The Area Wage Index of The Medicare Inpatient Hospital Prospective Payment System: Perspectives, Policies, And Choices

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THE AREA WAGE INDEX OF THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM: PERSPECTIVES, POLICIES, AND CHOICES

Guest Author: Anthony Wellever[1]

BACKGROUND

The Prospective Payment System (PPS) compensates acute care hospitals for operating and capital costs incurred in treating Medicare inpatients based on predetermined rates for each discharge. Payment per discharge is calculated by multiplying the weight of one of 511 diagnosis related groups (DRGs) assigned to the stay by an adjusted standardized amount. The standardized amount is the national average cost per Medicare case. According to the Social Security Act, the standardized amount must be adjusted "for area differences in hospital wage levels by a factor (established by the Secretary [of Health and Human Services]) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national hospital wage level" (SSA Section 1886(d)(3)(E)). This adjustment factor is referred to as the hospital wage index.

A previous RUPRI Policy Brief described how the wage index was calculated and used, and identified the major unresolved issues associated with it.[2] That Policy Brief outlined two primary issues. First, rural health advocates claim that rural hospitals are systematically disadvantaged because of the mix of occupations included in the wage index calculation. Second, they claim that labor market areas are improperly drawn, resulting in too much variation in wages within labor markets and across labor market boundaries. This Policy Paper expands upon that discussion by summarizing the positions of various rural health advocates and recording the actions taken by Congress and the Health Care Financing Administration (HCFA) to improve the wage index. Finally, it outlines the research needed to energize the policy discussion of the uses and methods of calculating the hospital wage index.

PERSPECTIVES

Recommendations of the Prospective Payment Assessment Commission, the National Advisory Committee, and the Medicare Payment Advisory Committee

From the first days of PPS, the Prospective Payment Assessment Commission (ProPAC) recognized the need to improve the area wage index. In ProPAC's 1985 *Report and Recommendations to the Congress* it suggested modifying the definition of labor market areas. This recommendation was repeated in 1986, 1987, 1992, and 1993. ProPAC recommended

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[2] See RUPRI Policy Brief, "Calculating and Using the Area Wage Index of the Medicare Inpatient Hospital Prospective System" (PB2000-5, June 2000) for additional background on the wage index.

removing the occupational mix effect on payments in 1991 and 1993 (ProPAC, 1985; 1986; 1987; 1991; 1992; and 1993).

In 1993, ProPAC made its most specific recommendation for revising the labor market area definition. It proposed defining *hospital-specific labor market areas* based on geographic proximity measured by the air-mile distance between nearby hospitals.[3] Each hospital's "nearest neighbor" wage index would include its own wage and hour information with those of other nearby hospitals. This definition would have replaced 370 labor markets and area wage indices with over 5,000 of them — one for each hospital (ProPAC, 1993). HCFA published its analysis of several nearest neighbor approaches in the *Federal Register* (May 27, 1994) and invited comment on the proposal.

ProPAC was the most consistent neutral voice within the federal government advocating for equitable payment for rural hospitals under PPS; however, it ceased to exist as an organization in 1997 when it was subsumed, along with the Physician Payment Review Commission, by the Medicare Payment Advisory Commission (MedPAC). To date, MedPAC has not taken up the cause of wage index reform.

The National Advisory Committee on Rural Health (NACRH), established in 1987 to advise the Secretary of Health and Human Services on ways to address health care problems in rural America, also made several recommendations for improving the hospital wage index (NACRH, 1999). Between 1989 and 1999, NACRH made eight recommendations to the Secretary on wage index improvements. Four of these recommendations were adopted and implemented by HCFA, dealing with topics such as annually updating the index and excluding wages and hours of sub-acute units and teaching physicians from the wage index calculation. In 1994 and 1999, NACRH recommended the incorporation of an occupational mix adjustment into the wage index. To date, NACRH has not proposed a specific change to the definition of labor market areas.

The newest wage index issue to emerge is the use of the hospital wage index to adjust payment levels for skilled nursing facilities and home health agencies under the prospective payment systems created for these providers by the Balanced Budget Act. (The current method for calculating the hospital wage index purposefully *excludes* all salaries and hours attributable to skilled nursing facilities and home health agencies owned by hospitals.)

Commenting on the FY 2000 proposed rules concerning the wage index, MedPAC suggested that unique labor price adjustments are needed for the new prospective payments systems created by the BBA (*Federal Register,* July 30, 1999). MedPAC said that alternative strategies should be explored and offered to assist HCFA in assessing alternatives. HCFA responded by saying that it agrees with MedPAC that "this is an area warranting further attention," but went on to say that the "new prospective systems for skilled nursing facilities, hospital outpatient services, and

[3] ProPAC did not specify a fixed radius that would be used to demarcate labor market areas. It suggested approaches such as including the closest 10 hospitals within a 50-mile radius or all hospitals within a 20-mile radius (expanded to 50 miles, if necessary, to ensure at least three hospitals in each labor market). ProPAC also suggested clustering a predetermined number of hospitals closest to the target hospitals without regard to spatial limitations.

home health agencies will continue to use the hospital wage index data for the foreseeable future." In addition, the wage index affects payment for Medicare+Choice plans, since annual changes in those payments are based on changes in spending in the traditional Medicare program.

The Positions of the American Hospital Association and the National Rural Health Association

Despite its potential impact, correction of hospital wage index problems has not captured the attention of hospital advocacy groups in the same way as elimination of the urban-rural differential.[4] In discussions with HCFA, the American Hospital Association (AHA) has not advocated for material changes in the wage index, saying that it will not commit to a plan in concept but must assess the effect of each specific plan on its members before agreeing to support major changes to the wage index (*AHA News*, July 26, 1993).

In 1992, The National Rural Health Association (NRHA) adopted a policy position to "challenge and correct the injustice" inherent in the wage index calculation. NRHA's *1998 Regulatory Agenda* proposed an occupational mix adjustment for the wage index, stating that "PPS wage indices should reflect the cost of hiring an average mix of employees." These policy positions notwithstanding, the membership of NRHA did not initially rally around the issue of wage index reform for several reasons. First, the issues surrounding the wage index calculation are difficult to understand. Even if they are understood, it is difficult to communicate the problems succinctly to policy makers. Despite agreement on the shortcomings of the wage index, NRHA did not have an alternative to propose. And finally, changes to the wage index will result in a redistribution of payments across rural hospitals.

The redistributive effect of wage index reform is, perhaps, the key reason why AHA and NRHA had not until recently pressed more vigorously for changes in the wage index. Reforms that result in greater payment equity do not ensure that all rural hospitals will receive greater Medicare payments. If some variation of the "nearest neighbor" labor market definition was adopted, for example, greater payment equity would prevail: the amount received by rural hospitals would be a truer reflection of the cost of providing services. Some rural hospitals would receive more money than they currently receive from Medicare, but some would receive less. Others would receive approximately the same amount they currently receive. Dependent on the good will of their members, trade associations and advocacy groups seldom play major roles in lobbying for policies that have a significant redistributive effect on them.

In the past two years both the AHA and the NRHA, along with the Federation of Hospitals and Health Systems, have drawn greater attention to the problems they perceive in the current wage index. In 1998 the AHA formed a special working group that included representation from

[4] When the Medicare Inpatient Prospective Payment System was introduced in 1983, it established separate standardized amounts (national average costs per Medicare case) for urban and rural hospitals. The urban amount was 25.3 percent greater than the rural amount. The urban-rural differential was phased out over five years beginning in 1989.

NRHA, for the purpose of recommending improvements in the wage index. That group recommended a phase-out of the costs related to teaching physicians, residents, and certified registered nurse anesthetists from the wage index calculation, with which HCFA agreed (*Federal Register*, May 7, 1999, p. 24726). The NRHA "Legislative and Regulatory Agenda," its principle vehicle for communicating policy recommendations, has included changing the wage index in each of the past three years. Its more aggressive campaign in 2000, the "Roadmap to a Healthy Rural America," includes wage index changes as a high priority issue (NRHA, 2000).

ENHANCEMENTS TO HOSPITAL WAGE INDEX POLICY

Changes to the Occupation Mix

Congress required HCFA to update the wage index annually beginning with cost reporting periods after October 1, 1993. Congress further required that the update be based on a survey of wages and wage-related costs of short-term, acute care hospitals. To the extent possible, Congress said, the survey should measure the earnings and paid hours of employment *by occupational category* and must exclude the salary costs of providing skilled nursing services. Both ProPAC and NACRH had recommended this change. Although HCFA updates the wage index annually, the update is based on data that is four years old. For example, the wage indices for FY 2000 were calculated on FY 1995 wage and hour data.

Use of a wage survey raises two issues: 1) which costs should be included in the survey and 2) whether the wage index should reflect the relative cost or price of labor. HCFA bases the wage index on the average cost of labor. Over the years, it has attempted to refine the input data. It added fringe benefits to the wage data (FY 1991); included contract labor costs for management contracts in the occupation mix (FY 1995); excluded sub-provider wage data (FY 1994); included contract physician Part A costs in the wage data (FY 1999); and began a five-year phase-out of teaching physician, resident, and certified registered nurse anesthetist labor costs from the wage data (FY 2000). Some of these changes were made on the recommendation of a hospital workgroup established in 1997 by HCFA to address wage index issues.

Advocates have suggested that the language of the Social Security Act requiring adjustments "for area differences in hospital wage levels" implies that the wage index measures differences in the *price* of labor and not the *cost* of labor. HCFA has vacillated on this issue over time. In 1987, HCFA expressed a willingness to take occupational mix into account in calculating the wage index (*Federal Register,* September 1, 1987); in 1989, it announced its intention to collect occupational-mix data (*Federal Register,* September 1, 1989). By 1991, HCFA had decided against making an occupation-mix adjustment to the wage index "at this time" for several reasons (*Federal Register,* June 3, 1991). Among the reasons cited were: the reporting burden on hospitals is heavy; the definition of the optimal mix of occupations (i.e., the market basket) is not known; the desirability of redistributing PPS payments is not clear; the belief that occupation-mix effect may be overstated; and there is uncertainty whether the wage index should properly measure the cost of labor without regard to the mix of employees or the prices paid for labor, holding constant for the mix of employees. HCFA also cites the burden that occupational mix

reporting will place on it and its contractors, pointing out problems with the accuracy of aggregate wage and hour data currently reported by hospitals.

In May 1994, HCFA reported that a group of hospital industry representatives showed little support for developing an occupation mix adjustment that, in their opinion, "creates additional reporting burdens with an unproven or minimal impact on the distribution of payments" (*Federal Register,* May 27, 1994).

Geographic Modifications

In 1988, HCFA promulgated rules allowing hospitals in rural counties adjacent to metropolitan areas (MAs) to apply for reclassification to the adjacent MA's labor market (*Federal Register,* May 27, 1988). Congress institutionalized reclassification in 1989 when it established the Medicare Geographic Classification Review Board (MGCRB). In its first year of operation, the MGCRB reclassified 930 hospitals for FY 1992, an approval rate of approximately 90 percent. Over 75 percent of the reclassified hospitals in the first year were located in rural areas, an amount equal to approximately 28 percent of all rural hospitals. Reacting to the unexpectedly large number of reclassifications, HCFA took steps to establish more restrictive criteria. Under rules established in 1994, the number of reclassified hospital shrank by approximately 60 percent *(Federal Register,* May 27, 1994).

In FY 2000, 441 hospitals (both urban and rural) were redesignated, for the purposes of the wage index, to a labor market with a higher wage index. Most of these redesignations resulted from appeals to the MGCRB, but some resulted from legislation passed by Congress. Congress decreed in the Balanced Budget Act of 1997 (Section 440) that the wage index applicable to any hospital that is not located in a rural area (i.e., is urban) *may not be less* than the area wage index applicable to hospitals located in rural areas of that state. In other words, Congress said that rural hospitals in any given state were to receive the lowest standardized amount paid in the state, regardless of the actual costs incurred by "low-cost" urban hospitals. In FY 2000, 185 hospitals in 39 MAs were affected by this law (*Federal Register,* May 7, 1999).

An additional 33 hospitals were redesignated by the Balanced Budget Refinement Act of 1999. Members of Congress inserted language into the Act making individual hospitals in their states eligible for the higher wage index of a "nearby" labor market area (*Federal Register,* May 7, 1999).

Reclassification from one labor market to another undoubtedly has benefitted certain rural hospitals. It does not, however, speak to the fundamental issues of labor market definition. The issues of labor market size and cross-boundary variation are not addressed. Reclassification makes merely marginal changes at borders of some labor markets.

In 1994, HCFA published its evaluation of 18 different labor market area definitions, including nine nearest neighbor approaches (*Federal Register,* May 27, 1994). Each proposal was compared to then current (FY 1994) MA-based wage indices. A comparison was also made to

the actual FY 1994 wage indices after reclassification. HCFA used three criteria to analyze each of the proposals: 1) wage conformity within labor market areas, 2) wage index conformity across labor markets, and 3) distributional equity improvements. Based on this analysis, HCFA concluded:

> [N]one of the options we initially reviewed were a significant improvement over the current reclassified wage index....[W]e believe that neither revisions to the current MSA-based [sic] system or the nearest neighbors labor market options studied constitute a demonstratable improvement over the current system (*Federal Register,* May 27, 1994).

HCFA also published comments it had sought the previous year on ProPAC's 1993 nearest neighbor wage index proposal. A total of 266 comments were received; 33 were in favor of the proposal; 128 were opposed; and 105 said they would support the proposal if changes were made to satisfy their concerns (*Federal Register,* May 27, 1994). The lukewarm response from the industry to hospital-specific wage indices made it somewhat easier for HCFA to decide to make no substantive changes to the definition of labor market areas.

FUTURE PROSPECTS

The changes Congress and HCFA have made to the wage index system over time likely have improved the fairness of the payment system. They have not, however, addressed substantively the issues of establishing an impartial market basket of occupational titles upon which to base the wage index or of redefining labor markets. The primary policy questions in regard to the hospital wage index are: 1) whether the marginal changes that have been made to the wage index over time obviate the need for more substantive reform, 2) whether equity in payment should be the primary objective, regardless of the effect on certain hospitals if changes are implemented in a "budget neutral" environment, and 3) whether the hospital wage index is the appropriate tool for measuring geographic variation in labor inputs for skilled nursing facilities and home health agencies.

To answer these policy questions, new policy research needs to be conducted. The occupational mix studies upon which advocates rely were conducted a decade ago. At that time, the *average* effect on rural hospital payments was approximately two percent. Since then, there have been changes in the collection of wage and hour data. Do those changes affect the payment differences between rural and urban hospitals? Studies are currently underway at the University of North Carolina Rural Health Research Program that will help answer that question (Dalton, 2000).

HCFA's 1994 analysis of various labor market alternatives was extremely thorough, but neither a complete report nor the data upon which conclusions were based were shared with the public. For example, HCFA reported that if labor markets were defined as being composed of the ten nearest hospital neighbors (with a minimum of two), 51.5 percent of hospitals would see a reduction in their wage indices. Further, 14.3 percent (749 hospitals) would see their wage

indices decline by more than ten percent (*Federal Register*, May 27, 1994). What the HCFA analysis did not point out is where, on an urban-rural continuum, these hospitals were located. No studies of the effect of changes in labor market areas have been conducted since HCFA's analysis.

Because changes to the wage index will result in a redistribution of payments in a budget-neutral environment, some advocates have urged Congress to add new money to address the problem. Senator Charles Grassley has introduced legislation (S.2828) that would apply the wage index to *each hospital's actual proportion of labor-related cost.* The payment system currently uses a uniform labor-related cost proportion of 71 percent. That is, 71 percent of the standardized amount is attributable to labor costs.[5] Senator Grassley's proposal is estimated (using 1996 hospital cost report data) to cost Medicare an additional $230 million in the first year. No payment simulations have been performed on this proposal to estimate the distribution of payments that will occur.

Clearly, informed policy-making requires a greater understanding of the effect of the area wage index on rural providers. Research needs to be conducted using the most recent data available. Now is an appropriate time to revisit the issue of the hospital inpatient wage index, if for no other reason than it will be used to adjust payments for the hospital outpatient, skilled nursing facility, and home health care prospective payment systems.[4] Failure to re-examine the policy and process of the wage index calculation may result in payment inequities for new free-standing PPS providers, and may exacerbate the financial problems of rural hospitals that have diversified into skilled nursing and home health. Medicare+Choice plans are also affected because changes in the payment for Medicare+Choice plans are based on a national average rate adjusted for local prices using the wage index.

MedPAC is a particularly good forum for considering changes to the wage index system. First, it recognizes the need to modify the wage index system, at least as it is used for skilled nursing facilities and home health agencies. Second, MedPAC has been charged by Congress, in the BBRA, to complete several studies related to financing health care services in rural areas. A thorough examination of the wage index calculation is a logical component of those studies.

Rural Commissioners should urge MedPAC staff to study labor market area issues and to make *specific* recommendations. In turn, MedPAC should recommend to Congress, if appropriate, that steps be taken to improve the wage index. MedPAC presents the best opportunity for a neutral third-party to revisit the issue of area wage index construction and to recommend methods for improving it.

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[5] See Rural Policy Brief "Calculating and Using the Area Wage Index of the Medicare Inpatient Hospital Prospective Payment System" (PB2000-5, June 2000) for more information.

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