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**Statement for the Record
of the
American Hospital Association
for the
Institute of Medicine**

**Meeting of the Board on Health Care Services
Geographic Adjustment Factors in Medicare Payment Commission**

September 16, 2010

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record. The Secretary of Health and Human Services, Kathleen Sebelius, commissioned the Institute of Medicine (IOM) to conduct a study on the data and factors related to Medicare geographic payment adjusters, including the hospital wage index. The AHA agrees that the wage index is not functioning optimally and alternatives should be considered. Thus, we would like to describe some of the broad principles that we feel should be used in developing, evaluating, and implementing changes in the Medicare wage index.

First, it is important to implement hold-harmless or transitional provisions when any wage index modifications are implemented. If additional funding is not added to the base, budget neutrality will penalize hospitals by carrying forward the adverse impact of the present wage index adjustment. Put differently, if revisions to the wage index are made without additional funding, they will simply redistribute the deficiency rather than eliminate it. The need for this funding is highlighted by the overall underfunding of Medicare inpatient and outpatient services. In aggregate, Medicare pays less than the cost of caring for America's seniors – covering only 93 percent of costs in 2008.

We also believe it is important for the wage index itself to be as accurate as possible by ensuring that both hospitals and Medicare are able to use consistent definitions, methodologies, rules and interpretations for the acquisition and application of wage data. When hospitals have compared the collection and processes of different fiscal agents used by Medicare, they have found



differences in the collection and/or processing of the data that underlies the wage index. A uniform and standardized process is needed to promote equity across the nation. At the same time, it is critical that there continue to be an exceptions process for hospitals with labor costs atypical for their local area or for local areas compared to other areas. Developing a single wage index to accurately capture differences in labor costs across hospitals is a complex task and likely to understate the costs in some areas. The continuation of an exceptions process, including reclassifications, would allow hospitals in areas with misrepresentative indices to seek redress.

In addition, we want to describe some of the fundamental concerns we have related to the data used to calculate the wage index and to the design of the wage index geographic areas.

DATA SOURCE

We have concerns that the Centers for Medicare & Medicaid Services' (CMS) Medicare cost reports, which currently are used to determine wage index values, may be an inaccurate measure of actual labor costs. Others, including the Medicare Payment Advisory Commission (MedPAC) in its research on the wage index, have considered the use of Bureau of Labor Statistics (BLS) data as an alternative to the hospital-reported cost report data. The BLS approach may offer significantly less reporting burden for hospitals; however, there are critical differences between the two data sets that must be carefully evaluated, as using a new data source would represent a fundamental change to wage index construction. While the BLS process may produce data estimates appropriate for the statistical reports issued by the BLS, we are concerned that more valid and precise information is needed for the hospital wage index, which is used to distribute billions of dollars in Medicare payments. Key differences between the CMS and BLS methodologies include:

- **Inclusion of non-hospital employers** – Hospitals employ workers who have occupational titles that may be used by other types of employers; however, hospitals often have special credentialing or qualification requirements for employees that are not required by other employers. Using data from hospitals only to set the wage index helps assure consistency in comparisons. However, the BLS wage data for a particular occupation are collected from *all employers*, not just short-term, acute-care hospitals participating in Medicare. Wage rates, however, vary depending on the type of employer (hospital, nursing home, physician office, insurance company, university, etc.), and the mix of employers varies by market. Thus, wage rates will be influenced by the specific mix of hospital vs. non-hospital employers of the same occupations. Consequently, the BLS data may not be an accurate reflection of labor costs experienced by hospitals in communities with a higher proportion of other types of health care organizations.

In addition, section 1886(d)(3)(E) of the *Social Security Act* specifies that the wage index must be based on data from “subsection (d) hospitals.” The BLS data set would need to be altered to remove the wages and hours for non-inpatient prospective payment system (PPS) providers to satisfy this requirement, or the law would have to be changed to accommodate the use of BLS data.

- **Different treatment of certain types of personnel in wage data collection** – Wages paid by companies that offer temporary employees to health care providers are included

in the BLS sample. Thus, contract workers are included. However, their wages reflect the lower rate that the employees are paid *by* the agency as opposed to what the hospitals pay *to* the agency for the contract workers. Failure to incorporate the costs of labor provided by a third-party organization would undermine the consistency of the information used to establish the index.

In addition, there are employee wages included in the current CMS data that are not included in the BLS data, such as Part A physicians' time unrelated to medical education. This may materially affect wage estimates in areas with a high penetration of teaching hospitals, particularly those that have provider-based clinics where employed physicians provide care not associated with teaching residents.

- **Process to review/verify data** – The Medicare wage index has a significant impact on the amount of payment hospitals receive in the inpatient prospective payment system. In order to assure that the adjustments made by the index are correct, hospitals must be able to examine and verify the data used to construct the index. However, unlike CMS' public process for review and correction of wage data at the hospital level, BLS has a strict confidentiality policy that ensures that the sample composition, lists of reporting establishments and names of respondents are kept confidential. Hospitals would be unable to verify the accuracy of the data.
- **Not designed to capture differences in wage growth between geographic areas** – Every six months, BLS surveys 200,000 establishments ("a panel"), building the full sample of 1.2 million unique establishments over a three-year period. The data collected at each of these different points in time is combined on a rolling basis to create the annual estimate.

Before estimates can be released, the five previous panels must be adjusted to the current reference period. This is done using a "single national estimate" of wage growth for broad occupational divisions called the *Employment Cost Index*. This approach fails to account for any differences in wage growth between markets over the three-year period. As BLS notes, "*This procedure assumes that there are no major differences [in wage growth] by geography, industry, or detailed occupation.*"

- **Pay-period rather than full-year data** – While CMS collects wage data for a 12-month period, the BLS survey captures only two payroll periods per year – one in May and the other in November – each capturing data from one-sixth of the total number of sampled establishments. (As noted above, data from six panels – with one survey every six months – are combined on a rolling basis over a three-year period to create the annual estimate.)
- **BLS excludes the cost of benefits** – According to the AHA Annual Survey, benefits represent more than 20 percent of hospitals' labor costs nationally. Looking across states, this percentage varies from a low of 16 percent to a high of 23 percent. Therefore, any adjustments made to include benefit costs would have to be market-specific. If benefits information is to be added, it would have to be collected on CMS' Medicare cost

report in order to adjust the BLS data. This would negate the potential benefit of eliminating the collection of hospital-specific wage data.

- **BLS excludes pay counted by CMS** – The BLS data excludes shift differentials, overtime pay and jury duty – all of which CMS includes. Overtime pay can be a cost associated with local labor shortages and shift differentials can vary as well, depending on local labor market conditions.
- **Full-time and part-time employees are equally weighted** – While CMS collects both wages and hours, BLS collects a count of workers within a series of wage ranges. The survey makes no distinction between full-time and part-time workers in estimating wage rates from the data collected. To the extent that the use of part-time versus full-time workers varies by market or type of employer, this could distort the wage calculation if part-time hourly wages are lower than full-time wages.
- **Data subject to sampling error** – Estimates using a sampling methodology like the BLS approach are going to be less reliable than using the entire universe of PPS hospitals, as is done by CMS. Both surveys would be subject to non-sampling error (e.g., errors from respondents providing incorrect data). However, the CMS process allows for extensive public scrutiny of the data while the BLS approach does not.

GEOGRAPHIC BOUNDARIES

We also are concerned that many of the current wage index geographic boundaries are unrealistic and their structure creates “cliffs” where adjacent areas have very different indices. Specifically, the current wage index methodology, with the exception of some commuting pattern adjustments, assumes that there is no inter-relationship between areas. By simply being on opposite sides of a geographic boundary, two hospitals can have very different reimbursement, even though they are competing for the same workforce. More refined areas – as in MedPAC’s proposal to vary wage indices by county – may be more realistic and less arbitrary. On the other hand, the “smoothing” approach, whereby wage index values or wages of neighboring areas are artificially constrained to allow only a 10 percent difference in wage indices, may mask actual variation in wages between areas. For example, there may be real, greater differences between outlying counties and an urban core.

In addition, MedPAC proposed to use the decennial Census to determine variation between the counties. So, MedPAC would use the 2000 Census data to establish the relationship between counties within a metropolitan statistical area until the 2010 Census is available. Using data this old may create differences in wage indices that are inconsistent with the actual difference experienced in wages.

Single rural area wage index. While a single wage index for all rural areas of a state may be reasonable for small states, we are concerned that it may not adequately reflect wage variation in large states. While varying the wage indices within rural areas may make sense, we recommend further examination of MedPAC’s approach as to whether the decennial census data produce accurate estimates of current area wage differences.

Year-to-year volatility. To recruit and retain a stable and experienced workforce, hospitals need to pay stable wages from one year to the next. Volatility in wage indices from one year to the next makes it difficult for hospitals to estimate Medicare payments for budgeting purposes. While the three-year rolling average employed by BLS may reduce volatility, alternative approaches should be examined, including those that do not rely on BLS data.

We look forward to a full discussion of possible changes to the wage index and appreciate IOM's and CMS' consideration of these issues in the meantime.