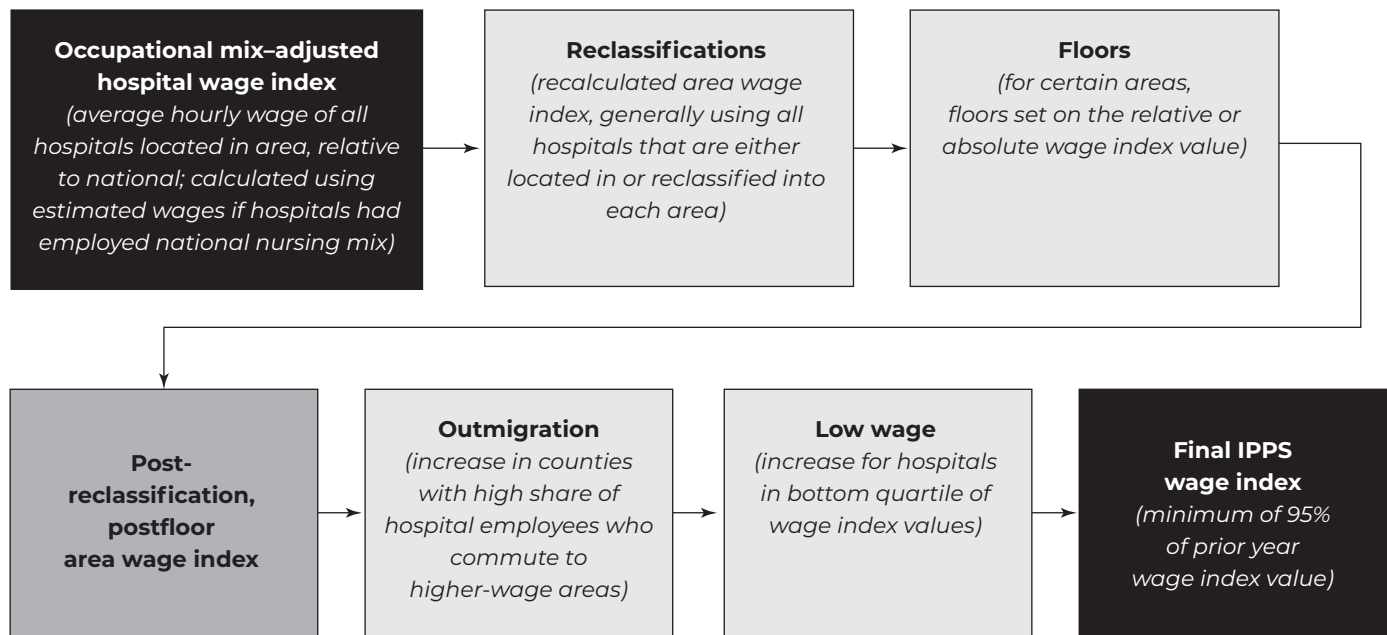
- **Reclassifications.** To address issues with broad definitions of labor market areas that can create

inequities among neighboring hospitals, the Congress created three geographic reclassification pathways that allow hospitals that meet specified criteria to be treated as if they were located in a different geographic area for the purposes of the IPPS wage index. Using these reclassifications, CMS calculates a post-reclassification wage index value for each labor market area using the data of hospitals that are either geographically located in the area or reclassified into the area. By statute and regulation, reclassifications must hold harmless hospitals that did not reclassify; therefore, the reclassification of hospitals can increase (but not decrease) the wage index of other hospitals that did not reclassify.

- **Floors.** To address stakeholder concerns related to perceived anomalies in relative wages, unfair disadvantages, and otherwise increase payments to certain hospitals, the Congress has created

**FIGURE
9-3**

Inpatient prospective payment systems wage index exceptions



Note: IPPS (inpatient prospective payment systems).

Source: MedPAC summary of CMS's fiscal year 2022 and 2023 IPPS final rules.

three wage-index floors, where certain areas are required to have a (post-reclassification) wage index value at least as high as a benchmark.

- **Rural and imputed rural floors.** The rural and imputed rural floors require that urban areas cannot have a lower wage index value than the state's rural area or, in the case of all-urban states, another benchmark (based on either the range of wage index values in all-urban states or the average percentage increase from the rural floor in other states).
- **Frontier floor.** The frontier floor requires that areas in low-population-density states have a wage index value of at least 1.0.
- **Outmigration.** To help hospitals in low-wage areas retain employees who live in that county but may otherwise commute to a higher-wage area, the Congress created an outmigration policy where the

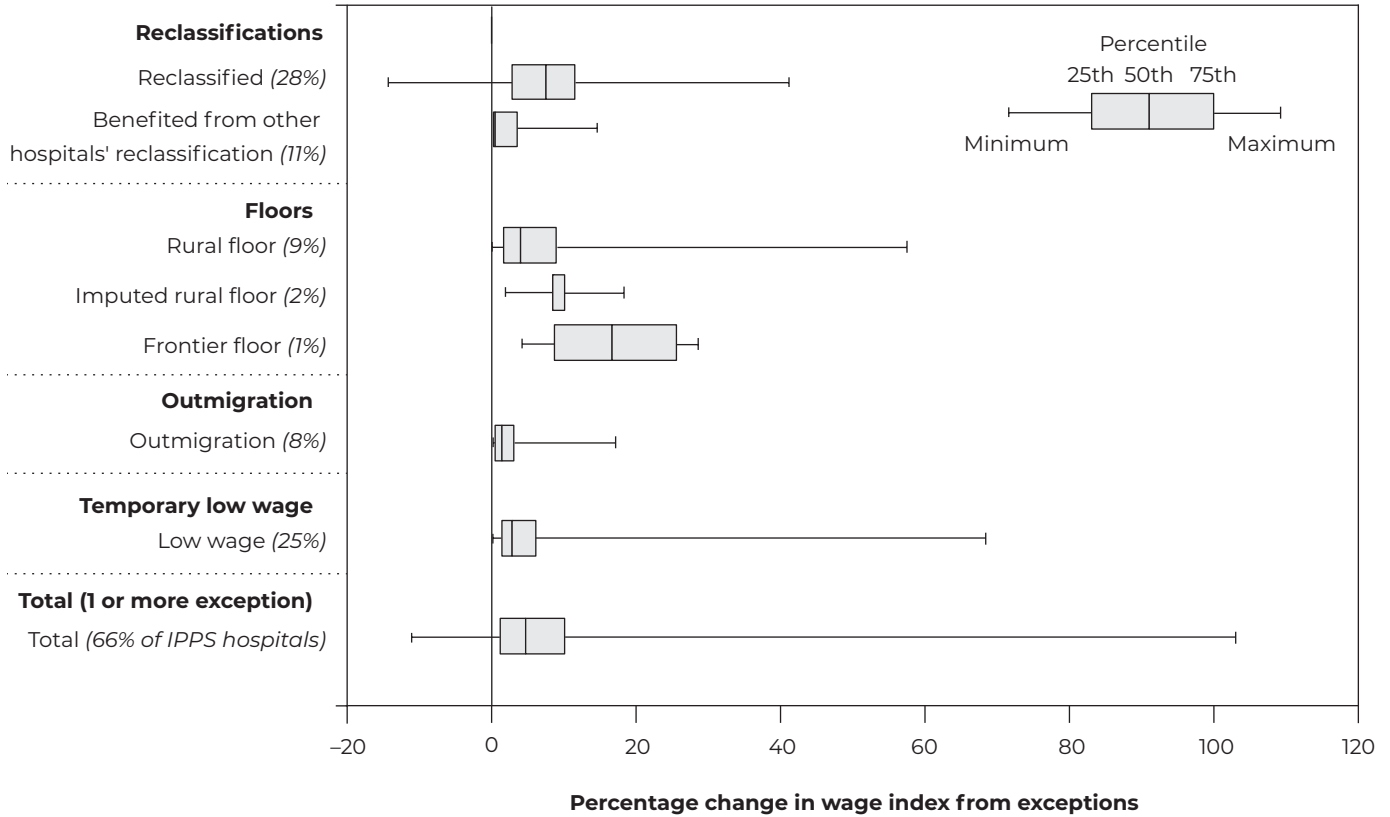
wage index value is increased for (nonreclassified) hospitals in certain counties that have a high share of hospital employees who reside in the county but commute to a higher-wage area.

- **Low wage.** In response to concerns about wage index disparities and circularity, in 2020 CMS created a temporary low-wage index exception, where the wage index value for hospitals in the bottom quartile of wage index values is increased by half the difference between the hospitals' wage index value and the bottom-quartile cut point.

In 2022, most hospitals received at least one wage index exception, and the effects can be substantial. In fiscal year 2022, about two-thirds of IPPS hospitals benefited from at least one IPPS wage index exception. (For comparison, about 40 percent of IPPS hospitals received at least one wage index exception in 2007 (Medicare Payment Advisory Commission 2007).)

FIGURE 9-4

Effect of IPPS wage index exceptions are often substantial, 2022



Note: IPPS (inpatient prospective payment systems). Each bar represents distribution of the percentage change in the wage index value from that exception, including the minimum; 25th, 50th, and 75th percentile; and maximum. The total bar represents the distribution of the cumulative percentage change in the wage index value among hospitals that received one or more exceptions. Figure excludes Indian Health Service hospitals.

Source: MedPAC analysis of fiscal year 2022 IPPS wage index public use files.

The effect of these wage index exceptions can be substantial. Among the two-thirds of IPPS hospitals with a wage index value affected by at least one wage index exception, over a quarter received a more than 10 percent increase in their wage index value, and some received a substantially higher increase (Figure 9-4).

The most common wage index exceptions are budget neutral—reclassifications, rural floor, and temporary low-wage exception—and they are paid for by reducing payments to all hospitals to support the increased wage index and payments to the subset of hospitals receiving

these exceptions. CMS estimated that for fiscal year 2022 these budget-neutral exceptions would increase IPPS payments by about \$2.2 billion dollars, or 2.2 percent, and therefore CMS decreased IPPS base rates to all hospitals by 2.2 percent as an offset.¹¹

The other wage index exceptions—imputed rural floor, frontier floor, and outmigration policy—are required to be implemented in a non-budget-neutral manner. In fiscal year 2022, CMS estimated that these exceptions would increase IPPS payments by about \$314 million, or 0.3 percent of total spending under the IPPS.

Concerns with Medicare's current wage index systems

In response to a mandate in the Tax Relief and Health Care Act of 2006, in 2007, the Commission conducted an analysis of the wage index for IPPS hospitals and other provider types and recommended an alternative wage index method that would more accurately reflect differences in labor costs across geographic areas (Medicare Payment Advisory Commission 2007). The Commission's recommendations were not implemented. Since our 2007 report, the inaccuracies and inequities in the current wage index systems have grown.

Consistent with our 2007 report, the Commission's key concerns with the current IPPS wage index are that it fails to accurately reflect differences in labor costs across geographic areas and creates inequities across hospitals. These inaccuracies and inequities stem from the data sources and definition of labor market areas used, and they are frequently exacerbated by the numerous wage index exceptions. In addition, the Commission remains concerned about the use of the initial hospital wage index by other provider types.

IPPS wage index can deviate from the labor costs faced by all employers of hospital occupations

The current use of lagged hospital cost report data and a limited occupational-mix survey can cause the current IPPS wage index to deviate from the labor costs faced by all employers of hospital occupations. The current wage index embeds individual hospitals' historic advantages and disadvantages (such as market power) and choices about the mix of occupations they employ and how they employ them, instead of just geographic differences in relative wages. This circularity risk can be a particular problem in market areas with few hospitals or hospitals under common ownership.

This use of data from only IPPS hospitals has also contributed to upward and downward wage index spirals: The highest hospital wage index values have increased over time, and the lowest have decreased.

IPPS wage index masks differences in relative labor costs within an area and can create large differences across adjacent areas

The current broad definition of labor market areas—MSAs and statewide rural areas—masks substantial

variation in relative wages within a labor market area such that hospitals with substantially different relative wages receive the same wage-adjusted payment rate. This masking of differences in relative labor costs occurs within both:

- MSAs, where labor costs are often higher at the center of the metropolitan area or high-cost suburbs and lower in outlying counties, which can be over 100 miles apart; and
- statewide rural areas, where all rural counties throughout the state are considered a single area, despite potentially being hundreds of miles apart and different distances to MSAs.

Defining labor market areas broadly can also create large wage index differences across adjacent areas and result in inequities where proximate providers on either side of a labor market area receive substantially different Medicare payment rates, despite facing similar relative wages.

IPPS wage index exceptions can exacerbate inaccuracies and inequities, can be manipulated, and add administrative burden

While there are motivations for each IPPS wage index exception, collectively, they detract from the core goal of the wage index—accurately and equitably reflecting differences in labor costs across geographic areas—because most have either no or a flawed empirical basis, can be manipulated, and add administrative burden. Collectively, they break the link between an area's wage index value and the underlying labor costs faced by employers in that area.

For example, the temporary low-wage index exception was enacted to address concerns that hospitals in areas with low hospital wages may be caught in a downward spiral due to low-wage index values that prevent them from raising their wages; however, there is no empirical basis for the specific magnitude of the increase in any area, and therefore the low-wage exception can overcorrect in some areas and undercorrect in other areas.

Similarly, geographic reclassification pathways partially mitigate a shortcoming of the current wage index—wage index cliffs across adjacent areas, due to the broad definition of labor market areas—but the ability of hospitals to reclassify to a higher-wage area can

create a domino effect. For example, a statewide rural area may have a wage index value significantly lower than that of an adjacent metropolitan area, and a rural hospital proximate to that metropolitan area may be able to reclassify into the metropolitan area and increase the hospital's wage index value. However, that reclassification then shifts the wage index cliff outward, extending to the rural hospital that reclassified and the neighboring rural hospitals that did not reclassify. In addition, geographic reclassification pathways provide opportunities for wage index manipulation, such as through the timing of reclassification requests. Indeed, CMS found that certain hospitals were timing their rural reclassifications, cancellations, and reapplications to obtain higher wage index values (Centers for Medicare & Medicaid Services 2020).¹²

The three wage index floors also create inaccuracies in the current wage index since there is no empirical basis for them. The Commission has long noted that the rural floor is based on an erroneous assumption that the labor costs in a state's urban areas are *always* higher than the labor costs in the state's rural areas (Medicare Payment Advisory Commission 2008, Medicare Payment Advisory Commission 2007).¹³ In addition, these floors further break the link between an area's relative labor costs and the area's wage index value because they can result in a single wage index value being applied across large geographic areas.

CMS has also noted that the rural floor in particular is subject to wage index manipulation, as high-wage urban hospitals in certain states reclassified to their state's rural area to increase the state's rural floor. This higher rural floor was then applied to all of the state's urban hospitals. And since the rural floor is implemented in a budget-neutral manner, these benefits to a minority of states were funded by all states.¹⁴

Last, the multitude of wage index exceptions adds significant administrative burden. The primary burden falls on CMS, through managing the exceptions, implementing policies to decrease hospitals' opportunities for manipulation, and responding to litigation. The IPPS wage index exceptions also are administratively burdensome to hospitals because many spend significant time and expense trying to maximize their ability to benefit from the various wage index exceptions.

IPPS hospitals can gain non-wage index benefits through reclassifications

One wage index exception—reclassification—can also be used to obtain various non-wage index benefits. For example, hospitals that reclassify to be treated as if located in a rural area can gain eligibility for rural hospital designations through which they can receive additional payments (sole community hospitals and Medicare-dependent hospitals), receive a rural hospital designation that has lower eligibility thresholds for the 340B drug program (rural referral centers), and receive increases in Medicare-funded residency slots available to “rural” hospitals.

Furthermore, in response to a court ruling, starting in fiscal year 2018, IPPS hospitals can maintain dual reclassifications, in which they first reclassify as rural through one pathway and then reclassify to a different area (potentially their original geographic area) through a different pathway. As a result, urban IPPS hospitals can reclassify to rural to gain non-wage index benefits without decreasing their wage index. In fiscal year 2022, over 450 hospitals maintained dual reclassifications, and over a quarter of these hospitals reclassified to their original geographic area. Of these, over 350 were urban hospitals that dually reclassified and became rural referral centers, which are subject to lower eligibility thresholds for the 340B drug savings programs.

Use of initial hospital wage index for other provider types is inaccurate and inequitable

The use of the initial hospital wage index for other provider types is inaccurate and inequitable for several reasons.

First, there continue to be concerns about inaccuracies and inequities from the initial hospital wage index data source and from the definition of labor market areas discussed above, regardless of provider type.

Second, because hospitals employ a mix of occupations different from other providers, such as SNFs, and relative wages for occupations can vary within an area, a wage index based solely on hospitals' labor costs does not necessarily accurately reflect geographic differences in labor costs among the types of workers hired by nonhospital providers, such as SNFs. For example, in areas where wages for the top occupation

employed by SNFs (NAs) is higher than the national average but the top occupation employed by hospitals (RNs) is lower than the national average, the SNF PPS wage index should be higher than the IPPS wage index since SNFs in that area face higher relative labor costs. Moreover, the wage index for other providers needs to be imputed for areas where there are no IPPS hospitals.

Third, the numerous wage index exceptions in the IPPS—but not in other PPSs—cause inequities across provider types and contribute to payment differences across settings. The IPPS wage index exceptions can cause wage index values to be substantially higher for IPPS hospitals than for other provider types in the same area, such as SNFs, which compete to a degree with IPPS hospitals for RNs, NAs, and other staff. Similarly, the existence of wage index exceptions for IPPS hospitals but not for other types of providers contributes to differences in Medicare payments for the same service across different settings (such as certain services provided in acute care hospitals and long-term care hospitals, or hospital outpatient departments and ambulatory surgical centers).

An improved approach for Medicare's wage index systems and resulting impacts

To accurately reflect geographic differences in labor costs faced by IPPS hospitals and other types of providers and to be more equitable across providers, the Commission asserts that Medicare's wage index systems should:

- **Use all-employer, occupation-level wage data with different occupation weights for the wage index of each type of provider.** Because all employers participate in the labor market and compete for similar types of workers, the wages and benefits used to construct a wage index should come from all employers of a given occupation. Using all-employer wage data also increases the number of employers with wage data in each area and therefore increases reliability and decreases the circularity that causes deviations between the labor costs reported by hospitals and broader labor market wages.

In addition, because different provider types (such as hospitals and SNFs) employ a different mix of occupations and an area's relative wages can vary by occupation, the calculation of an area's relative wages should use different occupation weights for the wage index of each provider type. (For example, while each wage index would use the same underlying all-employer, occupation-level relative wages, the IPPS wage index should weight these occupation-level relative wages to reflect the national occupational mix for acute care hospitals while the SNF PPS wage index should use occupation weights reflecting the national mix of occupations for SNFs.)

- **Reflect local area differences in wages between and within MSAs and statewide rural areas.** Because relative wages can vary within a large labor market area (i.e., an MSA and statewide rural area), the wage index should use data at a local area level (such as counties) in order to recognize this variation.
- **Smooth wage index differences across adjacent local areas.** Because proximate providers across adjacent local areas (such as county lines) compete for similar employees, the wage index should smooth wage index differences across adjacent local areas.
- **Have no exceptions.** Because exceptions decrease the accuracy of the wage index, increase opportunities for manipulation, and add administrative burden, the wage index method should have no exceptions. To the extent that policymakers want to increase payments to certain hospitals or other types of providers—in particular, to those that are important for access and vulnerable to closure—these payment increases should be targeted specifically to those providers to achieve defined and relevant policy goals, not made inefficiently through unrelated policies such as the wage index.

Based on these principles, we modeled an illustrative IPPS wage index (see text box, p. 388–389) and an illustrative SNF wage index. Our illustrative models used a combination of Bureau of Labor Statistics (BLS) all-employer, occupation-level wage data at the MSA level, combined with Census Bureau occupational-level data at the county level and BLS benefits data (which are available only at the regional level). Relying on a

greater number of data sources could be perceived as increasing complexity and administrative burden, but we maintain that an improved wage index system based on these data sources would result in a lower administrative burden for CMS and hospitals relative to the current approach, which requires CMS to review wage data submitted by hospitals via costs reports, conduct a separate occupational mix survey, and deal with large numbers of requests for reclassification from hospitals and their wage index consultants. In addition, by relying on BLS and Census occupation-level data from substantially more employers, our illustrative wage indexes are more accurate and robust in their measurement of relative wages for a provider type in a given area, as well as less manipulable. Though the underlying wage information in the BLS and Census data may be slightly less transparent than data collected directly from individual hospitals by CMS, the Commission maintains that the reduction in circularity achieved by using BLS and Census data is a worthwhile trade-off, especially as these data are publicly available. Further, as BLS and Census data continue to be updated, such as to include more detailed occupations, those changes would be automatically incorporated into the wage index.

In developing our illustrative model, we acknowledge that opinions differ as to the “correct” definition of labor market areas. Recognizing that the market area definitions used in the current wage indexes (MSAs and statewide rural areas) can be too large and that counties could be too small to accurately represent labor market areas, we created a hybrid that allows variation by county within a market area, but within limits.

We found that our improved IPPS wage index would more accurately reflect geographic differences in labor costs faced by IPPS hospitals and would therefore be more equitable than the current IPPS wage index. We found similar results for SNFs when we modeled an improved SNF PPS wage index (using the same underlying data as the IPPS wage index but using occupation weights specific to SNFs). Implementing these improved wage indexes in a budget-neutral manner would not change aggregate geographic-adjusted IPPS payments or aggregate geographic-adjusted SNF PPS payments but would significantly redistribute Medicare payments across IPPS hospitals and across SNFs. Policymakers would need to phase

in the new wage indexes over multiple years (or apply a stop-loss policy) to limit large changes to providers’ Medicare payments within any given year.

An improved IPPS wage index would be more accurate and equitable

By design, our illustrative IPPS wage index would more accurately reflect geographic differences in labor costs faced by IPPS hospitals than the current IPPS wage index. It would decrease the circularity risk of the wage index reflecting hospitals’ historical advantages and disadvantages, such as market power, that have caused IPPS hospitals’ labor costs to materially differ from the broader labor costs across all employers in a geographic area. Further, because our illustrative IPPS wage index reflects differences in labor costs at the county level and constrains wage index cliffs, it would be more equitable across hospitals by more closely aligning wage index values with each county’s labor costs and reducing differences in the wage indexes of neighboring hospitals in different labor market areas, without the administrative burden for providers and CMS of current reclassification exceptions.

Implementing such changes to the IPPS wage index in a budget-neutral manner would not change aggregate geographic-adjusted IPPS payments but would redistribute Medicare payments across IPPS hospitals.¹⁵ (In response to court cases, CMS has proposed wage index policy changes starting in fiscal year 2024 regarding the treatment of data from hospitals that reclassify to rural areas. If implemented, these would change the specific results in this chapter but not our conclusions.)

MedPAC’s illustrative IPPS wage index decreases circularity risk and more accurately reflects labor market costs

One key design difference between the current IPPS wage index and the Commission’s illustrative wage index is the source of data, including the set of employers included and level at which the data are collected (Table 9-2, p. 390).

Basing our illustrative IPPS wage index on a broader range of employers’ data—all employers in an area—decreases the circularity risk of the wage index reflecting hospitals’ historical advantages and disadvantages, such as market power, that have

Modeling an improved IPPS wage index

To develop an illustrative inpatient prospective payment systems (IPPS) wage index consistent with the Commission's principles for Medicare's wage index systems, we took the following steps:

- **Collected all-employer, occupation-level wage data for the most common occupations employed by general acute care hospitals, by statewide rural areas, by metropolitan statistical area (MSA), and nationally.** We used the 2019 Bureau of Labor Statistics (BLS) Occupational Employment and Wage Survey (OEWS) of about 1.1 million establishments. These data are aggregated to MSAs—or, for New England, to New England City and Town Areas—and nonmetropolitan areas in a state, as well as nationally. We collected this occupation-level data for the 36 occupations that comprised at least 0.5 percent of national institutional wages for general acute care hospitals.¹⁶ Because the BLS data are at the establishment level, they automatically incorporate changes in telework over time.

- **Calculated acute care hospital occupation weights.** Using the OEWS data, we calculated a weight for each occupation that reflected the occupation's share of national institutional wages for acute care hospitals (among the included occupations). The two occupations with the highest weights were registered nurses (47 percent) and medical and health services managers (5 percent).
- **Calculated an initial wage index value for each labor market area as the occupation-weighted average hourly wage (AHW) for the area relative to the national average.** We had BLS calculate initial wage index values, using the identified occupations and weights.¹⁷

$$\text{Wage index value for area} = \sum (\text{AHW for occupation in area} / \text{AHW for occupation nationally}) \times \text{occupation weight}$$

(continued next page)

caused IPPS hospitals' labor costs to materially differ from the broader labor costs across all employers in a geographic area.¹⁸ In other words, in some areas, hospitals pay substantially more or less than the average premium over other employers for the same types of workers (see examples in Table 9-3, p. 390).¹⁹ And because the wage index is budget neutral (apart from certain exceptions), the higher wage index values in areas where hospitals pay more than other employers in the same area come at the expense of all other hospitals. For example, because the hospitals in Santa Rosa, CA, are in a stronger financial position (or under more pressure) to pay wages above the all-employer average in that area, their current wage index is artificially high. That increase comes at the expense of other areas, such as rural Arizona, where hospitals may have less ability to raise their wages.

As a result of these data source improvements, aggregate IPPS payments under the Commission's illustrative IPPS wage index would shift away from hospitals located in areas where IPPS hospitals pay more than other employers in the area and toward hospitals located in areas where IPPS hospitals pay less than the average premium over other employers in the area. For example, we found that 19 percent of hospitals were located in an area where the relative labor costs for RNs using all-employer data was at least 5 percent higher than when using only hospital data. We estimated that under our illustrative wage index, IPPS payments to these hospitals (currently paying relatively low wages) would increase by 1.4 percent when including the temporary low-wage index exception and 2.2 percent when excluding the temporary exception (Table 9-4, p. 391).

Modeling an improved IPPS wage index (cont.)

- **Applied benefits' share of total compensation in that region, relative to the national average.** Because the OEWS data include only wages and not benefits, we applied BLS data from the National Compensation Survey on benefits' share of total compensation to adjust for regional variation in benefits.
- **Applied a county-level intra-area adjustment factor, up to 5 percent.** Because relative wages can vary within a labor market area but BLS data are not available at the county level, we supplemented the BLS data with data from the Census Bureau's American Community Survey. We used the Census data and the same occupational weights to calculate an intra-area adjustment factor that reflected the county's wage index value relative to its broader labor market area (MSA or statewide rural area), up to plus or minus 5 percent.²⁰ For each county, we applied this factor to the BLS-based wage index value of the county's broader labor market area. The 5 percent cap was chosen

for illustrative purposes as a balance between recognizing intra-area variation while limiting the maximum difference across counties in the same parent area (at 10 percent, i.e., from -5 percent to +5 percent of the parent area).

- **Smoothed wage index values across adjacent counties such that the maximum difference was 10 percent.** As a final step, we compared the county-level wage index values across adjacent counties and increased the wage index value of any county that was more than 10 percent below that of an adjacent county. We iteratively repeated this process until all the adjacent counties had a wage index value that was at most 10 percent below that of an adjacent county. The 10 percent cap was chosen as a balance between limiting the difference across adjacent counties and limiting the number of counties that would be subject to smoothing from a geographically distant county, creating a domino effect. ■

Another way to view the circularity risk of basing the IPPS wage index solely on the data of IPPS hospitals is to look at how the lowest and highest wage index values have changed over time (Table 9-5, p. 391). For example, in 2022, the area with the highest current IPPS wage index prior to exceptions was San Jose, CA, with a value of 1.86, a substantial increase from its value of 1.53 in 2007. When hospitals in high-wage index areas, such as San Jose, are able to increase their wages much faster than the national average, those increases come at the expense of other hospitals that receive lower payments due to the budget-neutrality aspect of the wage index. This risk is a particular concern if the hospitals' wages are materially higher than other employers' wages for similar employees in the market. The Commission's illustrative IPPS wage index would remove this circularity risk and bring the wage index

for high-wage index areas, such as San Jose, and for low-wage index areas, such as rural Alabama, closer to their pre-exception values in 2007.

As a result of shifting to wage data from a broader set of employers, aggregate IPPS payments under our illustrative wage index would shift away from hospitals located in areas with the highest current wage index values and toward hospitals in areas with the lowest wage index values that are currently supported by the temporary low-wage exception (Table 9-6, p. 392). For example, among the 37 percent of hospitals with a current wage index between 0.7 and 0.9, we estimated that IPPS payments would increase by 2.0 percent when including the temporary low-wage exception and by 3.1 percent when excluding the temporary low-wage exception. (Among the 2 percent of hospitals with

**TABLE
9-2**

MedPAC’s illustrative IPPS wage index includes data from a broader range of employers and at a more granular occupation level

Current IPPS wage index	Illustrative IPPS wage index
<i>Data from IPPS hospitals only</i>	<i>Data from all employers of hospital occupations</i>
Based on IPPS hospital reported data (cost reports and occupational mix survey)	Based on surveys of all employers of hospital occupations (BLS and Census)
<i>Partially accounts for hiring decisions</i>	<i>Fully accounts for hiring decisions</i>
Hospital cost reports include aggregate wages across all occupations, and the occupational-mix survey can only apply national weights to the collected four categories of nursing occupations, which account for about half of hospitals' wages	All wage data at occupation level, so can apply national weights to all hospital occupations
Note: IPPS (inpatient prospective payment systems), BLS (Bureau of Labor Statistics).	
Source: MedPAC.	

**TABLE
9-3**

Labor costs reported by IPPS hospitals do not necessarily reflect labor costs across all employers in the area

Labor market area	RN labor costs relative to national average		Percentage difference (all employers vs. IPPS hospitals)
	IPPS hospital data (current)	All employer data (illustrative)	
Examples of areas where hospitals pay substantially more than other employers, making current wage index value too high			
Santa Rosa, CA	1.94 (N = 5)	1.34	-31%
Longview, WA	1.20 (N = 22)	0.90	-25
Rural Massachusetts	1.36 (N = 3)	1.04	-24
Examples of areas where hospitals pay substantially less of a premium over other employers, making current wage index value too low			
Valdosta, GA	0.63 (N = 3)	0.82	30%
Rural Arizona	0.88 (N = 7)	1.07	21
Cleveland-Elyria, OH	0.81 (N = 31)	0.93	15

Note: IPPS (inpatient prospective payment systems), RN (registered nurse). The N indicates the number of hospitals contributing to that area’s wage index value, which can include both those geographically located in the area and those that reclassified into the area.

Source: MedPAC analysis of 2022 IPPS final rule wage index files and Bureau of Labor Statistics wage index data.

**TABLE
9-4**

Under MedPAC’s illustrative IPPS wage index, IPPS payments would shift toward hospitals in areas where hospitals pay less than market area wages for RNs

Percent change in IPPS payments if moved to alternative wage index from current wage index

RN relative wages: all employers vs. IPPS hospitals only	Share of hospitals	Including temporary low-wage exception			Excluding temporary low-wage exception		
		Aggregate	25th percentile	75th percentile	Aggregate	25th percentile	75th percentile
Much higher (>5%)	19%	1.4%	0.2%	4.1%	2.2%	0.0%	6.3%
Higher (2% to 5%)	21	1.1	-0.3	2.7	1.5	-0.3	3.8
Similar (+/- 2%)	24	0.0	-0.5	1.9	0.0	-0.6	3.1
Lower (-5% to -2%)	16	-0.7	-1.9	1.4	-0.9	-2.4	2.8
Much lower (<-5%)	17	-2.9	-4.1	0.9	-4.3	-6.1	0.9

Note: IPPS (inpatient prospective payment systems), RN (registered nurse). Analysis includes IPPS hospitals (other than Indian Health Service hospitals) with a published 2022 wage index and that provided IPPS services in 2021. IPPS payments exclude uncompensated care, were estimated under a budget-neutral policy, and assumed no changes in eligibility for enhanced IPPS payments. Components do not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, and Bureau of Labor Statistics and Census data.

a current wage index less than 0.7, all of which are in Puerto Rico, we estimated that IPPS payments would increase by 14.1 percent when excluding the low-wage exception but decrease by 6.2 percent when including the temporary low-wage exception, because the over 50 percent increase to the wage index value from the temporary exception is an overcorrection.)

Another benefit of the Commission’s illustrative wage index is that it uses fixed occupational weights, which remove the opportunity for hospitals to manipulate their average wage (and thus their wage index) by adjusting the hospital’s mix of employees. For example, the hospital could choose to contract with a company to provide groundskeeping and exterior maintenance

**TABLE
9-5**

Highest and lowest current IPPS wage index values have grown over time; illustrative wage index has a narrower spread

Areas with highest and lowest current wage index values, as of 2022	Current IPPS wage index (prior to exceptions)				Illustrative
	2007	2012	2017	2022	2022
Highest: San Jose, CA	1.53	1.66	1.74	1.86	1.47 to 1.55
Lowest in continental U.S.: rural Alabama	0.77	0.73	0.69	0.65	0.74 to 0.90
Lowest: Aguadilla, Puerto Rico	0.38	0.35	0.35	0.30	0.42 to 0.49

Note: IPPS (inpatient prospective payment systems). For areas with more than one county, the alternative IPPS wage index can have a range of values because of the county adjustment and potential smoothing to mitigate wage index cliffs.

Source: MedPAC analysis of CMS IPPS final rule wage index files and Bureau of Labor Statistics and Census data.

**TABLE
9-6**

Under MedPAC’s illustrative IPPS wage index, IPPS payments would shift toward hospitals in areas with low current wage index values that are currently supported by temporary low-wage index exception

Percent change in IPPS payments if moved to illustrative wage index from current wage index

Current wage index value	Share of hospitals	Including temporary low-wage exception			Excluding temporary low-wage exception		
		Aggregate	25th percentile	75th percentile	Aggregate	25th percentile	75th percentile
<0.7	2%	-6.2%	—	—	14.1%	—	—
0.7 up to 0.9	37	2.0	0.3	3.2	3.1	1.0	5.7
0.9 up to 1.1	41	0.7	-1.0	1.9	0.8	-2.0	2.7
1.1 up to 1.3	13	-1.0	-2.4	1.2	-1.4	-3.6	1.4
1.3 up to 1.5	5	-3.5	-6.2	-2.6	-4.7	-7.1	-3.6
>1.5	3	-6.8	—	—	-9.9	—	—

Note: IPPS (inpatient prospective payment systems). Analysis includes IPPS hospitals (other than Indian Health Service hospitals) that provided IPPS services in 2021 and had a published 2022 wage index. IPPS payments exclude uncompensated care, were estimated under a budget-neutral policy, and assumed no changes in eligibility for enhanced IPPS payments. Components do not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, and Bureau of Labor Statistics and Census data.

for a fixed annual fee rather than employ low-wage workers who would bring down the hospital’s wage index. They could also contract out coding of claims to a firm to reduce relatively low-cost coders. They could also make sure all of their legal work was paid on

an hourly basis in a way that their external counsel’s hourly wage would be included in the hospital’s average hourly wage for wage index purposes. In general, a new fixed-weight wage index would prevent wage index concerns from distorting hospitals’ hiring decisions.

**TABLE
9-7**

MedPAC’s illustrative IPPS wage index reflects differences in labor costs at a more granular level than the current wage index and mitigates wage index cliffs

Current IPPS wage index

Broad labor market areas

Reflects differences in labor costs across broad labor market areas (MSAs and statewide rural areas) with a single wage index value for each (prior to any wage index exceptions)

No limit on wage index cliffs

Adjacent areas can have materially different wage index values, both before and after wage index exceptions

Illustrative IPPS wage index

Smaller labor market areas

Reflects differences in labor costs across counties (including those within the same MSA or statewide rural area, up to +/-5%)

Limit on wage index cliffs

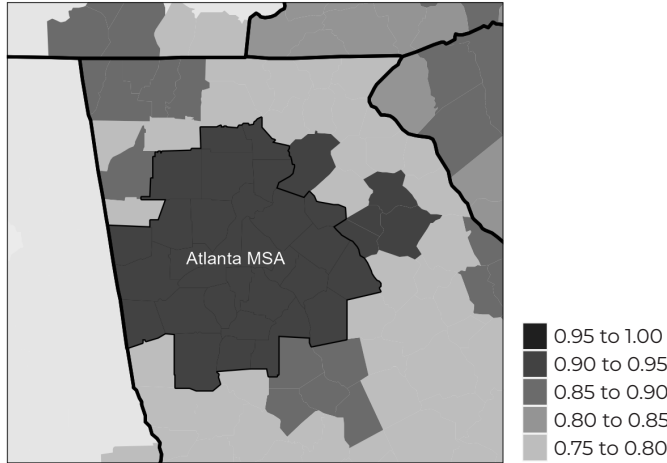
Each county’s wage index value is constrained to be at most 10 percent below wage index value of highest adjacent county (including those in different states)

Note: IPPS (inpatient prospective payment systems), MSA (metropolitan statistical area).

**FIGURE
9-5**

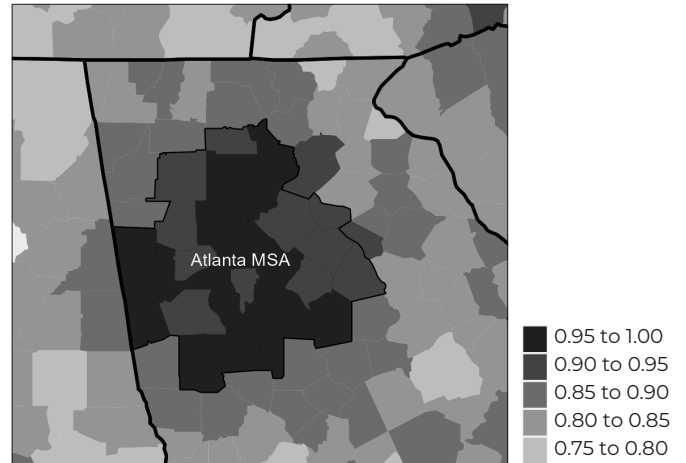
MedPAC’s illustrative IPPS wage index reflects differences in labor costs at the county level and removes large wage index cliffs across adjacent counties: Atlanta

**Current IPPS wage index
(prior to exceptions)**



Each MSA and statewide rural area has a single wage index value, masking any variation in labor costs within each labor market area and creating large wage index cliffs across counties on either side of an MSA or statewide rural area

Illustrative IPPS wage index



Wage index values vary at the county level (including within each MSA and statewide rural area) and there is a smoother transition in wage index values across counties on either side of an MSA or statewide rural area

Note: IPPS (inpatient prospective payment systems), MSA (metropolitan statistical area). IPPS wage index prior to exceptions is the wage index adjusted for occupational mix.

Source: MedPAC analysis of CMS final rules for fiscal year 2022 and Bureau of Labor Statistics and Census data.

In addition to reflecting labor market costs more accurately and reducing the potential for manipulation, our illustrative IPPS wage index’s use of data from all employers in an area would decrease the administrative burden on CMS because the agency would no longer need to audit hospital cost report wage data or field an occupational-mix survey.

MedPAC’s illustrative IPPS wage index varies at the county level and mitigates wage index cliffs

Another key design difference between the current IPPS wage indexes and the Commission’s illustrative wage index is the geographic unit at which variation in labor costs are reflected and constrained (Table 9-7).

Because our illustrative IPPS wage index reflects differences in labor costs at the county level and constrains wage index cliffs, it both recognizes differences in labor costs within a broader labor market area (i.e., MSA or statewide rural area) and allows for a smoother distribution of wage index values across adjacent counties. (For an example, see Figure 9-5.) This design therefore makes our illustrative wage index more equitable across hospitals by more closely aligning wage index values with each county’s labor costs and reducing differences in the wage index values of neighboring hospitals in different labor market areas, without the administrative burden or opportunities for manipulation created by the current reclassification exceptions.

**TABLE
9-8**

Under MedPAC’s illustrative IPPS wage index, IPPS payments would shift toward hospitals in counties with higher labor costs than the average in their broader labor market area

Percent change in IPPS payments if moved to illustrative wage index from current wage index

County labor costs relative to broader labor market area average (MSA or statewide rural area)	Share of hospitals	Including temporary low-wage exception			Excluding temporary low-wage exception		
		Aggregate	25th percentile	75th percentile	Aggregate	25th percentile	75th percentile
Much higher (>5%)	6%	0.9%	-0.5%	3.1%	1.9%	-1.5%	6.1%
Higher (2% to 5%)	20	1.0	0.7	3.5	1.3	0.7	5.5
Similar (+/- 2%)	52	-0.1	-1.1	1.9	-0.2	-1.6	3.0
Lower (>-2% to -5%)	15	-2.4	-3.0	0.7	-2.8	-4.0	1.4
Much lower (<-5%)	7	-0.1	-1.5	1.4	0.6	-1.1	4.9

Note: IPPS (inpatient prospective payment systems), MSA (metropolitan statistical area). Analysis includes IPPS hospitals (other than Indian Health Service hospitals) that provided IPPS services in 2021 and had a published 2022 wage index. IPPS payments exclude uncompensated care, were estimated under a budget-neutral policy, and assumed no changes in eligibility for enhanced IPPS payments.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, and Bureau of Labor Statistics and Census data.

As a result of these improvements, aggregate IPPS payments under the Commission’s illustrative wage index would shift away from hospitals in counties with labor costs lower than their MSA’s (or statewide rural area’s) average and toward those in counties with higher labor costs (Table 9-8). For example, we found that 6 percent of IPPS hospitals were located in a county where labor costs were at least 5 percent higher than the average for their broader labor market area (MSA or statewide rural area). We estimated that, under our illustrative wage index, IPPS payments to these hospitals would increase by 0.9 percent when including the temporary low-wage exception and by 1.9 percent when excluding the temporary exception, reflecting the fact that the current wage index prior to exceptions generally underestimates the labor costs faced by hospitals in counties where labor costs are higher than the MSA or statewide rural average. (The results vary across individual counties because of interactions with other inaccuracies in the current wage index.)

Aggregate IPPS payments would also shift toward the small share of hospitals in counties where the wage index value was increased under the illustrative model

so that it would not be more than 10 percent below that of an adjacent county (data not shown).

MedPAC’s illustrative IPPS wage index removes opportunities for wage index manipulation by having no exceptions

A third key design difference between the current IPPS wage indexes and the Commission’s illustrative model is that our model has no wage index exceptions and instead addresses concerns with the current IPPS wage index by broadening the data sources and using more granular definitions of labor market areas. As a result, it also removes hospitals’ ability to manipulate the wage index and lowers the associated administrative burden on CMS.

Because the current wage index exceptions include a mix of those that address underlying inaccuracies and inequities in the current wage index and those that further break the link between an area’s labor costs and its wage index values, aggregate IPPS payments under the Commission’s illustrative wage index would shift slightly away from hospitals that currently receive a wage index exception and toward those

**TABLE
9-9**

Under MedPAC’s illustrative IPPS wage index, IPPS payments would shift slightly toward hospitals with a wage index currently unaffected by wage index exceptions

Exceptions that affect the current wage index	Share of hospitals	Percentage change in IPPS payments if moved to illustrative wage index from current wage index					
		Including temporary low-wage exception			Excluding temporary low-wage exception		
		Aggregate	25th percentile	75th percentile	Aggregate	25th percentile	75th percentile
None	33% 47%	0.2%	-1.0%	2.3%	0.6%	-0.5%	4.6%
Reclassified	29	-0.5	-2.0	1.4	-0.7	-3.1	2.5
Rural floor	9	0.0	-1.5	2.4	0.4	-0.8	5.3
Imputed rural floor	2	-0.9	—	—	-1.1	—	—
Frontier floor	1	-2.3	—	—	-4.8	—	—
Outmigration	7	-0.6	-2.0	2.8	-0.7	-2.2	4.1
Temporary low-wage	25	1.8	-0.2	3.2	N/A	N/A	N/A

Note: IPPS (inpatient prospective payment systems). Analysis includes IPPS hospitals (other than Indian Health Service hospitals) that provided IPPS services in 2021 and had a published 2022 wage index. IPPS payments exclude uncompensated care, were estimated under a budget-neutral policy, and assumed no changes in eligibility for enhanced IPPS payments. The sum of “share of hospitals” is greater than 100 percent because hospitals can receive more than one wage index exception.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, and Bureau of Labor Statistics and Census data.

that do not (Table 9-9). For example, we found that 33 percent of IPPS hospitals had a 2022 wage index that was unaffected by wage index exceptions when including the temporary low-wage index exception; we estimated that under our illustrative wage index, IPPS payments to these hospitals would increase by 0.2 percent. Excluding the temporary low-wage index exception, we estimated that IPPS payments to the 47 percent of hospitals not receiving a wage index exception would increase by 0.6 percent. The hospitals not receiving a wage index exception were a heterogeneous group (including a mix of those with very low and high current wage index values, geographic locations, and ownership types), a majority of which would see increases under our illustrative wage index (data not shown).

However, the shift in IPPS payments would be much larger among certain hospitals benefiting from wage index exceptions, such as hospitals and areas that currently manipulate their wage index. For example,

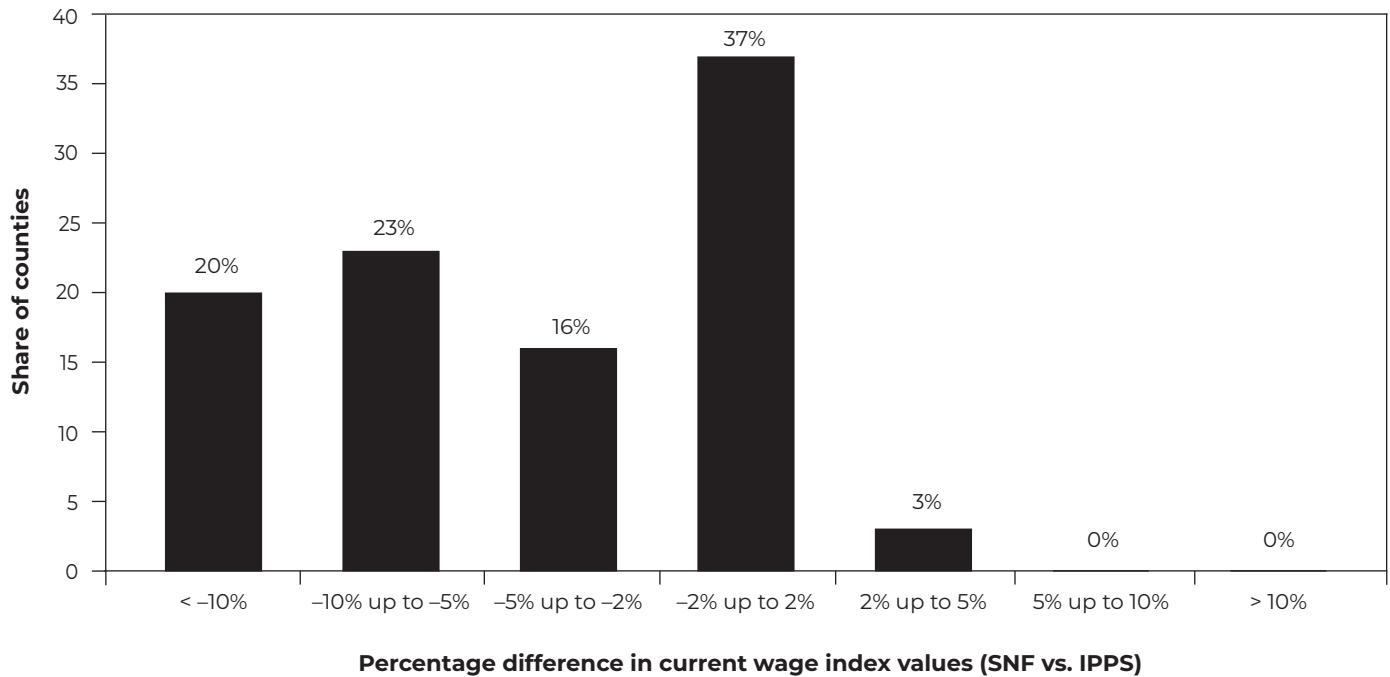
CMS has long noted wage index manipulation in Massachusetts. In 2008, one hospital with high relative wages converted from a critical access hospital (with wages that did not contribute to the IPPS wage index) to an IPPS hospital shortly after it merged with a larger health system. A spokesperson for the system stated that “the change from critical access to rural has the potential to help hospitals across the state of Massachusetts” (Elvin 2016). Indeed, the rural floor—the lowest possible wage index value that all urban areas in Massachusetts receive—for Massachusetts was 1.28 in 2022 and was solely based on this hospital’s data. Nearly all of the hospitals in Massachusetts had their wage index value raised to that floor, an increase in some instances of over 35 percent.²¹

Removing IPPS wage index exceptions would also remove inequities between IPPS hospitals and other types of providers

Under the current wage index policies, there are many areas where the initial hospital wage index value

**FIGURE
9-6**

Current IPPS exceptions result in inequities for SNFs and other types of providers relative to IPPS hospitals



Note: SNF (skilled nursing facility), IPPS (inpatient prospective payment systems). Analysis includes counties with an IPPS hospital (but no Indian Health Service hospitals). For counties with multiple IPPS wage index values due to exceptions, the average was used.

Source: MedPAC analysis of 2022 SNF PPS and IPPS final rule wage index files.

used by other providers, such as SNFs, is substantially lower than the IPPS wage index value because IPPS hospitals are eligible for wage index exceptions that other providers are not (Figure 9-6). This difference can create inequities between SNFs and IPPS hospitals as they compete, to some degree, to hire RNs and other staff. For example, SNFs and other providers located in areas with a very low initial hospital wage index (such as Puerto Rico and rural Alabama) are at a hiring disadvantage relative to neighboring IPPS hospitals since only IPPS hospitals can benefit from the temporary low-wage exception, which increases the wage index for hospitals in some areas by over 35 percent. Similarly, only IPPS hospitals (and their outpatient departments) are eligible for other wage index exceptions, such as reclassifications, wage index floors, and outmigration, each of which can substantially increase the IPPS wage index.

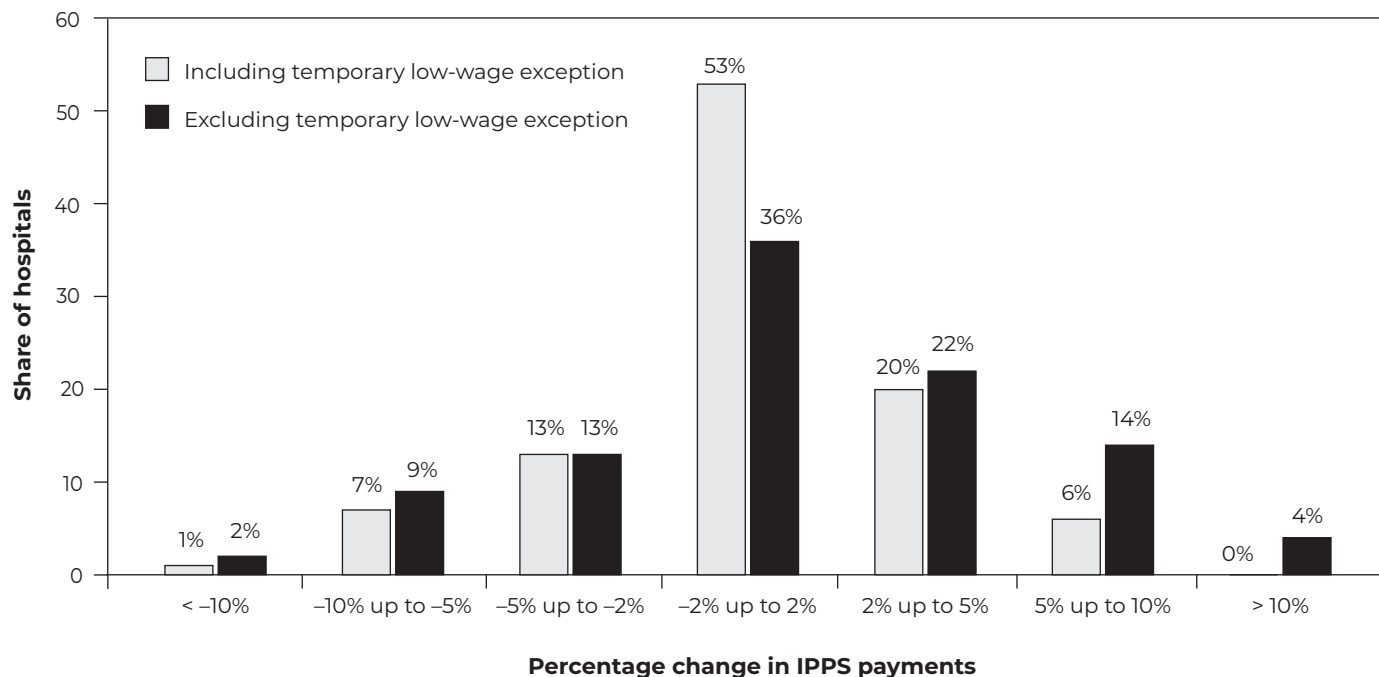
Redistributional effects of MedPAC’s illustrative IPPS wage index on many hospitals would be material

Because of the large inaccuracies in the current IPPS wage index, moving to the Commission’s illustrative IPPS wage index would have a material effect on many IPPS hospitals (Figure 9-7). We estimated that IPPS payments, once fully phased in, would fall by more than 5 percent for about 10 percent of hospitals, and payments would rise by more than 5 percent for 6 percent of hospitals when compared with the current wage index inclusive of the temporary low-wage index exception and for 18 percent of hospitals when excluding the temporary low-wage exception.

Because hospitals with various wage index characteristics are distributed across different types of hospitals, at least a quarter of hospitals across

FIGURE 9-7

MedPAC’s illustrative IPPS wage index would materially affect many hospitals’ IPPS payments



Note: IPPS (inpatient prospective payment systems). Analysis includes IPPS hospitals (other than Indian Health Service hospitals) that provided IPPS services in 2021 and had a published 2022 wage index. IPPS payments exclude uncompensated care, were estimated under a budget-neutral policy, and assumed no changes in eligibility for enhanced IPPS payments.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, and Bureau of Labor Statistics and Census data.

different locations, ownership category, and teaching status would see higher payments, and over a quarter of hospitals would see lower payments (Table 9-10, p. 398). Within these hospital groups, the largest positive shift in aggregate payments (+2.2 percent when excluding the temporary low-wage policy) would be toward hospitals in rural, nonmicropolitan areas. This difference is in part because they would no longer need to pay for the rural floor budget-neutrality adjustment from which only urban hospitals can benefit and in part because they tend to be in areas where all-employer relative wages are higher than IPPS hospitals’ reported relative wages.

The hospitals that would experience the largest changes in IPPS payments under the Commission’s illustrative IPPS wage index share one or more wage

index characteristics (Table 9-11, p. 399). For example, about three-quarters of the hospitals that would experience a more than 10 percent decrease in IPPS payments (when excluding the temporary low-wage exception) were located in areas where the hospital-specific labor costs for RNs are much higher than for competing employers in the same area—that is, areas where all-employer relative costs for RNs are more than 10 percent below that of hospital-specific labor costs. The vast majority of these hospitals had an extremely high current wage index value (>1.5). Most of the remaining hospitals that would experience a more than 10 percent decrease in IPPS payments are those that currently receive a more than 35 percent increase in their wage index from a current wage index exception. In both of these cases, these hospitals

**TABLE
9-10**

Effect of MedPAC’s illustrative wage index on IPPS payments would vary across and within categories of hospitals

Percent change in IPPS payments if moved to illustrative wage index from current wage index

Characteristic	Share of hospitals	Including temporary low-wage exception			Excluding temporary low-wage exception		
		Aggregate	25th percentile	75th percentile	Aggregate	25th percentile	75th percentile
Location							
Metropolitan	77%	-0.1%	-1.7%	2.4%	-0.1%	-1.7%	3.4%
Rural micropolitan	16	0.3	-0.8	1.6	0.3	-2.1	4.7
Other rural	7	0.9	-0.6	2.1	2.2	0.1	6.1
Ownership							
Nonprofit	61	-0.2	-1.7	2.1	-0.3	-2.3	3.4
For profit	25	0.6	-0.9	2.3	1.1	-0.5	4.2
Government	14	0.2	-1.0	2.0	0.4	-1.8	4.9
Teaching status							
Teaching	40	0.0	-2.0	2.4	0.0	-2.3	3.3
Nonteaching	60	-0.1	-1.1	2.0	0.0	-1.4	4.3

Note: IPPS (inpatient prospective payment systems). Analysis includes IPPS hospitals (other than Indian Health Service hospitals) that provided IPPS services in 2021 and had a published 2022 wage index. IPPS payments exclude uncompensated care, were estimated under a budget-neutral policy, and assumed no changes in eligibility for enhanced IPPS payments. Weighted average may not be 0 due to missing data and rounding.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, Census geographic files, and alternative MedPAC wage index data.

receive substantially higher wage indexes at the expense of all other hospitals. In contrast, hospitals that would experience large increases in payments include hospitals that currently have very low wage index values and pay less than the average premium over other employers.

Transition policy

Since many providers would be materially affected by a move to an improved wage index system such as the one we modeled, the transition would need to be phased in over time. As examples, the transition could be phased in over multiple years or managed through a stop-loss policy so that no provider experiences changes (positive or negative) in Medicare payments of more than a specified percent in any one year due to the transition to the improved wage index.

An improved SNF PPS wage index would be more accurate and equitable

All of the inaccuracies and inequities with the current initial hospital wage index for IPPS hospitals also apply to SNFs. As noted, the initial hospital wage index’s use of hospital-reported data can be circular and diverge from an area’s more general labor market costs, including those faced by SNFs. In addition, the broader definition of geographic labor market areas masks variation in labor costs among counties within an MSA or statewide rural area and can lead to large wage index cliffs. These geographic inaccuracies and inequities are exacerbated for SNFs and other providers, which are not eligible for wage index reclassifications.

Therefore, using the Commission’s wage index approach, which uses BLS and Census data, for a SNF PPS wage index would be an improvement because

**TABLE
9-11**

Hospitals that would experience more than a 10 percent decrease or increase in IPPS payments under the alternative IPPS wage index shared several characteristics

Common characteristics of IPPS hospitals for which the illustrative IPPS wage index would . . .

Decrease IPPS payments by 10% or more

- Hospitals located in areas where hospitals pay wages for registered nurses that are much higher than those paid by competing employers in the same area
- These are typically areas with extremely high current wage index values (>1.5)
- Hospitals that receive a substantial increase (>35%) in their wage index values from current wage index exceptions

Increase IPPS payments by 10% or more

- Hospitals located in areas where hospitals pay registered nurses less than the average premium over competing employers in the same area
- These are typically areas with extremely low wage index values (<0.7 when excluding temporary low-wage exception)

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 IPPS final rule wage index files, and Bureau of Labor Statistics and Census data.

our illustrative wage index is based on broader labor market data, reflects variation at the county level, and mitigates wage index cliffs. In addition, using an illustrative SNF wage index—developed using the same method and underlying data as for IPPS hospitals but with occupation weights specific to SNFs—would further improve accuracy (over the illustrative IPPS wage index) by more closely reflecting differences in labor costs faced specifically by SNFs.

Applying SNF-specific occupation weights is important for two reasons. First, SNFs employ a different mix of occupations than IPPS hospitals, with NAs making up a much greater share of SNFs’ institutional wages (28 percent vs. 4 percent for IPPS hospitals) and RNs making up a much smaller share (17 percent vs. 47 percent for IPPS hospitals).²² Second, relative wages in an area vary across occupations (Table 9-12, p. 400). For example, in some parts of the country, such as certain areas in California, wages for both NAs and RNs are higher than the national average, but the gap between the areas’ wages and the national average is smaller for NAs than for RNs. Since SNFs employ many more NAs than RNs, and vice versa for IPPS hospitals, the SNF PPS wage index value in these areas should be lower than the IPPS wage index value as SNFs face lower relative labor costs. Conversely, in areas such as North Dakota, where the labor costs for NAs are above the

national average but the labor costs for RNs are below the national average, the SNF PPS wage index value should be higher than the IPPS wage index value.

We modeled an illustrative SNF PPS wage index using the methodology outlined in the text box on pp. 388–389 but using SNF-specific occupation weights. Because of the differences in relative labor costs across occupations in the same area, our illustrative SNF PPS wage index has wage index values that are materially lower than those of our illustrative IPPS wage index in some counties and materially higher in others (Figure 9-8, p. 401). (By contrast, under current policy, the wage index values of the hospital wage index used in the SNF PPS are almost always lower than those of the IPPS wage index.)

Implementing the Commission’s illustrative SNF PPS wage index in a budget-neutral manner would not change aggregate SNF PPS payments but would redistribute payments more equitably across SNFs. As with IPPS hospitals, SNF payments would be redistributed:

- away from SNFs located in areas where IPPS hospital-specific labor costs are higher than those of competing employers and toward those in areas where competing employers’ labor costs are higher;

**TABLE
9-12**

Relative hourly labor costs for an area can vary across occupations

Labor market area	Hourly area labor costs		Percent difference (NA vs. RN)
	Top SNF occupation: NA	Top IPPS occupation: RN	
National average	\$15	\$37	0
Areas where illustrative SNF wage index value should be lower than IPPS wage index value			
San Jose–Sunnyvale–Santa Clara, CA	19 (1.3 times national average)	68 (1.8 times national average)	-29%
Rural California	17 (1.1 times national average)	47 (1.3 times national average)	-9
Areas where illustrative SNF wage index value should be higher than IPPS wage index value			
Bismarck, North Dakota	17 (1.1 times national average)	30 (0.8 times national average)	41%
Rural North Dakota	17 (1.1 times national average)	32 (0.9 times national average)	34

Note: SNF (skilled nursing facility), NA (nursing assistant), IPPS (inpatient prospective payment systems), RN (registered nurse). Labor market areas include metropolitan statistical areas and statewide rural areas. Results calculated on unrounded values.

Source: MedPAC analysis of 2019 Bureau of Labor Statistics data.

- away from SNFs located in areas with the highest current wage index values and toward those in areas with the lowest wage index values; and
- away from SNFs located in counties with labor costs lower than their broader labor market area average (i.e., MSA or statewide rural area) and toward those in counties with labor costs higher than their broader labor market area average (data not shown).

In addition, our illustrative SNF PPS wage index would shift PPS payments away from SNFs located in areas where the labor costs of NAs relative to the national average is unusually low (or the relative labor costs of RNs are unusually high) and toward SNFs in areas where relative labor costs of NAs are unusually high (or the relative labor costs of RNs are unusually low). This contrast is due to the illustrative SNF PPS wage index weighting the relative labor costs of the most common

SNF occupation (NAs) more highly, while the current wage index is driven by the relative wages of the most common IPPS occupation (RNs).

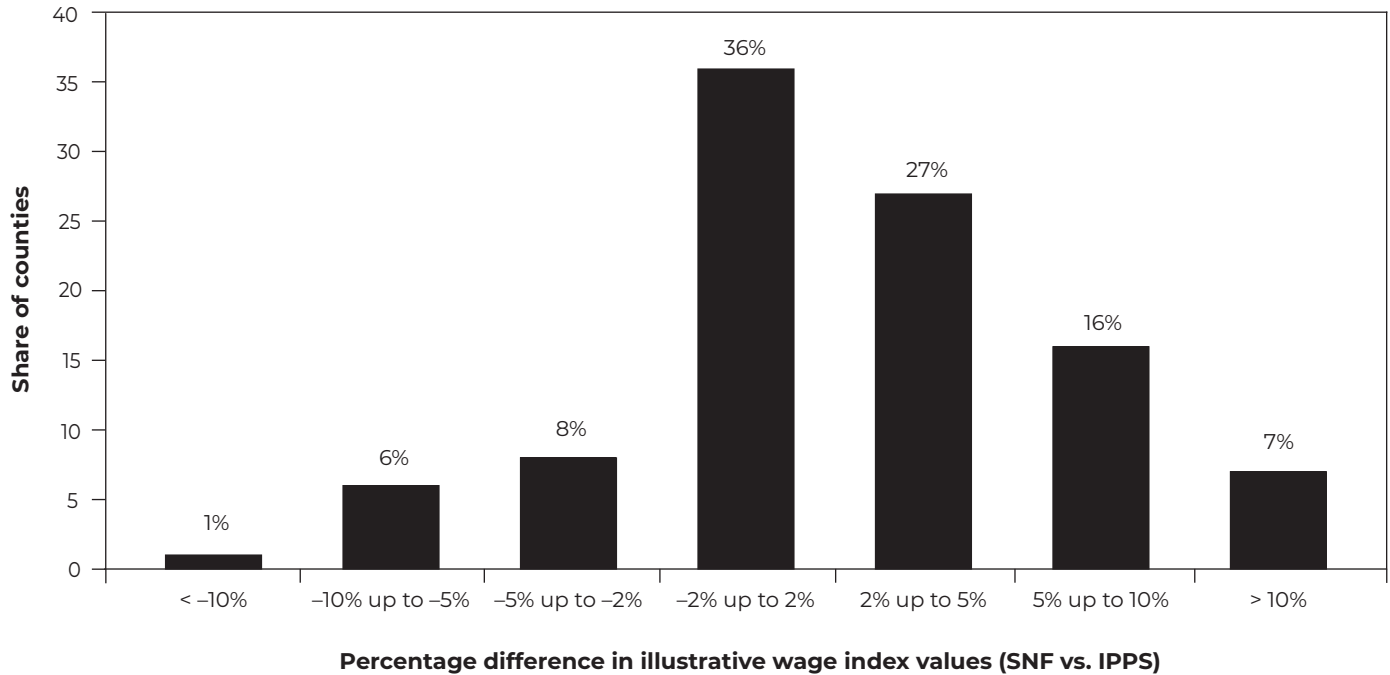
Redistributional effects of MedPAC’s illustrative wage index on many SNFs would be material

Because of the large inaccuracies in the current hospital wage index used by SNFs, moving to the Commission’s illustrative SNF PPS wage index would have a material effect on many SNFs (Figure 9-9, p. 402). We estimated that SNF PPS payments would fall by more than 5 percent for 12 percent of SNFs and rise by more than 5 percent for 27 percent of SNFs.

Because SNFs with various wage index characteristics are distributed across different types of SNFs, we estimated that at least a quarter of metropolitan SNFs, SNFs with different ownership, and freestanding and

**FIGURE
9-8**

MedPAC's illustrative SNF PPS wage index has wage index values that are higher than those in our illustrative IPPS wage index in some counties and lower in others, reflecting SNFs' relative labor costs



Note: SNF (skilled nursing facility), IPPS (inpatient prospective payment systems).

Source: MedPAC analysis of Bureau of Labor Statistics and Census data.

hospital-based SNFs would see increases in payments and over a quarter of SNFs would see decreases. However, we estimated that the majority of SNFs in rural areas would see increases in payments, including an aggregate increase of 4 percent (Table 9-13, p. 403). The shift in payments to rural areas would be larger than for IPPS hospitals, in part because SNFs, unlike IPPS hospitals, cannot currently reclassify to higher-wage areas.

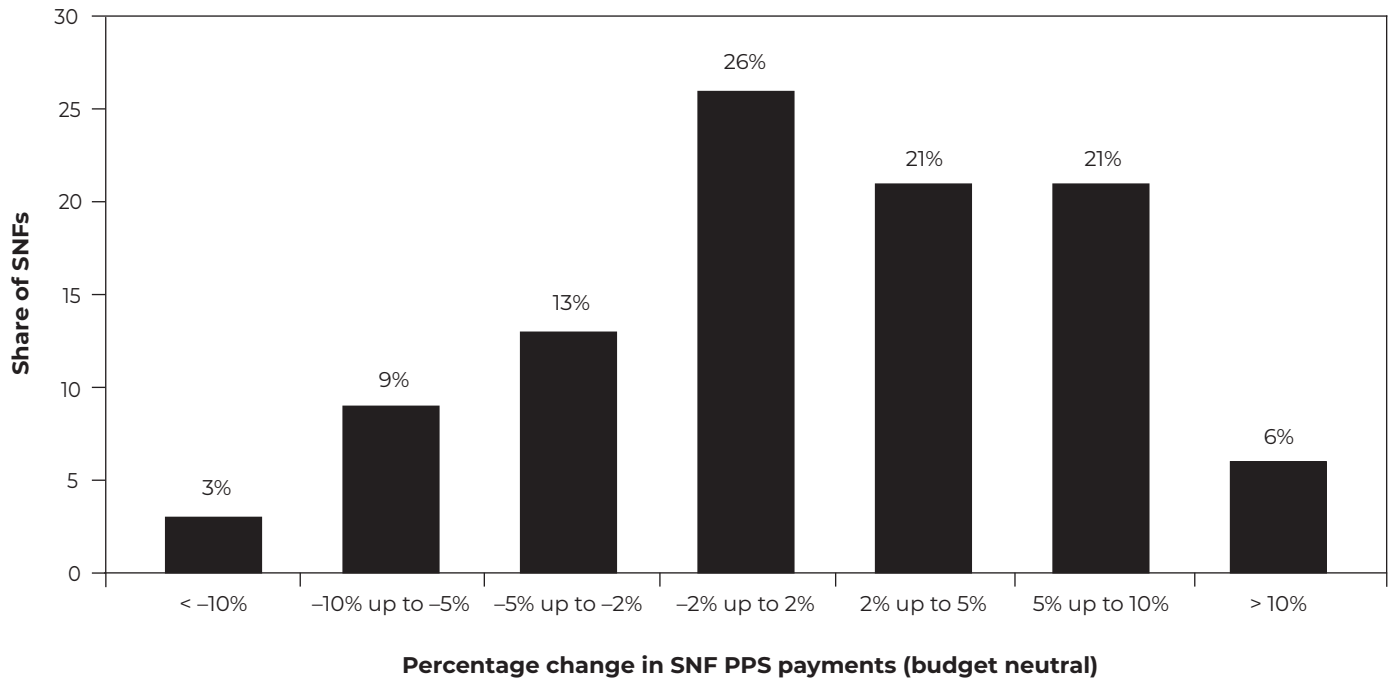
The SNFs that would experience the largest changes in IPPS payments under the Commission's illustrative IPPS wage index share one or more wage index characteristics. SNFs most adversely affected would be those located in areas where the current hospital wage index value is artificially high because of circularity or where SNFs' relative labor costs are materially lower than those of IPPS hospitals. More

specifically, of the 3 percent of SNFs that we estimated would experience a more than 10 percent decrease in SNF PPS payments, the vast majority were located in areas with an extremely high current wage index value (>1.5) or in areas where the labor costs of NAs relative to the national average were materially (>10%) below the relative labor costs of RNs. Conversely, SNFs most positively affected would be those located in areas where the current hospital wage index value is artificially low because of circularity or where SNFs' relative labor costs are materially higher than those of IPPS hospitals.

As with IPPS hospitals, because some SNFs would be substantially affected by implementation of an improved wage index such as the one we modeled, policymakers would need to take steps to phase in the new wage index over time.

**FIGURE
9-9**

MedPAC's illustrative SNF PPS wage index would materially affect many SNFs' PPS payments



Note: SNF (skilled nursing facility), PPS (prospective payment system). SNF PPS payments estimated under a budget-neutral policy.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, CMS's 2022 SNF final rule wage index files, and Bureau of Labor Statistics and Census data.

Moving to better wage index systems

The Commission's key concerns with the current wage index systems are that they fail to accurately reflect differences in labor costs across geographic areas and create inequities across providers. In particular, the IPPS wage index can deviate from the labor costs faced by all employers of hospital occupations, and it masks differences in relative labor costs within areas and creates large differences across adjacent areas. These inaccuracies and inequities stem from the data sources and definition of labor market areas used, and they are frequently exacerbated by numerous wage index exceptions that are easily manipulated and add administrative burden for CMS and hospitals. In addition, we are concerned about the use of the initial hospital wage index by other provider types. A better wage index system is therefore needed.

RECOMMENDATION 9

The Congress should repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:

- **use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;**
- **reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and**
- **smooth wage index differences across adjacent local areas.**

RATIONALE 9

The current wage indexes are broken and have become more distorted since the Commission last

**TABLE
9-13**

MedPAC’s illustrative SNF wage index would shift aggregate SNF PPS payments toward SNFs in rural areas

Percent change in SNF PPS payments if moved to illustrative wage index from current wage index

Characteristic	Share of SNFs	Aggregate	25th percentile	75th percentile
Location				
Metropolitan	72%	-0.8%	-3.4%	4.3%
Rural micropolitan	14	4.1	1.5	7.3
Other rural	14	4.0	1.1	6.8
Ownership				
Nonprofit	23	1.3	-1.0	6.2
For profit	71	-0.3	-2.4	5.1
Government	6	0.5	-1.9	4.6
Facility type				
Freestanding	95	0.0	-2.0	5.4
Hospital based	3	0.2	-2.7	7.0

Note: SNF (skilled nursing facility), PPS (prospective payment system). Analysis includes SNFs with a published 2022 wage index that provided SNF services in 2021. SNF PPS payments estimated under a budget-neutral policy. Components may not sum to 100 percent due to missing data and/or rounding.

Source: MedPAC analysis of 2021 Medicare Provider Analysis and Review data, 2022 SNF final rule wage index files, Census geographic files, and Bureau of Labor Statistics and Census data.

systematically analyzed them in 2007. To improve the accuracy and equity of Medicare’s wage index systems for IPPS hospitals and other providers (such as, but not limited to, SNFs), Medicare needs wage indexes that are less manipulable, accurately reflect geographic differences in market-wide labor costs at the local area (e.g., county) level, and limit how much wage index values can differ among providers that are competing with each other for patients and employees. Therefore, we are recommending wage indexes based on a broader set of labor cost data that are smoothed across local areas to limit differences. The change in wage indexes would be material and therefore would need to be adopted over time. But eventually the Medicare program would have wage indexes that are more equitable across regions, more equitable across provider types, and not in need of the current array of exceptions, which compound over time and lead to additional exceptions.

IMPLICATIONS 9

Spending

- Because these improvements would be implemented on a budget-neutral basis, this recommendation would have no direct effect on federal program spending relative to current law.

Beneficiary and provider

- This recommendation would cause a material redistribution of Medicare payments across providers; however, we do not expect it to materially impact beneficiaries’ access to services or providers’ willingness to treat Medicare beneficiaries.
- Transitioning to wage indexes that better reflect geographic differences in labor costs would make Medicare payments more accurate and equitable. ■

9 — APPENDIX A

Current IPPS wage index exceptions

Based on requirements in statute and through regulation, CMS applies multiple exceptions to the initial hospital wage index to generate a final inpatient prospective payment systems (IPPS) wage index for each hospital. The modifications in fiscal year 2023 are:

- allowing hospitals to reclassify and then using those reclassifications (and hold-harmless policies) to create a post-reclassification wage index for each area;
- applying the highest of three wage index floors to create a post-reclassification, postfloor wage index for each area and state combination;
- applying an outmigration adjustment to the wage index value for hospitals in eligible counties (that did not reclassify); and
- applying a low-wage index policy that increases the wage index value for hospitals in the bottom quartile of the distribution.

Post-reclassification wage index

To address issues with broad definitions of labor market areas, the Congress created three geographic reclassification pathways that allow hospitals that meet specified criteria to be treated as if they were located in a different geographic area for the purposes of the IPPS wage index (Table 9A-1, p. 406).

Starting in fiscal year 2016, in response to legal rulings, CMS published guidance allowing IPPS hospitals to have simultaneous Section 412.103 and Medicare Geographic Classification Review Board (MGCRB) reclassifications.²³ For purposes of wage index calculation, the MGCRB reclassification is the determining factor: A dually reclassified hospital's wage index value is reflective of its MGCRB reclassified area; however, it will retain its rural status from Section 412.103 for the purposes of certain wage index policies (such as the wider average hourly wage thresholds for rural hospitals seeking MGCRB reclassifications) and other non-wage index payment policies (such as eligibility for rural hospital designations and additional residency slots). Similarly, a hospital can hold dual Section 412.103 and Lugar reclassifications (Table 9A-1).

To calculate a post-reclassification wage index value for each area, CMS aggregates the occupational-

mix-adjusted wage data of hospitals that are either geographically located in the area or reclassified into the area. As a result, a hospital's wage data can contribute to the area wage index of both its geographic and its reclassified location.

By statute and regulation, reclassifications must hold harmless hospitals that did not reclassify.²⁴ Therefore, the reclassification of hospitals can increase (but not decrease) the wage index of hospitals that did not reclassify.

Postfloor wage index

The Congress has created three wage index floors to address stakeholder concerns related to perceived anomalies in relative wages and unfair disadvantages and to otherwise increase payments to certain hospitals (Table 9A-2, p. 407).

To calculate the postfloor wage index value for each area and state combination, CMS applies the highest relevant floor to each post-reclassification wage index value. (Because the floors apply based on the hospital's geographic location and not the area to which it reclassified, any area with hospitals from multiple states will have a separate wage index value for each area and state combination. In addition, because the post-reclassification wage index value for an area can be lower for reclassified hospitals than for those that did not reclassify, it is possible for a floor to apply to reclassified hospitals but not hospitals geographically located in that area.)

Outmigration policy

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a county-level outmigration wage index policy for hospitals located in counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. The MMA specified that the outmigration policy would apply to counties that have (1) a higher average hourly wage than the area in which the county is located and (2) a relatively high share of hospital employees who reside in that county but

**TABLE
9A-1**

IPPS hospital geographic reclassification pathways

Reclassification pathway	Eligibility	Process
Lugar counties (rural to urban)	Hospitals in rural counties that, per OMB standards, would have been deemed outlying counties of an MSA if the commuting rates had included all contiguous MSAs (instead of a single MSA). These hospitals are treated as being located in the MSA to which the greatest number of workers in the county commute.	Automatic reclassification (but IPPS hospitals may waive their Lugar status to become eligible to receive the outmigration exception).
§412.103 (urban to rural)	Hospitals that meet any of the following criteria: <ol style="list-style-type: none"> located in a rural census tract of an MSA; or located in an area designated as rural by any state law or regulation (or the hospital is designated as rural); or would qualify as a rural referral center or as a sole community hospital if the hospital were located in a rural area. 	Hospitals must request to reclassify and submit documentation that meet criteria. The reclassification then remains in effect without need for reapproval unless the hospital cancels its reclassification or there is a change in the circumstances under which the classification was approved.
Medicare Geographic Classification Review Board	Hospitals must generally meet two types of criteria: <ol style="list-style-type: none"> proximity to the requested area wages above current areas and comparable with the requested area* 	Hospitals must request to reclassify and submit documentation that meet criteria. If board agrees the eligibility criteria are met, the reclassification remains in effect for 3 years.

Note: IPPS (inpatient prospective payment systems), OMB (Office of Management and Budget), MSA (metropolitan statistical area).
 *Proximity can be demonstrated by distance from the hospital to the requested geographic area (no more than 15 miles for an urban hospital or 35 miles for a rural hospital) or by at least 50 percent of the hospital's employees residing in the requested area; no proximity requirement is needed for sole community hospitals or rural referral centers. The hospital's three-year average occupational-mix-adjusted average hourly wage must be (1) higher than that of the area in which it is located (since 2006, at least 106 percent for an urban hospital or at least 108 percent for a rural hospital) and (2) at least a certain percentage of the average hourly wage of the requested area (since 2011, at least 84 percent for urban hospitals and 82 percent for rural hospitals). Hospitals that were ever classified as a rural referral center or that are the predominant or only hospital in the urban area are exempt from wage requirements. In addition to requests from individual hospitals, all hospitals in a county or a state may collectively request a redesignation; separate criteria apply.

Source: Omnibus Budget Reconciliation Act of 1987, Balanced Budget Refinement Act of 1999, Omnibus Budget Reconciliation Act of 1989, and CMS IPPS rules and regulations.

commute to work in a labor market area with a higher wage index value.²⁵ In addition, the MMA required that a hospital in an eligible outmigration county can receive the outmigration adjustment only if the hospital has not reclassified to another area.²⁶

The outmigration policy calculates each eligible county's wage index value increase as the percentage of hospital employees residing in the county who are employed in any higher wage index area, multiplied by

the sum of the products of (1) the amount by which the wage index value of the higher area exceeds the wage index value of the qualifying county and (2) that area's share of the hospital employees in the county who commute to any higher wage index area.

The MMA required the outmigration policy to not be implemented in a budget-neutral manner.

**TABLE
9A-2**

IPPS wage index floors

Floor	History	Implementation
Rural floor (for urban areas)	The Balanced Budget Act of 1997 established a rural floor policy that ensures that the wage index value of a hospital located in the state’s urban area is no less than the wage index of hospitals located in the state’s rural area.	CMS calculates the rural floor for a state using the wage data of all hospitals located in the state’s rural area (including those that reclassified). ^a For each urban area and state combination, CMS applies the rural floor for the state where the hospital is geographically located. The floor is required to be budget neutral and applied directly to the wage index value. ^b
Imputed rural floor (for urban areas in all-urban states)	Starting in fiscal year 2005, CMS adopted an imputed rural floor policy for hospitals in all-urban states in response to stakeholder comments that they were disadvantaged relative to states that benefited from a rural floor. CMS extended this policy through fiscal year 2018, after which it lapsed. The American Rescue Plan Act of 2021 required the reestablishment of the imputed rural floor policy starting in fiscal year 2022.	CMS calculates the imputed rural floor for each all-urban state using the highest of two methods: <ul style="list-style-type: none"> • the highest wage index value in the all-urban state, multiplied by the higher of (1) the ratio of the state’s lowest-to-highest wage index value; or (2) the average of such ratios across all all-urban states; and • the lowest wage index value in the all-urban state, multiplied by the average percentage increase in the wage index from the rural floor among all urban areas that received their state’s rural floor (prior to the rural floor budget-neutrality factor). For each urban area in an all-urban state, CMS applies the imputed rural floor for the state where the hospital is geographically located. The floor is required to be non-budget neutral. ^c
Frontier floor (for low-density states)	The Affordable Care Act of 2010 established a frontier floor that, beginning in fiscal year 2011, set a wage index floor of 1.0 in low-density states.	CMS has determined the qualifying frontier states with a population density of fewer than 6 people per square mile to be Montana, Nevada, North Dakota, South Dakota, and Wyoming. The floor is required to be budget neutral.

Note: IPPS (inpatient prospective payment systems).
^a For fiscal years 2020 through 2022, CMS excluded the data of hospitals that reclassified from the rural floor; this change was the subject of a legal challenge and a court found CMS did not have the authority to make the change.
^b Prior to fiscal year 2011, CMS applied the rural floor budget-neutrality adjustment at a state level.
^c From 2005 through 2018, CMS implemented the imputed rural floor in a budget-neutral manner. The American Rescue Plan Act of 2021 required the reinstated policy to not be implemented in a budget-neutral manner.

Source: Balanced Budget Act of 1997, Affordable Care Act of 2010, American Rescue Plan Act of 2021, and CMS IPPS rules and regulations.

Low-wage index policy

In response to concerns about wage index disparities and circularity, CMS issued a request for information

to engage stakeholders during the fiscal year 2019 rulemaking (Centers for Medicare & Medicaid Services 2018). CMS summarized these comments in subsequent IPPS rules, stating that “many stakeholders expressed

that circularity, where low-wage hospitals remain locked in a downward spiral due to low-wage index values that prevent them from raising their wages, was the most important wage index issue facing the system and it needed to be addressed quickly” (Centers for Medicare & Medicaid Services 2021).

Based on these comments, for fiscal year 2020, CMS implemented a temporary low-wage index policy to provide an opportunity for low-wage index hospitals to increase employee compensation (Centers for Medicare & Medicaid Services 2019). The policy is set to last at least through fiscal year 2023 (and proposed to continue through 2024).

CMS designed the low-wage index policy to increase the wage index values of hospitals in the lowest quartile by half the difference between the hospital’s wage index value (postfloors and outmigration, as applicable) and the 25th percentile among all IPPS hospitals. Therefore, the low-wage index policy provides a substantial increase to hospitals with the lowest wage index values and a smaller increase to hospitals with wages close to the 25th percentile.

CMS has implemented the low-wage index adjustment in a budget-neutral manner.

This policy is the subject of pending legal challenges (Centers for Medicare & Medicaid Services 2022).²⁷ ■

Endnotes

- 1 The Congress required the labor share to be 62 percent for IPPS hospitals with a wage index value of less than 1. For other hospitals, CMS applies its annual estimate of the labor share, which in fiscal years 2022 and 2023 was 67.6 percent.
- 2 Starting in fiscal year 1991, the Congress required the IPPS adjustment for area wage levels to be based on the wages and wage-related costs of “subsection (d)” hospitals, which includes hospitals paid under the IPPS as well as certain other IPPS-eligible hospitals paid according to a different methodology, such as hospitals in Maryland that are paid through a state waiver.
- 3 In determining whether to include a hospital’s wage data, CMS evaluates the data for accuracy and reasonableness, including relativity to each area’s average hourly wage. CMS provides hospitals with an opportunity to correct their data and publishes a list of hospitals with the wage data it plans to exclude in the proposed rule.
- 4 CMS refers to the areas it uses in the hospital wage index as core-based statistical areas (CBSAs). “CBSA” is a broader term for types of areas defined by the Office of Management and Budget (OMB). One type of CBSA is an MSA. In defining urban areas, CMS uses OMB’s metropolitan divisions, defined as a county or group of counties within an MSA that has a population core of at least 2.5 million. CMS considers a smaller type of CBSA—micropolitan statistical areas—as rural. OMB generally issues major revisions to MSAs and other areas every 10 years (most recently in 2015) and issues more minor revisions episodically.
- 5 Statute requires that the budget-neutrality adjustment be calculated without taking into account the requirement that the labor share for hospitals with a wage index value of less than 1.0 be set at 62 percent.
- 6 CMS allocated the data of 23 multicampus hospitals that report under a single provider number. CMS excluded data for an additional 61 hospitals with data that CMS determined were aberrant or missing.
- 7 The count of urban areas includes 31 metropolitan divisions across 11 MSAs and includes imputed data for one area with no included providers. There are 47 rural areas (including Puerto Rico), as four states (Connecticut, Delaware, New Jersey, Rhode Island) and the District of Columbia do not have a statewide rural area area.
- 8 In the Consolidated Appropriations Act, 2001, the Congress required CMS to collect data on the occupational mix of IPPS-eligible hospitals at least every three years and to use these data to construct an occupational-mix adjustment to the IPPS wage index.
- 9 The Congress required the occupational-mix adjustment to be implemented in a budget-neutral manner. Concerning the budget-neutrality factors, CMS publishes a single factor that accounts for updated wage data both from cost reports and from the occupational-mix survey.
- 10 In addition, CMS uses fixed wage index values for Indian Health Service (IHS) hospitals that is not based on any wage data. CMS sets the wage index value of IHS hospitals at 1.4448 (or 1.9343 for hospitals in Alaska). IHS hospitals file a modified (Method E) cost report, which does not use certain worksheets in the regular hospital cost report form, including the wage and hours data from Worksheet S-3. As the wage index approach for IHS hospitals is different from all other IPPS hospitals, the rest of the discussion in this chapter excludes IHS hospitals.
- 11 As required by law, CMS applies the rural floor budget-neutrality adjustment directly to the wage index values. CMS applies the other wage budget-neutrality adjustments to the national IPPS base rate.
- 12 To decrease opportunities for manipulation, starting in fiscal year 2022, CMS finalized requirements that would require a rural reclassification be in effect for at least one year before cancellation can be requested (Centers for Medicare & Medicaid Services 2021).
- 13 Similarly, the Commission supported CMS’s discontinuation of the imputed rural floor in 2019 (Medicare Payment Advisory Commission 2018); however, effective fiscal year 2022, the Congress required the reestablishment of the imputed rural floor.
- 14 To limit this opportunity for manipulation, in the fiscal year 2020 rule, CMS finalized a policy change to exclude urban-to-rural reclassified hospitals from the calculation of the rural floor (Centers for Medicare & Medicaid Services 2019). However, this action was the subject of a legal challenge, and therefore, starting in fiscal year 2023, CMS reverted to its prior policy of including the data of urban-to-rural

- reclassified hospitals in the calculation of the rural floor (Centers for Medicare & Medicaid Services 2022).
- 15 In all of our modeling of effects, we estimated the direct effect of changing the wage index value. We did not attempt to project the indirect effects of eliminating wage index exceptions, such as whether some hospitals would lose rural hospital designations that make them eligible for additional payments since these designations and payments would depend on whether exceptions were maintained for these non-wage index purposes.
 - 16 “Institutional wages” refers to wages of staff providing IPPS-covered services, and therefore excludes wages for physician and other clinician services paid under the physician fee schedule. To identify the most common occupations employed by IPPS hospitals, we used the general medical and surgical hospitals category (North American Industry Classification System 62210). (We also collected and included data for another 26 occupations that were more common for other sectors, as described later.)
 - 17 We asked BLS to construct this wage index for us so that it could use data that need to be suppressed when reported publicly. As a data check, we also reconstructed the wage index from publicly available data, and we set to “missing” any individual index values for which this calculation differed from the BLS-constructed wage index by more than 10 percent, or if the aggregate weight of the occupations with wage data in that area was less than 33 percent.
 - 18 Using all-employer data decreases but does not eliminate the circularity risk. For example, about 30 percent of RNs were employed by general acute care hospitals.
 - 19 While IPPS hospitals often pay more than competing employers for a given clinical occupation (such as RNs), what drives inaccuracies in the current wage index is that the premium that hospitals pay over other employers varies substantially across labor market areas.
 - 20 To increase the reliability of this adjustment, we included only occupations with at least 30 employees (or, for the RN occupation, at least 50 employees) and only calculated a wage index adjustment if the aggregate weight of the occupations with wage data in that county was at least 50 percent.
 - 21 The two urban hospitals that had an even higher wage index value than the rural floor were two high-wage hospitals located in the Boston area that reclassified to rural Massachusetts, thereby raising the wage index value to 1.32 for hospitals in the “rural Massachusetts” area (i.e., the one in Nantucket and two in Boston). While CMS’s policy in effect from 2020 to 2022 prevented urban hospitals that reclassified to rural from increasing the state’s rural floor, the inclusion of these hospitals could still increase the wage index value for the statewide rural area. Starting in 2023, as the result of litigation, urban hospitals that reclassified to be treated as if located in a rural area (and that did not dually reclassify) were allowed back into the calculation of the rural floor.
 - 22 To identify the most common occupations employed by SNFs—which often have a colocated nursing facility—we used the North American Industry Classification System category for nursing care facilities (623100) since there was not a category specific for SNFs. While the occupation weights for the SNF component may differ some from nursing facilities as a whole, we believe that these nursing facility weights are a better approximation than the current approach of using aggregate wage data from hospital cost reports. In rulemaking, CMS could explore options for further improving occupational weights.
 - 23 In 2015, the Court of Appeals for the Third Circuit issued a decision in *Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services*. The hospital first successfully reclassified with a §412.103 designation. The hospital then sought to reclassify, based on its newly acquired rural status, to a nearby urban area using an MGCRB reclassification. CMS denied the reclassification because the hospital would not qualify under existing regulations (Geisinger would have had to first cancel its §412.103 reclassification and use the proximity requirements for an urban hospital rather than use the more relaxed proximity requirements for rural hospitals). The court ruled in favor of the hospital and stated that the reclassification rule was unlawful since the statutory text of Section 401 unambiguously requires the Department of Health and Human Services to treat §412.103 hospitals like hospitals that are actually located in rural areas, inclusive of MGCRB reclassification purposes.
 - 24 Statute requires that urban hospitals that did not reclassify must be held harmless from reclassifications into their urban areas. To achieve this result, if the inclusion of data from hospitals that reclassified reduces the wage index value for an urban area, CMS maintains the (prefloor) wage index value for non-reclassified hospitals at their pre-reclassification value. Rural hospitals are held harmless from reclassifications both into and out of the rural area. Also, reclassifications cannot reduce a hospital’s wage index value below the rural wage index value in the same state.
 - 25 To determine a county’s eligibility for the outmigration adjustment, CMS established the following two qualifying criteria: (1) the three-year average hourly wage of the county’s hospitals equals or exceeds that of the labor market area in which the county is located and (2) at least 10 percent of the county’s hospital employees commute to one or more metropolitan statistical areas with higher wage index values.

- 26 CMS clarified that hospitals can waive their automatic Lugar reclassification in order to receive the outmigration adjustment.
- 27 For example, a group of hospitals challenged CMS's finalization of the low-wage policy in fiscal year 2020, in particular that the policy is contrary to the statutory requirement to reflect hospitals' labor costs relative to the national level and that it was implemented in a budget-neutral manner by reducing the base payment rate for all

hospitals. The District Court of the District of Columbia made a summary judgment in favor of the plaintiffs and stated that an additional briefing on the appropriate remedy is required (*Bridgeport Hospital, et al. v. Becerra*, No. 1:20-cv-01574). On March 2, 2022, the court found that CMS did not have the authority to adopt the low-wage policy in 2020 and ordered additional briefing on the appropriate remedy; however, CMS is continuing this policy in 2023 while it evaluates the court's decision, which is subject to potential appeal.

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