Medicare Wage Index

What it is, how it works, and why it is important

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Introduction

The Medicare Wage Index (WI) is one of the factors that adjust a hospital's overall payment from the Medicare program. Labor costs can be a significant expense for any business and must be monitored to ensure profitability and efficiency. Through the wage index, Medicare is able to maintain a consistent payment structure across IPPS hospitals while recognizing that the cost of labor varies in markets across the nation.

With the release of the latest CMS Public Use File (PUF) data on January 30th, hospitals are not only reviewing their average hourly wage for FFY 2018 but also beginning to review their wage index in preparation for the FFY 2019 wage index. Additionally, hospitals will need to prepare their Medicare Occupational Mix Survey in July 2017.

It seems that hospitals' reimbursement personnel are in a continuous cycle of reviewing their wage index in addition to their other responsibilities. This paper will explore aspects of the wage index including how labor markets are defined and various adjustments that can impact how it is calculated. It will also review recent changes to the wage index as well as opportunities that hospitals can take advantage of during their own review process.

The Purpose of the Wage Index

The inpatient prospective payment system (IPPS), as a result of the Medicare statute (Section 1886(d)(3)(E) of the Social Security Act or "Act"), requires that all per-discharge payments to hospitals reflect the geographic differences in their labor costs. The Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This creates what is known as the Medicare Wage Index, a description of which is found on the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html

To illustrate how the wage index works, take for example a smaller hospital that may be only several miles away (e.g., a 20 to 30 minute drive) from a major metropolitan area that might have a wage index value drastically lower than the values for other hospitals located in that area. These differences in wage index values will allow a hospital in the larger area to offer higher salaries to its employees, thereby enhancing its ability to recruit talented personnel from an area that also has a need for the given resource. Arguments can be made that it costs more to live in the major metropolitan area and that the larger hospitals offer more acute services, therefore, the higher average hourly wage (AHW) can be substantiated.

Labor Markets

The sole purpose of the Medicare Wage Index is to allocate payments and to ensure they are consistent across IPPS hospitals in different areas, while maintaining budget neutrality. In order to construct each IPPS hospital's wage index value, the Centers for Medicare and Medicaid Services (CMS) calculates an average hourly wage for (i) each Core-Based Statistical Area (CBSA) established by the Office of Management and Budget (OMB), and (ii) each residual, or "rest of state," area; (that is also labeled as a rural area).

On February 28, 2013 OMB bulletin no. 13-01 was released. This document revised delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas (CSA). This document impacted the entire country and was ready for use in Federal Fiscal Year (FFY) 2014. However, CMS chose not to use the delineations in FFY 2014, instead opting to begin using them in FFY 2015.

On July 15, 2015 the OMB released OMB bulletin no. 15-01 which updated the February 28, 2013 memorandum and made some minor changes to areas across the country. It is the most recent document that defines labor markets. See https://www.census.gov/population/metro/data/omb.html

The CMS wage index is derived from data included in the wage index forms from the Medicare Cost Report (worksheet S-3 Parts II and III), the Hospital Wage Index Medicare Occupational Mix Adjustment (MOMA) Survey, hospitals' payroll records, contracts, and other wage-related documentation.

In computing the wage index, CMS develops an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amount in the calculation of the hospital's Medicare payment. It should be noted that while the average hourly wages of hospitals in a designated area are used to calculate the wage index for that area, contiguous or nearby areas can have very different wage index values.

Revised Labor Markets

The purpose of the February 28, 2013 OMB bulletin was to establish revised delineations for the Nation's Metropolitan Statistical Areas, Micropolitan Statistical Areas, and CSAs, as well as delineations of New England City and Town Areas. The delineations reflect the Standards for Delineating Metropolitan and Micropolitan Statistical Areas that OMB published in the June 28, 2010 Federal Register (75 FR 37246 -37252) and the application of those standards to Census Bureau population.

Both the change in the standards and the application of new Census Bureau data have resulted in an increase in the number of CSAs. These areas were first introduced in the year 2000 standards, and can impact many geographic reclassifications. This is mainly because, in order for a county or group application to meet approval of the Medicare Geographic Classification Review Board (MGCRB), both the geographic area and desired areas must reside in the same CSA. Metropolitan and Micropolitan Statistical Areas, in various combinations, may become the components of a CSA. It should be noted that CSAs complement, but do not supersede Metropolitan and Micropolitan Statistical Areas, which retain their separate component identities.

Wage Index Exemptions

Hospitals can receive a wage index value that is greater than their calculated geographic wage index through a variety of ways. The four common exceptions noted by CMS that impact most hospitals are:

- Reclassifications;
- Out-migration adjustment;
- Rural Floor and Imputed Rural Floor; and
- Frontier State.

Reclassifications

The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with Sections 1886(d)(8)(B) and 1886(d)(10) of the Act. Per the statute, a hospital has the opportunity to seek a higher wage index as either an individual hospital or group (county) of hospitals or by special reclass. In FFY 2017, 816 hospitals benefited from such reclassifications. Hospitals compete against other hospitals in various labor markets for doctors, nurses and other qualified personnel. In order to maintain the level of quality healthcare that is necessary, hospitals would be at a disadvantage should they not be able to reclassify and receive a comparable wage index value. There are separate criteria for Individual and Group reclassifications including:

Geographic Reclassification Criteria for an Individual Hospital (see, e.g., 42 CFR § 412.230)

- The pre-classified AHW of the desired CBSA is greater than the hospital's AHW and the standardized amount in the desired CBSA is greater than the hospital's standardized CBSA;
- The hospital may not be re-designated to more than one area;

- The distance from the hospital to the desired CBSA is no more than a) 15 miles for urban hospitals, or b) 35 miles for rural hospitals; OR at least 50% of the hospital's employee's reside in the target CBSA;
- The hospital's 3-year AHW is a) for Rural hospitals, at least 106% of its current location's 3-year AHW, or b) for Urban hospitals at least 108% of its current location's 3-year AHW (CBSA);
- The hospital's 3-year AHW is a) for Rural hospitals, at least 86% of the desired location's 3-year AHW, or b) for Urban hospitals, at least 84% of the desired location's 3-year AHW (CBSA).

Geographic Reclassification Criteria for a Group/County (see, e.g., 42 CFR § 412.234)

- The county 3-year AHW (Wages/Hours) is at least 85% of the target CBSA 3-year AHW (Rounding is not permitted);
- All hospitals in the county must apply for the reclass;
- The county must be adjacent to the target CBSA;
- Urban counties must be in the same CSA as the target CBSA;
- Rural counties (reclassifying to urban CBSAs) must demonstrate that the county in which the hospitals are located meets the Metropolitan Test standards for redesignation using Census Data;
- The pre-classified AHW of the target CBSA is greater than the county's AHW.

If a hospital or group of hospitals were to satisfy the above criteria, they may choose to file either an individual or group wage index geographic reclassification application with the MGCRB. These applications are due 13 months prior to the beginning of the next FFY. For example, reclass applications that would be approved for FFY 2018 were due on September 1, 2016.

Out-Migration Adjustment (see, e.g., 42 CFR § 412.64)

A hospital that is located in a county that has a specific number of residents that travel to a different county for employment may be eligible to receive this adjustment. However, if that county or hospital located in that county does reclassify into another county, it is not eligible for such an adjustment.

Hospitals that reclassify must annually review this adjustment and compare it to the impact they receive from their reclassification to determine which wage index value is greater. In FFY 2017, there were 700 hospitals eligible to receive an out-migration adjustment; however, only 374 actually received the adjustment. The remaining 326 reclassified and forfeited this adjustment, as no hospital can receive a reclassified wage index amount and the out-migration adjustment.

Rural and Imputed Rural Floor (see, e.g., Section 4410 of the Balanced Budget Act of 1997, Pub. L. 105-33 and 42 CFR § 412.64)

Section 4410 of the Balanced Budget Act of 1997 established the rural floor adjustment. This adjustment ensured that hospitals in metropolitan areas would not have a wage index value lower than that of hospitals in rural areas of the state.

This adjustment can be applied in all fifty states and Puerto Rico. Forty-seven states and Puerto Rico are eligible to receive the traditional rural floor adjustment, and three all-urban states receive the imputed rural floor benefit. For FFY 2017, 32 states and Puerto Rico actually received the rural floor benefit for 397 hospitals (367 hospitals [traditional rural floor] and 30 [imputed rural floor]).

The states that do not have a rural area are considered "all-urban." Since these "all-urban" states did not have a rural hospital, CMS created the imputed rural floor

by regulation, and this policy has been in effect since FFY 2005. In FFY 2005, Massachusetts, New Jersey, and Rhode Island were considered all-urban states and were therefore not eligible to have a rural floor impact. In later years, Massachusetts, as a result of having a rural area and a new rural hospital ceased to be an all-urban state. New Jersey and Rhode Island remained the only two states that did not have designated rural areas, and therefore are "all-urban". Beginning in FFY 2015, Delaware was included as "all-urban" as a result of no longer having a designated rural area.

The imputed rural floor is calculated by taking the lowest and highest wage index value in each all-urban state to create a low-to-high average. A low-to-high average can never be greater than one. All-urban states have the discretion to use their individual low-to-high average or the aggregate low-to-high average divided by the number of all-urban States (there are three) in the calculation of the imputed rural floor (whichever is greater) and then multiply that factor by the highest wage index value in the state and by the national budget neutrality factor.

This calculation did not benefit Rhode Island, due to Rhode Island only having one labor market. In FFY 2013, the calculation was adjusted so that hospitals in Rhode Island could benefit. At that time only four hospitals in Rhode Island benefited from this adjustment. For FFY 2017, 18 hospitals in New Jersey, 10 hospitals in Rhode Island and two hospitals in Delaware benefited from the imputed rural floor. (see also Federal Register Vo. 77, No. 92 (May 11, 2012) at 27950)

Frontier State Adjustment (see, e.g., 42 CFR § 412.64)

No hospital in a county with less than six people per square mile can receive a wage index less than 1.00 (Alaska and Hawaii excluded). Section 10324 of the Patient Protection and Affordable Care Act requires that hospitals in frontier states not be assigned a wage index of less than 1.0000. For FFY 2017, 50 hospitals will receive the frontier floor value of 1.0000 for their FY 2017 wage index. These hospitals are located in five states: Montana, Nevada, North Dakota, South Dakota, and Wyoming.

Medicare Occupational Mix Adjustment Survey

Section 304(c) of Public Law 106-554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data every three years on the occupational mix of employees. Each short-term, acute-care hospital participating in the Medicare program is required to submit this survey which is used to construct an occupational mix adjustment to the Medicare Wage Index. The law also requires the application of the occupational mix adjustment to the wage index. CMS began collecting data October 1st, 2004.
Per the CMS website, please note that, ***"Critical Access Hospitals (CAHs) are not paid under the IPPS, therefore, CAHs are not required to complete the survey. Also, hospitals that terminated participation in the Medicare program before January 1, 2016 or terminated after January 1, 2016, but before December 2016, resulting in less than 11 months of data from CY 2016, are not required to complete the survey."***

The purpose of the Medicare Occupational Mix Adjustment (MOMA) survey is to adjust the AHW by accounting for differences in management choices of staffing. Simply explained, providers with a higher mix of lower paid personnel (i.e. medical assistants and nursing aides) receive a higher occupational mix factor. Subsequently providers with a higher mix of RNs would receive a lower factor. Hospitals are required to submit their 2016 surveys (January 1, 2016 through December 31, 2016) by July 1st, 2017. The preliminary (unaudited) MOMA survey data should be released by October 2017, if CMS follows a similar schedule to previous survey releases. This newly completed survey will impact Medicare FFY 2019 through FFY 2021. Currently FFY 2017 and FFY 2018 will use data from the 2013 survey filed in July 2014.

A copy of the survey and associated instructions may be found at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/2016-Occupational-Mix-Survey-Hospital-Reporting-Form-CMS-10079-for-the-Wage-Index-Beginning-FY-2019.html

Conclusion

The current system for calculating and reviewing wage index has been under scrutiny over the past decade. The recent revisions to the labor markets, as well as major changes to other factors in Medicare reimbursement, have helped to quell the debate for now.

CMS has also recently released transmittal 10 and a few adjustments to the wage index schedules on the Medicare cost report. These adjustments deal with the contracted labor and home office sections of the wage index. These areas have helped hospitals improve their wage index over the past decade and CMS, through their MACs, have increased their focus on these areas. Hospitals should concentrate their reviews on these areas and be prepared should CMS not offer an "open window" review period. The result is that hospitals should have most, if not all of their wage index data, accurate at time of cost report submission.

If CMS were to develop a new system for wage index, it will not be without its challenges and will have its detractors and supporters. Any new system must be an accurate gauge for calculation of a hospital's wage index value and may also eliminate the need for any exceptions (reclassification, out-migration, etc.) The potential elimination of these exemptions is where many hospitals in the country will feel the greatest impact as these exemptions permit them to receive a higher wage index value.

Another concern regarding any proposed change is the timing and accuracy of the data used to support its calculation. This will undoubtedly bring with it much conversation and deliberation until any change is finalized. Additional concerns for providers will be the availability of the data and the new reporting mechanism that will need to be developed.

The wage index system that is in place now is not broken. Other areas seem to warrant more immediate attention. Subtle changes can be made to assuage the concerns of those opposed to the present system and should be addressed before major changes that impact thousands of hospitals are made. Changes should not be made based solely on the fact that such changes could potentially reduce the amount of paperwork to be filed.

Implementing any type of substantial wage index change recommended by HHS will be a difficult task for all involved. A majority of hospitals could see a decrease to their wage index values. Regardless of the scenario, any new system that Congress adopts would most likely be phased-in over time, as this has been CMS' recent process when adopting a major change. It is likely that providers and their associations will have an opportunity to weigh in on both the timing and the final structure of this system.

Until the proposed system and its potential impact on hospitals can be analyzed, it seems reasonable and prudent for the current system to continue. Hospitals should do all they can to monitor their labor costs and the impact that those amounts have on their hospital(s) and on the hospitals in their current and projected areas. Evaluation of data as well as a hospital's collection of this data must be a focal point of discussion when measuring labor costs. Active involvement with legislators and hospital associations is also paramount to safeguard against any change that could negatively impact a hospital or health system.

To find out more about the impact of the Medicare Wage Index on your hospital or to inquire about the potential for a reclassification or other adjustment, contact Scott Besler at sbesler@besler.com.