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HHS Proposes Changes to the Medicare Wage Index System

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Medicare, like any large organization or business, has long known that labor costs vary across the nation. For example, a small community may lie less than 20 miles from a large metropolitan area, but the two are likely to be worlds apart when it comes to what the average health care worker in each city is paid. Which only makes sense—after all, it typically costs quite a bit more to live in a city of three million people than it does in a community of only 20,000.

So, to ensure equitable reimbursement rates across a range of geographies whose labor costs vary, Medicare uses a wage index system to adjust the labor portion of its payments to providers. Currently, that index is calculated by taking the average hourly wage (AHW) paid by hospitals within a geographic area and dividing it by the national AHW.

But under a new proposal, that method of calculation would

change—in a way that could impact hospitals across the spectrum.

The impetus for change stems from the Affordable Care Act, which required the Department of Health and Human Services to develop a comprehensive plan to reform the Medicare wage index system. HHS submitted its plan to Congress on April 11, with recommendations to abandon the current method of calculation, which uses core-based statistical areas (CBSAs) and metropolitan statistical areas (MSAs), in favor of a commuting-based wage index (CBWI). HHS and CMS believe the change will allow for greater accuracy in accounting for a hospital's true cost of labor.

CMS is proposing that the CBWI be calculated for each hospital by weighting the AHW of the hospital's employees based on their home ZIP code, which will yield a hospital-specific AHW. The hospital specific wage index will then be calculated by dividing the hospital-specific AHW by the national AHW.

What could this mean for your hospital? Simply put, your wage index would be based on where your employees live rather than where they

work. In addition, each hospital would have its very own wage index rather than a wage index value applied to all hospitals within a given geographic area. The hospitals most impacted by the change would be those whose employees live outside the area where the hospital is located. HHS has also taken the step of outlining what it perceives to be the advantages and concerns of adopting a CBWI.

Advantages

Under the current wage index system, more than a third of DRG hospitals nationwide reclassify to another CBSA to optimize their reimbursement. Reclassifications are generally applied for through the Medicare Geographic Classification Review Board or are automatic if the hospital resides in a “Lugar” county. Named after Indiana senator Richard Lugar, a proponent of the 1987 law that sought to correct the Office of Management and Budget’s (OMB) classification system for the hospital labor market, Lugar reclassifications are automatic and occur when a county is adjacent to another CBSA and the commuting pattern to that CBSA would assign the hospital to a single CBSA under OMB rules.

Hospitals can also enhance their wage index value through an “out-migration adjustment” based on certain factors. Outmigration adjustments allow for wage index blending for counties in low wage index areas based on the number of county residents who commute to higher wage index areas.

CMS anticipates that the accuracy of the CBWI will allow for the elimination of all geographic

reclassifications. Wage index reclassifications are an area of great scrutiny, and phasing them out is a priority objective for CMS.

Concerns

The first issue HHS anticipates having to confront is the availability of accurate and timely commuting data. For one thing, if the CBWI is accepted by Congress, CMS believes a new reporting mechanism will be necessary to capture employee home ZIP codes. And for another, employee specific information will need to remain confidential and not be an administrative burden on providers.

The second issue involves the potential for providers to change their hiring patterns to optimize their wage index. Since the CBWI will calculate a weighted AHW based on an employee’s home ZIP code, this may give a provider an incentive to direct its recruiting efforts at specific areas, especially in populous metro areas, to optimize its AHW. Despite the concern, CMS believes any change in provider behavior wouldn’t be any greater than steps taken to reclassify in the current environment and could be mitigated by federal policy.

The third issue centers around the impact of the CBWI on other Medicare payment systems, such as those for skilled nursing facilities and home health agencies. This has not yet been determined.

Looking Ahead

As usual, CMS expects the wage index process to be budget neutral. Therefore, some providers will gain while others will lose in the transi-

tion. HHS proposes to shift to the CBWI in a manner that will give providers adequate time to adjust to the change in reimbursement.

While the use of the CBWI to establish a hospital-specific wage index is only a proposal at this point, wage index reform in its entirety has been a top priority for CMS and Congress. All providers should begin the process of evaluating their data collection methods and analysis in this area and continue active dialogues with their lobbying groups and legislators.

We’re Here to Help

Moss Adams LLP will continue to keep you informed of new developments regarding the wage index and other financial and operational issues vital to the well-being of your organization. In the meantime, for more information about this and other health care topics, please contact your Moss Adams Health Care professional.

Cheryl has built her experience in the health care field since 1981. She specifically focuses on various Medicare and Medicaid reimbursement issues and related billing and coding issues. Her experience includes project management for operational issues, organization structures, work standards and third-party reimbursement issues. Cheryl has also worked with health care providers on graduate medical education programs, compliance with CMS’s provider-based requirements, such as signage, attestations, and certification and licensure of the provider-based departments in conjunction with the applicable state departments. In addition,

she provides client support during Medicare and Medicaid audits and appeals. Cheryl works closely with hospitals in various states on their payment and funding issues, which include services such as wage indices and geographic classifications and reclassifications.

Paul has been in public accounting since 2006. His experience includes providing audit and consulting services to numerous types of health care organizations, including long-term care organizations. Paul has extensive experience with not-for-profit and governmental health care organi-

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