Dear Colleague:

As you know, the AHA Board of Trustees has been examining an issue of great importance to the hospital field: improving the accuracy, fairness and effectiveness of the Medicare area wage index (AWI). At its recent meeting, your AHA Board adopted a set of principles and actions on the AWI to address concerns about what many – hospital leaders and policymakers alike – consider a deeply flawed formula.

I want to share the process and the actions the AHA Board adopted. These actions are the result of one of the most exhaustive policy development processes undertaken by the AHA in recent memory.

**Process:**

In July 2011, the AHA Board created the Medicare Area Wage Index Task Force to identify and evaluate the strengths and weaknesses of the current AWI; develop a set of principles by which to evaluate various proposals to modify the AWI; evaluate public policy proposals and studies to change the AWI; and make recommendations to improve the AWI. The task force’s report and recommendations were shared with the AHA’s Regional Policy Boards and Governing Councils on multiple occasions during their development.

In addition, the task force report, along with supporting materials, was shared with the entire AHA membership. As part of the process, AHA members also were provided with the specific financial impact of these proposals on their organizations based on modeling that was deemed to be accurate by an independent expert consultant.

At its April meeting, your Board determined that more feedback from the membership would be beneficial. The Board authorized the creation of a review committee, the Area Wage Index Advisory Review Committee (AARC), composed of members of both the Board and the task force. It charged the AARC with conducting a July 11 open session for interested hospital and health system members and state, regional and metropolitan hospital associations to comment on the task force’s recommendations and their projected impact; and providing a recommendation to the board for the disposition of the report. More than 60 members attended the July 11 session, and more than 20 members provided specific input. In addition, about 30 members submitted written comments for the AARC’s consideration. Moreover, three independent expert consultants were asked to provide their views of the task force recommendations. All of these comments were made available to the AHA membership for their review.
**Actions:**

After consideration of the remarks made at the open forum, written comments received, and deliberations among committee members that also noted the opinions of the outside experts, the AARC made a set of recommendations, which the AHA Board adopted.

Your Board recognizes that any changes to the AWI will have various effects for all hospitals. While there was a lack of field consensus about the task force’s draft recommendations and report that would maintain the field unity necessary for effective advocacy of these changes, the AHA Board also recognizes that the status quo is not sustainable for hospitals with low wage indices and urges action to address this issue.

That is why the AHA Board adopted the following recommendations:

- Amend the report’s principles and use them to guide AHA’s comments on proposed changes to the AWI in the future. (Attachment A reflects the revised principles.)

- Release the task force report with a cover letter explaining the Board’s changes, identifying key areas that lack field consensus and noting that the report is intended to add to the public policy discussion about AWI reform similar to the release of reports by the Centers for Medicare & Medicaid Services (CMS), the Institute of Medicine, and the Medicare Payment Advisory Commission.

- Take four interim action steps:

  1. Immediately advocate for a task force recommendation that CMS should designate one fiscal intermediary (FI)/Medicare administrative contractor (MAC) to complete all wage index data collection and processing to improve the accuracy and consistency of the wage index.

  2. Support CMS’s planned implementation of regulatory changes based on 2010 census data to the core-based statistical areas (CBSAs) that are used to delineate AWI labor markets. CMS plans to implement these changes in the Medicare Inpatient Prospective Payment System rule setting rates for fiscal year (FY) 2015. The changes will affect wage index values because some rural counties will become part of CBSAs; some urban counties will become part of statewide rural areas; and some CBSAs will be combined or get split apart.

  3. Develop and advocate for a policy that does not allow the spread between the highest and lowest wage index values to increase—for at least three years—after these census changes are adopted in FY 2015. After three years, conduct an evaluation of the consequences of the policy.
AWI data show that the gap between the highest and the lowest wage index values has widened over time. For example, in FY 2002, the difference between the lowest and highest post reclassification values was 107 percent. By FY 2012, the difference had grown to 134 percent. The AARC believes that the spread should not be allowed to expand for at least a three-year period so that the percentage difference between the highest and lowest AWIs remains the same. Prohibiting expansion of the spread can be accomplished, while at the same time requiring that hospitals with the lowest wage index values not experience further declines in their AWIs.

4. AHA staff also should explore the use of alternative data sources for calculating the AWI. AHA should engage with CMS on building a new and better data source, and with the Bureau of Labor Statistics (BLS) to explore the use of its Occupational Employment Statistics (OES) survey and to suggest improvements to the survey that could make it a useful data source for purposes of the AWI.

I would like to thank all of the members who provided input into this process, whether through the governance process, the special July 11 open forum or through your letters and emails. I especially want to thank the members of the task force and the review committee for their tireless and thoughtful examination of this issue.

Although there was a clear lack of field consensus about the task force report and recommendations as a whole, the exhaustive process has yielded strong guidance on policy actions the AHA can take to improve the AWI.

The hospital field faces many challenges and opportunities on a variety of issues in the coming years. Facing them together makes us stronger as we work to fulfill our mission of caring for patients and communities.

Please don’t hesitate to contact me if you have any questions.

-Rich
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 changes to the Medicare AWI adjustment. The AHA Board adopted the following principles based on the work of the Task Force and the AARC.

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, unless there is new money available.

It is clear that, in today’s fiscal environment, wage index reform will be budget neutral and, therefore, redistributational. However, if that assessment changes, new money could be pursued to mitigate the impact of changes. 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 total labor costs hospitals face in a market area.
Accuracy is a vital component of a successful wage index system. Labor costs should be as complete as possible including salaries and wages of hospital employees as well as benefits, agency costs, contract labor costs, and all other relevant labor costs for operating an institution. Each hospital faces different realities about the type of labor needed in a market. 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 the creation of unjustifiably large differences between the highest and lowest wage indices.

Three factors contribute in unintended ways to the increasing spread between the highest and lowest wage indices. One is that an individual hospital’s wage data, especially in markets with only one or a few hospitals, may influence its own wage index value. Another is that a low wage index hospital can be caught in a downward spiral because it does not have the funds it needs to raise its wages at a rate competitive with other hospitals nationally; as a result, its wage index continues to decline. These two factors constitute a phenomenon referred to as “circularity” which arises due to the
nature of an index methodology. Lastly, reclassifications also can contribute to the difference between the highest and lowest wage indices.

7. While certain adjustments to the wage index may be necessary to accurately capture differences in labor costs across hospitals, the revised system should minimize the need for reclassifications and exceptions.

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.