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Area Wage Index Update

Enhancing your Wage Index Value and Medicare Reimbursement

Healthcare Summit 2018:
Simplifying Healthcare

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Agenda

- Introduction
- Defining Medicare Area Wage Index
- Worksheet S3 part II, III, IV Reporting
- Occupational Mix Survey
- Geographic Reclassifications and RRCs
- FFY 2019 CMS Proposed Rule highlights and FFY 2020 Timetable

Defining Medicare Area Wage Index

- Adjustment factor used in Medicare prospective payment system to account for variable labor costs across the country
  - Average of 1.0000
  - Highest Santa Cruz CA 1.9046 – Lowest, Rural AL, 0.6701
- Factor is based on the average hourly wage (AHW) of **inpatient acute-care** hospitals, and it's composite core-based statistical area (CBSA)
- CMS uses IPPS AWI data to calculate the portion of Medicare payments made to other types of providers:

SNF	HHA	Hospice	IRF
IPF	LTCH	Hospital OPPS	

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Defining Medicare Area Wage Index

Medicare cost report worksheets contain this data

- S-3 part II, III and IV
- A Costs
- A6 reclassifications
- A81 related organization, home office
- A82 physicians

Data is updated each year

Generally, the higher your hospital's AHW on w/s S3 part II, the higher your AWI factor – but not always….

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Defining Medicare Area Wage Index

- All hospital's in a Core Based Statistical Area (CBSA) combine their AHW data and in generally share the same AWI factor - Metropolitan and Rural areas
- Exceptions are made for geographic reclassifications and other statutory exemptions

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Defining Medicare Area Wage Index

Hospital's Average Hourly Wage (AHW)

Salaries and Paid Hours

- Hospital employees
- Home Office & Related Organizations
- Physicians

Contract Labor

- Direct patient care
- Admin & General, Housekeeping, Dietary

Wage Related Costs (Employee Benefits)

Additional CMS Adjustments

- Occupational Mix Factor
- Mid-Point mark up factors
- Budget neutrality

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Defining Medicare Area Wage Index

Average Hourly Wage (AHW)

- Computed on hospital's cost report worksheets S3 part II and III
- Final AHW reported on CMS final rule in annual Federal Register update
  - CMS = Centers for Medicare and Medicaid Services
- Cost report AHW vs. Federal Register AHW rarely agree
  - Due to various post-cost report adjustments

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Defining Medicare Area Wage Index

Core Based Statistical Areas (CBSA)

- Generally the metropolitan areas and rural areas in the country
- Currently 509 CBSAs
- Each CBSA has its own AWI factor, based on the composite AHW of its hospitals
- Hospital’s within a CBSA should coordinate to optimize its CBSAs AWI

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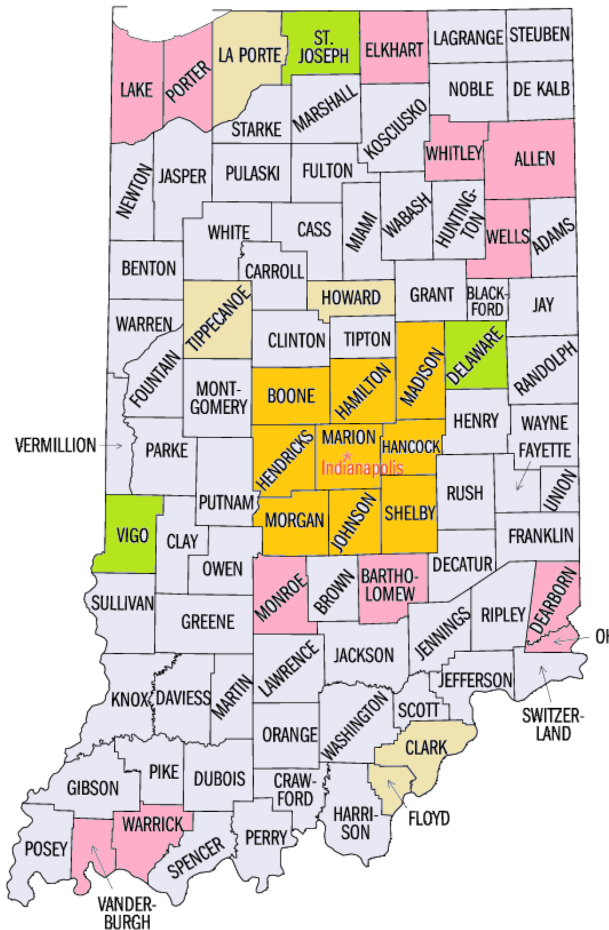
CBSAs Concept – Indiana Example



CBSA #	CBSA Name	# Hosp in CBSA	# Hosp in State
15	Indiana	15	15
14020	Bloomington, IN	2	2
17140	Cincinnati, OH-KY-IN	18	1
18020	Columbus, IN	1	1
21140	Elkhart-Goshen, IN	2	2
21780	Evansville, IN-KY	5	4
23060	Fort Wayne, IN	5	5
23844	Gary, IN	10	10
26900	Indianapolis-Carmel-Anderson, IN	27	27
29020	Kokomo, IN	2	2
29200	Lafayette-West Lafayette, IN	3	3
31140	Louisville/Jefferson County, KY-IN	10	4
33140	Michigan City-La Porte, IN	2	2
34620	Muncie, IN	1	1
43780	South Bend-Mishawaka, IN-MI	3	3
45460	Terre Haute, IN	2	2

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CBSAs – Evansville, Indiana

21780 - Evansville, IN-KY

May Reporting Period **Federal Fiscal Year 2019**

Provider #	Hospital	Cost %	Salaries	Hours	AHW
150082	Deaconess Hospital	49.80%	$268,212,915	7,138,442	$37.57
150100	Saint Mary's Medical Center	32.21%	$173,492,052	4,191,583	$41.39
150149	The Women's Hospital	6.31%	$33,970,591	880,677	$38.57
150175	Heart Hospital at Deaconess Gateway	2.49%	$13,433,979	315,117	$42.63
180056	Methodist Hospital	9.18%	$49,459,601	1,431,377	$34.55
			$538,569,138		

CBSA AHW - $38.59

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CBSA AWI Calculation

CBSA Composite Average Hourly Wage

Divided by:

National Average Hourly Wage

Preliminary CBSA Area Wage Index Factor

Multiplied by

Rural Floor Budget Neutrality Factor

Final CBSA Area Wage Index Factor

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Summary – Average Hourly Wage (AHW)

- Every hospital calculates their own AHW, compiled on the worksheet S3 series
- Each CBSA calculates its own AHW, based on the hospitals that comprise it
- Hospital salaries and hours are further adjusted by CMS, and final AHW and AWI values are reported in the inpatient PPS final rule (usually published in early August).

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Summary – Core Based Statistical Area (CBSA)

- Major metropolitan areas throughout the country
- Each state has a rural area
  - Except for DE, NJ and RI
- Urban CBSAs with a lower AWI than its Rural CBSA will be granted the Rural CBSA AWI value
- Hospitals are encouraged to work together to achieve the most optimal AHW for their CBSA

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Summary – Area Wage Index (AWI)

- CBSA AHW divided by the National AHW = CBSA AWI value
- AWIs are determined based on prior year cost report data
  - FFY 2020 AWI values are based on Medicare cost reports with beginning dates of 10/1/2015 through 9/20/2016
- AWI values are applied only to the labor portion of the Medicare standardized payment

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IPPS Calculation

	San Francisco	Minneapolis	Atlanta
FFY ‘19 AWI	1.7287	1.1050	.9359
Standard Labor (full update)	$3,863.17	$3,863.17	$3,506.83
Total Labor Payment	$6,678.26	$4,268.80	$3,282.04
Non-labor payment	$1,793.01	$1,793.01	$2,149.35
Base Rate	**$8,471.27**	**$6,061.81**	**$5,431.39**
Avg. CMI	1.6000	1.6000	1.6000
Discharges	3,000	3,000	3,000
IPPS Payment	**$40,662,000**	**$29,097,000**	**$26,071,000**

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Hospital's Annual Responsibilities for Wage Index

- Medicare cost reports are due each year, 5 months after their FYE
- Wage Index data is reported on the worksheet S3 series
- Every year, CMS allow hospitals to "update" their annual wage data
  - Previous cost report data is used for upcoming FFY AWI calculations
  - Annual deadline around September 1 to submit proposed adjustments
  - CMS audit is completed in November
  - Updated wage data is published, and subject to additional adjustments
- Every three years, hospitals must submit an updated Occupational Mix Survey

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Hospital's Annual Responsibilities - Guidance

- CMS Provider Reimbursement Manual (PRM) contains instructions for completing Medicare worksheets
- Periodic updates to instructions
- Appeal court cases

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Worksheet S3 part II, III, IV – S3 Part II Detail

While all data is required to be accurately reported, we recommend extra focus on these specific areas:

- Paid Hours
- Wage Related Costs
- Contract Labor
- Physician Compensation
- Home Office

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S3 Part II Detail – Paid Hours

- Reported in Column 5 of S3 part II

- Cost report instructions are not extensive, leading to confusion
  - **"Enter on each line the number of paid hours corresponding to the amounts in column 4"**

- Many sources to provide hours:
  - General ledger
  - Labor Distribution Report
  - FTE report
  - **Payroll Register** – desired type of report to use

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S3 Part II Detail – Paid Hours

For Wage Index reporting, three big things to remember:

- Salary is reported as expensed, but Hours are reported as Paid
- Understand all your hospital's payroll department Pay Codes
- When comparing your payroll report to GL salaries, it is critical to obtain reconciliation of costs to ensure accurate hours are used

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S3 Part II Detail – Paid Hours

Common adjustments to paid hours:

- Accrued hours
  - Payroll report with paid hours recommended
- PTO paid at termination, or sold back for cash
  - Set up separate pay codes for these occurrences
- On Call Pay – call back minimum
- Payroll report contains non-hospital employees
- Hours corresponding to salaries offset by revenue on w/s A

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S3 Part II Detail – Paid Hours

Common adjustments to paid hours:

- Baylor Plan
  - Pharmacists, surgery personnel, technicians
- Low Census and FMLA
- Hours double counted
- Hours related to capitalized salary

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S3 Part II Detail – Wage Related Costs

- Total wage related costs reported on lines 17 through 25 on worksheet S3 part II
- All items in this section are to be input.
- **Only data reported in lines 17, 18 and 22 are included in the AHW and AWI calculations.**
- First identify total costs, then allocate to the appropriate employee categories, represented on lines 17 through 25.

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S3 Part II Detail – WRC – w/s S3 part IV

	Retirement Costs
1	401K Employer Contributions
2	Tax Sheltered Annuity (TSA) Employer Contribution
3	Non Qualified Defined Benefit Plan Costs
4	Qualified Defined Benefit Plan Costs
	Plan Administrative Costs
5	401K/TSA Plan Administration fees
6	Legal/Accounting/Management Fees-Pension Plan
7	Employee Managed Care Program Admin Fees
	Health and Insurance Costs
8	Health Insurance (Purchased or Self Funded)
9	Prescription Drug Plan
10	Dental, Hearing, and Vision Plan
11	Life Insurance
12	Accident Insurance
13	Disability Insurance
14	Long-Term Care Insurance
15	Workers Compensation Insurance
16	Retirement Health Care Cost
	Taxes
17	FICA-Employers Portion Only
18	Medicare Taxes - Employers Portion Only
19	Unemployment Insurance
20	State or Federal Unemployment Taxes
	Other
21	Executive Deferred Compensation
22	Day Care Cost and Allowances
23	Tuition Reimbursement

Report ALL wage related costs on S3 part IV, not just line 17 "core" amounts

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S3 Part II Detail – WRC – Consulting Costs

Consulting Fees for benefits provide unique reporting for hospitals

- Typically incurred for pension and health insurance plans
- Consulting costs can be included within the appropriate benefit category on worksheet S3 part IV
- Invoices with description of services are best support for MAC audit
- Hospital benefits by being able to claim the labor costs of the service only – hours do not need to be reported.

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S3 Part II Detail – WRC – Pension

Defined Contribution Plans

- Costs associated with defined contribution plans (i.e. 401k) are recorded in year expensed
- Defined contribution amounts reported on lines 1 and 2 of S3 part IV

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S3 Part II Detail – WRC – Pension

Defined Benefit Plans

- Reporting method adjusted in FFY 2013 wage index calculation
- Contributions for 3-year period must be determined. Average amount to be reported.
- 3-year period is current year, and previous 2 years
- Prefunding Installment
- Defined Benefit amounts are to be reported on lines 3 (non-qualified) and 4 (qualified) of S3 part IV

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S3 Part II Detail – WRC – Allocation of Costs

- Most accurate method is to directly allocate costs…..if reported in GL as such
- Most hospitals will have the majority of the fringe benefit expenses in the Employee Benefits cost center
- Hospitals not limited to only salary allocation
- FTE allocation can be considered (i.e. Tuition, Health Insurance, Day Care, other insurance if applicable)
- Mixed basis is usually preferred as next best option after direct allocation

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S3 Part II Detail – WRC – General Guidance

- Understand the reporting of all fringe benefits in GL.
- On an annual basis, discuss with your HR manager any changes in policies or new benefits offered to hospital employees
- Validate all employees are eligible for all benefits
- Utilization of the mixed allocation method can bring significant impact to the AHW for some hospitals
- Total wage related costs typically range between 20-30% of total salary

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S3 Part II Detail – Contract Labor

- Line 11 of worksheet S3 part II– Direct patient care
  - Nursing, Therapists, etc.
- Line 12 – Contract Management
  - Management positions in non-general services areas
- Line 28 – Administrative & General
  - Legal, consulting, administration most critical
  - Home office and related organization
- Line 33, 35 – Housekeeping and Dietary

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S3 Part II Detail – Contract Labor

General Guidance for reporting Contract Labor

- Invoice support is critical for contract labor
- Contact your vendors for labor portion and paid hours
  - Require contracts to include labor rates
  - Hours worked required before payment
- Do not include excluded area cost center data (i.e. physician costs in NRCC)
- While I&R and physician teaching time is to be reported, it is not included in the final calculation of a hospital’s AHW for wage index

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S3 Part II Detail – Contract Labor

General Guidance for reporting Contract Labor

On Call Services – including Physicians

- Transmittal 6 confirmed specific guidance on this provision
- Must be either providing patient care, or completing the on-call time on hospital site

Transmittal 10 (Nov. 2016) provided further guidance

- Labor needs to be reported in proper cost center (A&G, Housekeeping, Dietary)
- Vendor attestations, declarations, emails not acceptable for supporting documentation.

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S3 Part II Detail – Physician Reporting

- For Worksheet A82 reporting, the following is required:

Salary	Contract
Part A (admin, teaching)	Part A (administrative)
Part B (professional)	**Part B (professional)**

- For wage index reporting, S3 part II only requires the following:

Salary	Contract
Part A (admin, teaching)	Part A (administrative)
Part B (professional)	

- Accurate time study documentation is required to support the reported Part A time.

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S3 Part II Detail – Physician Reporting

- We have seen recent MAC audit adjustments in this area
- Time studies need to be completed each year in accordance with the regulations
  - Talk with your MAC representative to understand their policy
- Physician contracts can be accepted provided Part A and B terms are referenced

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S3 Part II Detail – Home Office

Beginning in FFY 2020, for cost reports with beginning dates on and after 10/1/15, home office reporting for wage index is different.

Only salary expenses are reported in the line 14 series:

- Line 14.01 will report home office salary amounts
- Line 14.02 will report related organization salary amounts
- Line 14 is no longer used

Wage Related Costs are now reported solely on the line 25 series:

- Line 25.50 – WRC for home office personnel
- Line 25.51 – WRC for related organization personnel
- Line 25.52 – WRC for HO Part A Physicians
- Line 25.53 – WRC for HO and Contract part A teaching physicians

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S3 Part II Detail – Home Office

Contract Labor for both Home Office and Related Organization

- Usually all administrative in nature, and should be reported on line 28 of worksheet S3 part II
- If direct patient care, report on line 11
- If Physician Part A, report on line 13

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S3 Part II Detail – Home Office

General Guidelines

- Ensure all core wage related costs are captured
  - Follow same guidelines for worksheet S3 part IV reporting
- Home office opportunities likely exist with contract labor, fringe benefits and paid hours
- Allocation of total costs and hours should include all healthcare and non-healthcare components

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Occupational Mix Survey

- Most recent survey filed by IPPS hospitals on July 1, 2017
  - Data updated every three years
  - Next updated survey is projected to be due by July 2020.
- 90% of hospitals are included in most recent PUF
  - CMS has talked of penalties in the past, but not strictly enforced (at least not yet)

Hospitals have opportunity to adjust its OcMix data through the wage index review process

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Occupational Mix Survey

- Calendar year data is used – not fiscal year
- Each hospital computes their own individual OcMix factor
- Each Applied to only the nursing salary portion of total salaries

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Occupational Mix Survey

Provider Occ Mix Categories	Wages	Hours	Provider % by Subcategory	National AHWs by Subcategory	Provider Adjusted AHW	Nurse Occ Mix Adjustment Factor
RN	$21,975,941	898,719	69.78%	$37.44	$26.12	
LPNs and Surgical Technologists	$2,298,553	170,119	13.21%	$21.78	$2.88	
Nursing Aides, Orderlies, & Attendants	$2,183,087	219,143	17.01%	$15.33	$2.61	
Medical Assistants	$0	-	0.00%	$17.23	$0.00	
Total Nurse Salaries and Hours	**$26,457,581**	**1,287,981**	**100.00%**		**$31.61**	**1.0078**
				Natl Rate -->	**$31.85**	
All Other Salaries and Hours	$37,445,371	1,935,510				
Total	**$63,902,952**	**3,223,491**				

- Hospital determines costs and hours per job categories – RN, LPN, Aides, Assistants and All Other
- Hospital adjusted AHW is calculated. National rates calculated using all hospital's OcMix data
- OcMix factor = Hospital AHW / National AHW

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Occupational Mix Survey – AHW Impact

Nurse Salaries as a % of Total	**41.40%**
All Other Salaries as a % of Total	**58.60%**
Wages (Updated by MidPoint Markup)	$64,346,688
Hours	2,177,845
Unadjusted AHW	**$29.55**
Nurse Occ Mix Wages	$26,847,882
All Other unadjusted Occ Mix Wages	$37,705,388
Salaries Adjusted for Occ Mix	**$64,553,270**
Hours	**$2,177,845**
Occ Mix Adjusted AHW	**$29.64**

- Determined by OcMix Data
- Hospital wage index PUF data
- Nurse OcMix Wages = $64,346,688 x 41.40% x 1.0078
- All Other Wages = $64,346,688 x 58.60%
- OcMix value over 1 has increased this hospital's AHW by $0.09

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Occupational Mix Survey – Your Data

Must obtain file from payroll department detailing the paid costs and hours:

- Per GL department
- Per Job Description
- Per Payroll Code

Data must be analyzed:

- Remove data in non-IPPS cost centers
  - Excluded Units
  - Nonreimbursable Cost Centers
- Analyze pay codes in same manner as wage index analysis
- Understand job descriptions to properly report in OcMix categories
- Part B physician data, if applicable

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Occupational Mix Survey – Your Data

Don't Forget these important items:

- Contract Labor
- Home Office
- Overhead Calculation

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Geographic Reclassifications

- A hospital, or group of hospitals, can reclassify to a different labor market and enhance its AWI factor if it can demonstrate its labor costs (AHW) are comparable to a different CBSA by meeting CMS criteria.
- Approved applications will last for 3 years
- For FFY 2019, 30% of all hospitals – 1,054 - were approved for some sort of reclassification

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Geographic Reclassifications

Several scenarios exists for hospitals to obtain geographic reclassification for wage index purposes:

- Individual hospital to urban area or rural area (42 CFR §412.230)
- All hospitals in rural county to urban area (42 CFR §412.232)
- All hospitals in urban county to another urban area (42 CFR §412.234)
- All hospitals in State reclassify to another State (42 CFR §412.235)

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Geographic Reclassifications - Applying

- Hospitals must submit applications to the Medicare Geographic Classification Review Board (MGCRB)
- Applications are required well in advance. For example, applications for FFY 2019, which begins October 1, 2018, were due on September 1, 2017.
- Beginning FFY 2020, CMS now has electronic filing: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html
- Decisions are usually made no later than February after applying

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Geographic Reclassifications - Eligibility

Hospital Type	Mileage*	AHW Test – Home CBSA	AHW Test – Desired CBSA
Urban	15 miles to county line	108%	84%
Rural	35 miles to county line	106%	82%
Urban Group	Adjacent county	N/A	85%
Rural Referral Center (RRC)	35 miles or nearest CBSA	N/A	82%

* Mileage is measured over approved roads, not “as a crow flies”

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Geographic Reclassifications – Calculating AWI

To determine the projected AWI for reclassified hospitals, it depends on how the AHW of the reclassified hospitals impact the “desired” CBSA AHW these are reclassified to:

If combined AHW of the reclassified and the desired CBSA is:	Then:
Greater than desired CBSA	All hospitals reclassified and in desired CBSA receive increased AHW and AWI factor
Within 1% of the desired CBSA AHW	All hospitals receive the desired CBSA AWI
Less than 99% of the desired CBSA AHW	Desired CBSA hospitals are not affected. Reclassified hospitals receive “blended” AHW of reclassified and desired hospitals, and that is used to calculate reclassified hospitals AWI factor

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Geographic Reclassifications – Calculating AWI

	Houston CBSA	Reclassified Hospitals	Combined
Number of Hospitals	51	5	56
OcMix Adj Wage Costs	$ 6.8 billion	$ 370 million	$ 7.1 billion
Total Hours	162m	9.5m	172m
AHW	$ 42.12	$ 38.79	$ 41.94
99% Test	$ 41.70		

Houston hospitals will use the $41.70 AHW to calculate their AWI

Hospitals reclassifying into Houston will also use the $41.70 AHW to calculate their AWI because the combined AHW of both hospital groups is at least 99% of Houston CBSA AHW by itself.

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Geographic Reclassifications – Calculating AWI

	Chicago CBSA	Reclassified Hospitals	Combined
Number of Hospitals	58	20	78
OcMix Adj Wage Costs	$ 9.3 billion	$ 1.7 billion	$11.2 billion
Total Hours	207m	43m	251m
AHW	$ 45.06	$ 41.60	$ 44.47
99% Test	$ 44.61		

Because the combined AHW is less than 99% of Chicago CBSA, the reclassified hospital's will use $44.47 to calculate their AWI

$0.13 cents difference – combined hospitals will use a 1.0272 AWI vs. Chicago's 1.0414 – resulting in millions lost in Medicare PPS reimbursement dollars

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Rural Referral Centers - Urban to Rural

- Urban hospitals have the ability to apply for rural referral center status (42 CFR §412.96, §412.103)
- A recent CMS ruling now allows for urban hospitals meeting criteria for RRC can reclassify back to urban status in regards to wage index
- Before this ruling, CMS required urban hospitals with RRC status to maintain the rural AWI rate

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Rural Referral Centers - Urban to Rural

The incentive for urban hospitals is to take advantage of additional reimbursement afforded to rural hospitals:

- 340b eligibility requirements – threshold lowered to 8% from 11.75%
- Indirect medical education – increases in caps, with restrictions
- Wage index reclassification criteria of RRC

Drawbacks include the following:

- If not already geographically reclassified, loss of Medicare reimbursement due to rural CBSA AWI can be substantial for one full year
- Loss of capital DSH payments
- Capping of operating DSH payments

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Geographic Reclassifications – Urban to Rural

- Eligibility
  - At least 275 beds
  - Hospitals with <275 beds need to meet additional criteria in regards to case-mix and discharge volume
- Applications can be made at any time, but certain date requirements are necessary for changes to be applied to future AWI calculations
- CMS has allowed hospitals to reclassify back to its “home” CBSA
- Hospitals must weigh pros and cons before considering RRC status and reclassification opportunities

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FFY 2019 CMS Proposed Rule - Highlights

- For FFY 2020 calculations, line 18 for Other Wage Related Costs will no longer be included
- Imputed rural floor calculations for DE, NJ, and RI are expiring beginning FFY 2019.
- Renewed discussion on alternative forms of computing AWI values, including Commuter Based Wage Index (CBWI) calculation.

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FFY 2020 Timetable – Upcoming Dates

- October 1, 2018 – Effective date of FFY 2019 AWI values
- **November 16, 2018** – Deadline for MACs to complete audit of FFY 2020 hospital wage data, including review of proposed adjustments
- February 15, 2019 – Deadline for hospitals to submit requests for corrections to be made to audited PUF, scheduled to be released on January 31, 2019.
- March 22, 2019 – Deadline for MAC secondary review of requested corrections
- April 4, 2019 – Deadline for hospitals to submit appeal request

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FFY 2020 Timetable – Upcoming Dates

- April/May 2019 – Proposed rule to be published
- April 30, 2019 – publication of updated FFY 2020 Public Use File (PUF)
- May 30, 2019 – Deadline for hospitals to submit correction request for data posted in the updated audited PUF and Proposed Rule.
- August 1, 2019 – approximate date for FFY 2020 publication, with final rule
- Don’t forget – mid-May, 2019 – publication of initial PUF for FFY 2021 wage index!!

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Questions

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