AHA Medicare Area Wage Index Task Force principles and recommendations from its draft final report – not for general distribution --

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Wage Index Principles
Taking into account its major concerns about the wage index, as well as other important considerations, the Task Force had a broad discussion of principles for the hospital field to use in evaluating and recommending for changes to the Medicare AWI adjustment. The Task Force agreed on the following principles:

1. Comprehensive reform of the wage index is absolutely necessary.

The wage index is applied on a nationwide basis, which the Task Force agrees is appropriate. However, the nationwide application of the wage index has exposed critical deficiencies in the current system that already have created and may lead to the creation of further inequities. The wage index no longer adequately addresses its intended purpose. Thus, the system needs comprehensive reform that addresses problems with, for example, data accuracy and consistency, large year-to-year changes in wage indices, and the current labor markets and system of reclassifications and exceptions.

2. Wage index reform must be implemented in a transitional and budget-neutral manner.

It is clear that, in today's fiscal environment, wage index reform will be budget neutral and, therefore, re-distributional. Because the wage index affects such a large portion of hospital payments, reform must be gradually phased-in to ensure hospitals do not have excessive changes in their payments from year to year.

3. The wage index should reflect, as accurately as possible, relative differences in the labor costs hospitals face in a market area.

Accuracy is a vital component of a successful wage index system. However, absolute accuracy will never be possible and hospitals should not let "the perfect be the enemy of the good."

4. The wage index data and methodology should be as consistent, easy to administer, transparent and as understandable as possible.

The data collection, review and calculation process should be as uniform, standardized, simple and understandable as possible to promote equitable and accurate wage indices across the nation. The calculation and development of each year's wage index should include an appeals process to ensure hospitals have the opportunity to correct any data errors.

5. The wage index system should minimize large year-to-year volatility in individual hospitals' wage index values.

To recruit and retain a stable and experienced workforce, hospitals need to pay stable wages from one year to the next. The wage index should be relatively predictable from year to year so that hospitals may make compensation and staffing plans.

6. The wage index should seek to minimize circularity and, thereby, seek to limit the possibility of creating unjustifiably large differences between the highest and lowest wage indices.

While variation in wage indices will exist by definition, the system should seek to minimize the problem of circularity, such as hospitals with low wage indices being unable to increase wages to become competitive in the labor market.

7. While certain adjustments to the wage index may be necessary to accurately capture differences in labor costs across hospitals, the current system of reclassifications and exceptions are unacceptable.

The current system of reclassifications and exceptions is burdensome, costly and often leads to anomalous results.

8. The wage index system should account for the fact that labor markets cannot realistically be defined as hard boundaries.

Under the current system, labor markets are treated as hard boundaries, meaning there can be substantial differences in the wage indexes of neighboring hospitals that are located near each other but are separated by a labor market boundary. This has, in part, led to the numerous exceptions to the basic calculation that have been incorporated in the system. Yet, at some wage levels, workers can be enticed across market boundaries to work at hospitals in other labor markets. Acknowledging and accounting for these circumstances is critical.

9. The wage index system should use labor markets that are defined broadly enough to encompass all hospitals competing for the same workers, but narrowly enough to avoid encompassing hospitals with wage costs that vary widely.

In moderate- to large-sized states, the statewide rural labor market often includes hospitals that are geographically far apart and that have wage costs that vary widely. While any set of administrative market boundaries, especially boundaries set according to a national formula, will be imperfect, defining labor markets as appropriately as possible will promote accuracy.

Wage Index Recommendations

The Task Force held extensive discussions of potential recommendations to reform the wage index. They agreed that it is unlikely that any set of recommendations would completely "fix" the wage index system for the hospital field. However, they felt very strongly that there are specific recommendations that would categorically improve the system for the field as a whole. The set of recommendations below helps address the Task Force's major concerns about the wage index, and stems from the principles outlined above. The recommendations, if implemented, would improve the wage index by eliminating the current system of reclassifications and exceptions and replacing it with commuting and smoothing adjustments based on up-to-date data. Doing so would balance the need to eliminate the burdensome, confusing and sometimes anomalous reclassification system with the need to acknowledge that labor markets cannot realistically be defined as hard boundaries. The recommendations also would improve the consistency of the wage index data, limit the amount of volatility in the improved system, ensure that there is an adequate transition from the current to the improved system, and decrease the problem of circularity.

Therefore, the Task Force makes the following recommendations on the inpatient hospital wage index (including the Puerto Rico wage index):

1. To improve the accuracy and consistency of the wage index, CMS should designate one FI/MAC to complete all wage index data collection and processing.

Centralizing wage index work will help eliminate differences in the collection and/or processing of the data that underlie the wage index and ensure consistent application of definitions, methodologies, rules and interpretations, thereby improving accuracy and consistency.

2. To ensure wage index reform does not cause sudden and extreme fluctuations in hospital payments, Congress should phase-in reform using a transitional period of at least five years.

As stated above, in today's environment of fiscal pressures, wage index reform will be budget neutral and, therefore, re-distributional. An adequate transition from the current system to the reformed system is important to ensure that changes in hospitals' wage indices are moderated. In a five-year transition, hospitals' wage indices in year one would be calculated as 80 percent of their wage index under the current methodology and 20 percent their wage index under the Task Force's methodology; year two would be 60 percent current methodology and 40 percent Task Force methodology. This would continue until year 5, in which hospitals' wage indices would equal 100 percent of their wage index under the Task Force's methodology. It is important to note that the Task Force generally felt a five year phase-in balanced the need to move quickly to a reformed wage index while allowing enough time for providers negatively affected to transition to the new system. However, a few Task Force members wanted a shorter transition period, such as three years or less.

3. To help limit year-to-year volatility in individual hospitals' wage indices, Congress should include all hospitals and hospital distinct-part units paid using the inpatient PPS wage index, including inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals, in the wage index data set.

Increasing the size of the dataset will decrease the amount of volatility hospitals experience in their wage indices. Including data from all hospitals paid using the inpatient PPS wage index is appropriate because these other hospital types both compete with PPS hospitals for labor and also see their payments adjusted using the pre-reclassification inpatient PPS wage index. While the Task Force also discussed the possibility of including CAHs in the wage index data set, they were concerned that, because CAHs do not see their payments adjusted using the wage index, their wage data may not be fully complete.

4. To ensure that hospitals do not experience excessive year-to-year volatility Congress should institute budget-neutral 3 percent stop-loss and stop-gain policies that would limit the amount by which a hospital's wage index could decrease or increase in a single year. These policies should apply both during and after the five-year transitional period.

Stop-loss and stop-gain policies would mitigate extreme wage index decreases and increases, and, thereby, improve the stability of hospital wage indices from year-to-year. Implementing both stop-loss and stop-gain policies could minimize or possibly eliminate the impact of the budget neutrality adjustment necessary for this policy.

5. To decrease the problem of circularity, Congress should increase wage indexes that are less than 1.0 using an exponential methodology similar to what is done with the geographic adjustment factor currently used by CMS in adjusting capital payments.

Puerto Rico wage indexes should be increased to, the lowest pre-reclassification wage index outside Puerto Rico (which in FY 2013 is 0.6797). The Task Force found that the use of only hospital data could lead to the problem of circularity. In small and medium-sized markets in particular, low wage index hospitals may face difficulties in being able to increase wages to become competitive in the labor market. Raising all wage indices of less than 1.0 to the power of 0.6848 would, in effect, compress wage index values up towards 1.0 and help combat the problem of circularity.

It is critical to note that, while most Task Force members supported this recommendation, several were strongly opposed to it. They were troubled by the arbitrary nature of the methodology. They also felt that its use did not improve the fairness and accuracy of the wage index because the methodology was not empirically justified – there is no evidence available to show that wage index values of less than 1.0 are inaccurate, do not reflect the wages paid by those hospitals, and should be artificially increased. Finally, these members were concerned about the size of the

budget-neutrality adjustment and re-distribution necessitated by this methodology and felt that it was excessive.

6. Congress should eliminate the current system of reclassifications and exceptions, except when reclassifications are done in a non-budget-neutral manner, and replace it with a wage index out-commuting adjustment, together with a 10 percent smoothing adjustment.

Developing a single wage index to accurately capture differences in labor costs across hospitals is a complex task. In certain circumstances, there may be substantial differences in the wage indexes of neighboring hospitals that are located in different market areas, but that compete with one another for labor; this could, in turn, lead to the need for an adjustment. However, the current system of reclassifications and exceptions is unacceptable and should be eliminated, except when reclassifications are done in a non-budget-neutral manner.[2] It should be replaced by an out-commuting adjustment, which more accurately and fairly addresses workforce competition across adjacent market areas, and which accounts for the fact that labor markets cannot realistically be defined as hard boundaries. Although both in-commuting and out-commuting adjustments moderate wage index differences across labor markets in a budget-neutral manner, an out-commuting adjustment tends to raise wage indices, while an in-commuting adjustment tends to lower them. Thus, hospitals' perception of an out-commuting adjustment is likely to be more positive. Implementing a 10 percent smoothing adjustment after application of the out-commuting adjustment will ensure against substantial differences in the wage indexes of neighboring hospitals that are located in different market areas, but that compete with one another for labor.

One Task Force member felt the out-commuting and smoothing adjustments should be implemented by adjusting wage indices on both sides of the relevant labor market borders – i.e., the low wage index should be raised, but the high wage index also should be lowered. This member was concerned that a large budget-neutrality cut will be required to finance all the Task Force's recommendations combined. Implementing the out-commuting and smoothing adjustments by adjusting both sides of the labor market

[2] If hospitals obtain special rural hospital status through Section 401 reclassifications, such as sole community hospital status, that status is not budget neutral. If hospitals solely obtain a different wage index through Section 401 reclassifications, however, that different wage index is applied in a budget neutral manner. Therefore, under this recommendation, Section 401 reclassifications would be eliminated when solely used to obtain a different wage index, but not when used to obtain special rural hospital status.

border would minimize or eliminate the budget-neutrality adjustment necessary for this policy.

7. Congress should require the use of up-to-date data on hospital-specific commuting patterns to administer the out-commuting adjustment.

It is essential that the out-commuting adjustment be based on up-to-date data. Collecting these data on a hospital-specific basis will allow the labor markets used in the wage index, particularly the statewide rural areas, to be refined and help ensure that they are defined broadly enough to encompass all hospitals competing for the same

workers, but narrowly enough to avoid encompassing hospitals with wage costs that vary widely.

Conclusions

Over the past year, the Task Force has engaged in an extraordinary amount of education, analysis and discussion about the AWI system. Throughout that process, Task Force members overwhelmingly agreed that the current system is greatly flawed in many respects and that its fundamental problems warrant a full and comprehensive reevaluation.

They also agreed that there was no one solution that would completely "fix" the wage index system for the entire hospital field. However, by not letting the "perfect be the enemy of the good," they were able to make a set of principles and recommendations that help address their major concerns about the wage index. Implementation of these recommendations will require both congressional and administrative action and resources and time for data collection and analysis. Some could be implemented relatively quickly, while others would take more time. But taken together, the Task Force's principles and recommendations will improve the accuracy, fairness and effectiveness of the hospital AWI.