Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages

March 3, 2021

Congressional Research Service
https://crsreports.congress.gov
R46702

CRS REPORT
Prepared for Members and
Committees of Congress

Congressional Research Service
Informing the legislative debate since 1914

SUMMARY

R46702

March 3, 2021

Marco A. Villagrana
Analyst in Health Care Financing

Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages

Medicare paid $112 billion for inpatient services at short-term, acute-care hospitals in 2018. Of the approximately 4,700 such hospitals in 2018, 3,220 were paid under the Medicare inpatient prospective payment system (IPPS), under which hospitals are paid a predetermined, fixed payment amount. The base IPPS payment amount is the same for all hospitals, but that amount is adjusted for geographic location, diagnoses, hospital services furnished, and quality performance, among other factors. In FY2021, the IPPS base payment for each Medicare beneficiary discharged from a hospital is $5,961.19 for a hospital's *operating* costs (e.g., labor and supply costs) and $462.22 for *capital* costs (i.e., depreciation, interest, rent, and property-related insurance and taxes).

To account for geographic differences in hospitals' labor costs, the IPPS base payment amount is adjusted by a *hospital wage index*. The wage index adjustment generally increases the IPPS payment amount to hospitals in geographic areas with average hospital wages above the national average; conversely, it decreases the IPPS payment amount to hospitals in areas with wages at or below the national average.

Although the wage index is intended to ensure the IPPS payment reflects geographic differences in wages, some hospital stakeholders in lower-wage areas have expressed concern about the fairness of the wage index due to the differences between relatively low and high hospital wage areas. In response to some of the concerns about the wage index, Congress created a number of exceptions. These exceptions allow qualifying hospitals to reclassify (change) to a higher wage index geographic area or to receive adjustments to their geographic wage index values. The National Academies of Sciences, Engineering, and Medicine (NASEM) estimated that nearly 40% of IPPS hospitals received a wage index reclassification or adjustment under one or more of these exceptions in FY2011. A comparable percentage of hospitals continue to receive reclassifications in FY2021, as noted in this report.

Although wage index reclassifications and adjustments usually increase the wage index of hospitals, independent analysts conclude that these exceptions may not address all concerns about the wage index. Some analysts argue that the need for exceptions indicates the wage index does not accurately reflect hospital labor markets. Other analysts argue that the effect of these exceptions further distorts hospital labor markets.

Some Members of Congress, hospitals, and independent analysts have expressed interest in the differences in Medicare hospital payments by geographic area, based on the wage index. Some of these stakeholders have recommended changes to the wage index to more accurately reflect labor market forces faced by hospitals. Although some modifications to the wage index have been implemented, there is no consensus about systematic reforms.

This report provides an overview of the Medicare hospital wage index, including a description of its role in the overall hospital IPPS payment, calculation of the wage index adjustment, the wage index's effect on Medicare payments for inpatient hospital services, stakeholders' concerns, exceptions and adjustments to the wage index, and proposals for wage index reforms. **Appendix B** contains a legislative history of the Medicare hospital wage index.

Contents

Figures

Tables

Appendixes

Contacts

Background

Medicare paid an aggregate of $112 billion for inpatient services furnished at short-term, acute-care hospitals in 2018.[1] Of the approximately 4,700 such hospitals in 2018, 3,220 were paid under the Medicare inpatient prospective payment system (IPPS).[2] Under IPPS, hospitals are paid a predetermined, fixed payment amount for services furnished to Medicare beneficiaries.

Since 1983, Medicare has paid most acute-care hospitals under the IPPS for inpatient hospital services provided to a Medicare beneficiary.[3] The IPPS base payment is for services associated with a Medicare beneficiary's inpatient hospital stay, including preadmission-related tests and services provided during the inpatient stay (i.e., from admission to discharge).[4] The IPPS base rate is calculated using costs reported by hospitals on the Medicare cost report for the cost reporting period that ended during the period October 1, 1982, through September 30, 1983, and is updated annually.[5] Under the IPPS, a hospital receives two payments, one for operating expenses and another for capital expenses. The IPPS *operating* payment covers a hospital's labor and supply costs. The IPPS *capital* payment covers depreciation, interest, rent, and property-related insurance and taxes. (For purposes of illustration, this report focuses on how the wage index is used in calculating the *operating* payment.)

The IPPS operating and capital base payments are the same for all IPPS hospitals, regardless of location.[6] These payments are the starting point and are subject to applicable adjustments. In FY2021, the IPPS operating base payment amount to a hospital for each Medicare beneficiary discharged is $5,961.19 and the capital base payment amount is $462.22.[7] The IPPS per discharge payment amount is updated annually by an inflation factor. This amount does not include applicable beneficiary cost sharing under the Medicare Part A hospital insurance benefit. This

[1] Medicare Payment Advisory Commission (MedPAC), Chart 6-14 in *Health Care Spending and the Medicare Program: A Data Book*, July 2020, at http://www.medpac.gov/-documents-/data-book (hereinafter, MedPAC, *Data Book*). Short-term, acute-care hospitals not paid under the Medicare inpatient prospective payment system (IPPS) are paid by Medicare under other payment methodologies, primarily based on hospitals' reported costs rather than on prospectively determined, fixed payment amounts.

[2] See Chart 6-1 and Chart 6-9 in MedPAC, *Data Book*.

[3] Prior to 1983, Medicare paid for inpatient hospital services based on a hospital's reasonable costs rather than a standard fixed amount. IPPS hospitals are distinguished from non-IPPS hospitals—psychiatric, pediatric, long-term care, critical access hospitals (CAHs)—by, among other factors, the method Medicare uses to pay non-IPPS hospitals. Some of these hospitals are paid under their own unique prospective payment system (PPS) such as long-term care hospital PPS, and CAHs are paid based on their costs—specifically, 101% of cost.

[4] The IPPS unit of payment is a hospital *discharge*. The IPPS payment is for a bundle of services that are provided during an inpatient stay (i.e., from admission through discharge, including related preadmission tests).

[5] Hospitals (and other Medicare-certified providers) are required to submit to CMS an annual cost report containing information such as facility characteristics, utilization data, and financial information including cost and charges by cost center (in total and for Medicare) and financial statement data. 42 U.S.C. §1395g; 42 C.F.R. §413.20.

[6] The IPPS operating base payment amount for FY2021 is $5,961.19, assuming a hospital submits quality data and is a meaningful electronic health record (EHR) user, and the capital base rate is $462.22. For simplicity, this report focuses on the IPPS *operating* payment unless otherwise noted.

[7] See Table 1A-1E in Centers for Medicare & Medicaid Services (CMS), "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals," 85 *Federal Register* 58432, September 18, 2020, at https://www.cms.gov/files/zip/fy-2021-ipps-fr-table-1a-1e.zip. Hereinafter, CMS, 85 *Federal Register* 58432, September 18, 2020.

amount is the full amount for hospitals that submitted quality data and are meaningful electronic health record (EHR) users.

Through adjustments, the Medicare IPPS base payment accounts for variation in local market conditions (including wages), the patient's diagnosis and associated procedures, and other factors in certain qualifying hospitals. All IPPS base payments are subject to two adjustments. One is a wage index adjustment, which accounts for the geographic differences in labor costs faced by hospitals in different labor markets.[8] The second adjustment alters payment to account for the patient's condition as reflected by the diagnoses and medical procedures performed, often referred to as *case mix*.[9] As noted above, this report focuses on how the wage index is used in calculating the operating payment. (See **Appendix A** and **Figure A-1** for an overview of all IPPS payment adjustments and how the wage index fits within all IPPS adjustments.)

The hospital wage index adjustment has been the subject of ongoing debate and analysis. The wage index generally leads to reductions in IPPS payment amounts to hospitals located in relatively low-wage areas and increased payment amounts to hospitals in relatively high-wage areas. Some hospitals in lower-wage areas have raised concerns that the wage index, as currently implemented, results in geographic differences that exacerbate disparities in Medicare payment amounts between low- and high-wage areas. Additionally, various independent analysts have recommended modifications to improve the wage index's fairness and accuracy. For example, some have recommended reducing large wage index differences between adjacent geographic areas, particularly differences between hospitals that are located near the boundaries of a wage index area. This approach is intended to improve the accuracy and fairness by reducing wage index "cliffs" between hospitals that are geographically proximate but in different wage index areas. Other analysts recommend using wage data from all health care employers rather than from only hospitals. This approach is intended to reflect a more complete picture of the labor market that hospitals face in a geographic area.

Congress has enacted numerous changes to the wage index since it was implemented in 1983.[10] These changes consist primarily of wage index exceptions that allow qualifying hospitals to reclassify to a nearby geographic area with a higher wage index or otherwise receive adjustments to their wage index values. Although these exceptions were created to resolve some stakeholder concerns with the wage index, the changes they implement may create or exacerbate other issues. For example, some analysts argue that a policy that necessitates as many exceptions as those available under the wage index indicates the wage index does not accurately reflect hospital labor markets.[11] Other analysts argue that the exceptions themselves further distort hospital labor markets. Policies designed to increase or decrease the wage index affect all hospitals, because most wage index reclassifications and adjustments are done in a budget-neutral manner—an increase in the wage index of some hospitals generally is offset by proportional reductions in Medicare IPPS payments for other hospitals so that aggregate Medicare spending does not increase as a result of most wage index reclassifications and adjustments.

---

[8] 42 U.S.C. §1395ww(d)(2)(H) authorizes the Secretary of Health and Human Services to adjust IPPS payments to account for "area differences in hospital wage levels."

[9] The classification system that groups similar clinical conditions and the procedures performed by the hospital during the hospital stay is referred to as the *Medicare Severity-Diagnosis Related Group* (MS-DRG). This system helps to relate the type of patients a hospital treats (i.e., a hospital's *case mix*) to the costs the hospital incurs. A weight is assigned to each MS-DRG that reflects the average relative costliness of cases in that group compared with the costliness for the average Medicare case. For FY2021, there are 765 MS-DRG groupings.

[10] A summary changes enacted by Congress is located in **Appendix B**.

[11] Wage index reclassifications and adjustments are addressed in more detail in the "Wage Index Geographic Reclassifications and Adjustments" section of this report.

This report provides an overview of the Medicare hospital IPPS, including an overview of the wage index used to adjust payments for geographical cost differences. The report also describes methods hospitals may use to request a reclassification of their wage index values and therefore Medicare payments. In addition, the report introduces stakeholders' concerns about the accuracy of the wage index and presents brief summaries of selected analyses and reform proposals. The report also provides a legislative history of the hospital wage index in **Appendix B**.

Labor *Costs* Versus *Prices*

As currently constructed, the wage index reflects the labor *costs* rather than the *prices* faced by hospitals in a geographic labor market. Specifically, the hospital wage index is the average hourly wage paid by hospitals in a defined geographic area relative to the national hospital average hourly wage. A 2012 analysis by the Institute of Medicine (now the National Academies of Sciences, Engineering, and Medicine, or NASEM) notes that the wage index is a *cost* index because it measures the variation in hospital-paid wages and benefits rather than the variation in the *price* that hospitals face for a defined group of goods and services (e.g., wages and benefits) between geographic areas.[a] In other words, rather than capture geographic differences in labor *prices*—the market-determined value of the labor used to provide a medical service—faced by hospitals in a geographic area, the Medicare wage index captures hospital-reported labor costs. The Medicare wage index does not include data of health service providers that may be similar to an IPPS hospital, such as rehabilitation or psychiatric hospitals with which IPPS hospitals likely compete for labor in a geographic labor market. Using only IPPS hospital costs as the basis for constructing the hospital wage index raises two different but related concerns—circularity and accuracy. For additional information about these and other criticisms of the Medicare hospital wage index, see "Concerns About the Hospital Wage Index" in this report.

a. Institute of Medicine, *Geographic Adjustment in Medicare Payment: Phase I—Improving Accuracy*, 2012, at https://www.nap.edu/catalog/13138/geographic-adjustment-in-medicare-payment-phase-i-improving-accuracy.

Adjusting Medicare Hospital Payments for Geographic Variation in Wages

As noted, the Medicare IPPS payment is adjusted for numerous factors, including one that reflects geographic wage differences. (**Figure A-1** illustrates the full range of IPPS adjustments.) The IPPS is composed of two payments: (1) an operating base payment and (2) a capital base payment. Both payments are adjusted for local-area labor costs, a patient's clinical condition, and other factors.[12] The following sections address how the wage index adjusts the *operating* payment portion of the IPPS payment.

Key Medicare Wage Index Terms

Average Hourly Wage: For a labor market area, the *average hourly wage* is the total wage costs divided by the total hours for all hospitals in the geographic area. A national average hourly wage is the total wage costs divided by the total hours for all hospitals in the United States (i.e., 50 states, District of Columbia, and Puerto Rico).

Base Payment: The Medicare hospital inpatient prospective payment system, or IPPS, *base payment* is the standard payment rate set by the Centers for Medicare & Medicaid Services (CMS) for a hospital inpatient stay. (IPPS is also defined below) There are two components of the base payment: one covers a hospital's *operating* costs, and the other covers *capital* costs. The amount of each base payment component is the same nationally; each component of the base payment is based on CMS estimates of the expected cost of providing hospital services to a Medicare beneficiary during an inpatient stay.

Budget Neutral: The requirement that net Medicare spending for inpatient hospital services does not increase due to increased Medicare payment rates to some hospitals. Payment increases to some hospitals must be "offset" by proportional Medicare payment decreases to other hospitals.

[12] For FY2021, the operating base rate of $5,961.19 assumes a full FY2021 payment update based on a hospital that submitted quality data and is a meaningful EHR user. The capital base rate for FY2021 is $466.22.

Capital Base Payment: The IPPS *capital base payment* is the part of the Medicare inpatient prospective payment system (IPPS) base payment for each inpatient stay that covers a hospital's capital-related costs. These costs include depreciation, interest, rent, and property-related insurance and taxes.

Geographically Adjusted Base Payment: The *geographically adjusted base payment* is the payment amount derived after the base payment has been adjusted by the wage index. CMS also terms this payment the *market adjusted payment*, referring to adjustments determined by the geographic labor market in which a hospital is located or to which a hospital reclassifies.

Hospital Wage Index: As required by Social Security Act §1886(d)(3)(E), the *hospital wage index* is a Medicare IPPS payment adjustment designed by CMS to reflect "the relative hospital wage level in a geographic area of a hospital compared to the national average hospital wage level."[a]

Inpatient Prospective Payment System: The IPPS is a Medicare payment method under which hospitals are paid a prospectively determined, fixed payment amount for each discharge of a Medicare beneficiary. The IPPS payment is adjusted for various factors related to a hospital's geographic location, a patient's diagnosis and associated procedures, and other factors for qualifying hospitals.

Labor Share of Base Payment: The *labor share* is the portion of the operating base payment that is attributable to labor and wage-related costs and therefore is adjusted by the wage index.

Nonlabor Share of Base Payment: The *nonlabor share* is the portion of the operating base payment that is *not* attributable to labor and wage-related costs and therefore is not adjusted by the wage index.

Operating Base Payment: The *operating base payment* is the part of the Medicare IPPS base payment for each inpatient stay that covers a hospital's operating costs (primarily labor and supply costs).

Sources: CMS, *Acute Care Hospital Inpatient Prospective Payment System*, Medicare Learning Network Booklet, March 2020; Medicare Payment Advisory Commission (MedPAC), *Hospital Acute Inpatient Services Payment System*, October 2020.

a. CMS Wage Index web page, "Wage Index," at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.

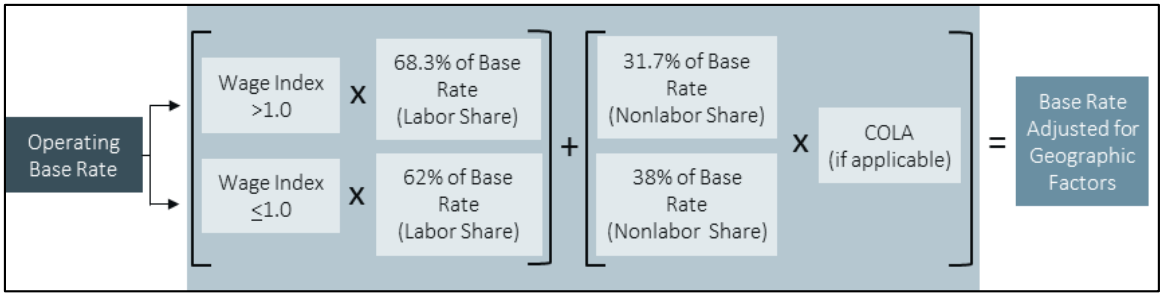
To apply labor costs to a hospital's operating payment, Medicare multiplies the labor-related share of the operating base payment by the wage index value assigned to the hospital's geographic area.[13] The share of the operating base payment attributed to labor differs depending on the hospital's wage index value.[14] The labor-related share of the operating base payment is 68.3% for hospitals with wage index values above the national average (i.e., a wage index value >1.0) and 62% for hospitals with wage index values equal to or below the national average (i.e., a wage index value ≤1.0).[15] **Figure 1** illustrates these steps.

[13] CMS, *Acute Care Hospital Inpatient Prospective Payment System*, Medicare Learning Network Booklet, March 2020, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf.

[14] In computing the capital portion of the IPPS, the wage index value is applied to the entire capital base payment.

[15] 42 C.F.R. §412.64(h) and (h)(2).

Figure 1. Medicare Wage Index Adjustment to the Hospital Inpatient Prospective Payment System (IPPS) Operating Base Payment



Source: Congressional Research Service (CRS), adapted from Medicare Payment Advisory Commission (MedPAC), *Hospital Acute Inpatient Services Payment System,* October 2020.

Notes: COLA = cost-of-living adjustment. For hospitals located in Alaska and Hawaii, the COLA adjustment is applicable only to the nonlabor share of the IPPS payment.

Constructing the Hospital Wage Index

Each IPPS hospital is assigned a wage index value based on the geographic area in which it is physically located. The wage index value determination involves four steps:

1. Defining geographic labor market areas
2. Determining hospital wages
3. Adjusting hospital wages for occupational mix
4. Calculating geographic area wage index values

Each step is addressed below.

Defining Geographic Labor Market Areas

Labor costs vary between geographic areas. These costs are influenced by the cost of living, local amenities, and labor productivity, among other factors. A labor market should include geographic areas in which employers compete for the same workers and must pay similar local market wages to attract employees.[16]

For the hospital wage index, the Centers for Medicare & Medicaid Services (CMS) uses *core-based statistical areas* (CBSAs) to define geographic labor market areas.[17] CBSAs are composed of metropolitan statistical areas (MSAs) and micropolitan statistical areas, as established by the Office of Management and Budget.[18]

[16] Institute of Medicine, *Geographic Adjustment in Medicare Payment: Phase I—Improving Accuracy*, 2012, at https://www.nap.edu/catalog/13138/geographic-adjustment-in-medicare-payment-phase-i-improving-accuracy. Hereinafter, Institute of Medicine, *Geographic Adjustment*.

[17] Between each decennial census, the Office of Management and Budget (OMB) periodically updates the metropolitan statistical areas (MSAs). In setting the FY2021 wage index values, CMS incorporated the geographic delineations reflected in "OMB Bulletin No. 18–04," released September 14, 2018, at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf. OMB has more recent updates of its geographic delineations, such as "OMB Bulletin No. 20-01," released March 6, 2020; CMS stated that it did not use this most recent OMB bulletin because the bulletin was not released in time for developing the FY2021 rule.

[18] An MSA and a micropolitan statistical area consist of a county or counties (or equivalent entities) associated with at least one urbanized area of at least 50,000 population or of at least 10,000 but less than 50,000 population, respectively.

Although CMS references CBSAs, in practice, CMS assigns a wage index value to each MSA in a state.[19] The non-MSAs, including micropolitan statistical areas, in a state receive a single wage index value; these areas are considered *rural*.[20] For FY2021, CMS recognizes 590 geographic labor markets in the 50 states, the District of Columbia (DC), and Puerto Rico for purposes of the wage index.[21] Of these, 517 are MSAs and the remaining 73 are non-MSAs (i.e., single statewide rural areas).[22] A state, DC, or Puerto Rico may have multiple statewide rural area wage index values. For example, there may be a wage index value for hospitals located in the state's rural area, a value for urban hospitals in the state that reclassify into the state's rural area, and a value for hospitals that reclassify into the state's rural area from a neighboring state.

To illustrate, Minnesota has eight CBSAs (the first eight items listed in **Table 1**, below). Any area outside one of these CBSAs is considered the statewide rural area. Minnesota has three non-CBSA statewide rural area wage index values, as indicated by the CBSA/area name "Minnesota" and the CBSA number "24" in the table below. The statewide rural area wage index values for Minnesota are for (1) within-state reclassification into Minnesota's rural area, (2) reclassifications into Minnesota's rural area from Iowa, and (3) reclassifications into Minnesota's rural area from North Dakota.

Table 1. Example: Medicare Hospital Wage Index Geographic Areas in Minnesota, FY2021

CBSA Number	CBSA/Area Name	Wage Index Value
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0905
40340	Rochester, MN	1.0440
31860	Mankato, MN	1.0288
41060	St. Cloud, MN	1.0203
20260	Duluth, MN-WI	0.9916
29100	La Crosse-Onalaska, WI-MN	0.9142
22020	Fargo, ND-MN	0.9089
24220	Grand Forks, ND-MN	0.9089
24	Minnesota	0.9089
24	Minnesota (hospitals reclassified from Iowa)	0.8904
24	Minnesota (hospitals reclassified from North Dakota)	1.000[a]

Source: CRS analysis of Table 3, CMS, 85 *Federal Register* 58432, September 18, 2020, at https://www.cms.gov/files/zip/tables-2-3-4a-and-4b-fy-2021-wage-index-tables-final-rule-and-correction-notice.zip.

Notes: CBSA = core-based statistical area; MN = Minnesota; ND = North Dakota; WI = Wisconsin.

a. North Dakota hospitals receive the frontier wage index adjustment, which sets the floor wage index value at the national average wage index value (1.0000) for hospitals located in a qualifying state. As of FY2021,

Each also has adjacent counties that have a high degree of social and economic integration with the core, as measured through commuting ties. See United States Census Bureau, "Metropolitan and Micropolitan," at https://www.census.gov/programs-surveys/metro-micro/about.html.

[19] CRS analysis of Medicare wage index data and personal communication with CMS staff.

[20] A rural area classification offers hospitals additional pathways for receiving special rural designations that provide certain payment benefits, such as sole community hospital or rural referral center status.

[21] See Table 3 in CMS, 85 *Federal Register* 58432, September 18, 2020.

[22] The total number of statewide rural wage index areas exceeds the number of states, DC, and Puerto Rico because each has multiple statewide rural area wage index values.

four states' hospitals qualify for the frontier adjustment: Montana, North Dakota, South Dakota, and Wyoming.

Determining Hospital Wages

CMS uses hospital-reported data to calculate each hospital's average hourly wages (AHWs). To do this, CMS uses hospital data for paid hours and the cost (in dollars) of wages and benefits, among other costs, for hospital employees and certain contract labor. (See **Figure 2** for an overview of wage index allowed and excluded costs.) These data include wages and hours worked for occupational categories such as certain physicians and nonphysician practitioners, pharmacists, plant operators, housekeepers, dietary workers, cafeteria workers, and those performing laundry and linen service.[23] Using these data, total wages are divided by total hours to calculate each hospital's AHW.

Figure 2. Hospital Labor Costs Used to Calculate the Wage Index

Included Costs	Excluded Costs
✓ Hospital services salaries and hours	⊘ Nonhospital services salaries and hours[a]
✓ Certain home office costs and hours	⊘ Graduate medical education costs
✓ Certain contract labor costs and hours	⊘ Certain provider-based salaries and hours[b]
✓ Certain wage-related costs (e.g., fringe benefits)	⊘ Non-IPPS salaries and hours[c]

Source: CRS review and analysis of CMS, 85 *Federal Register* 32460, May 29, 2020, at https://www.govinfo.gov/content/pkg/FR-2020-05-29/pdf/2020-10122.pdf.

Notes:

a. Such as Skilled Nursing Facility services.

b. Certain Medicare certified providers, such as federally qualified health centers and rural health clinics, can be hospital-based if they are located in the same building or campus as a hospital and meet specified criteria.

c. Such as Critical Access Hospital services.

Adjusting Hospital Wages for Occupational Mix

A hospital's AHW is intended to reflect the market-driven cost of labor faced by that hospital in its specific geographic labor market. However, the AHW wage also reflects hospitals' choices to hire different combinations of health care professionals. For example, Hospital A and Hospital B treat similar patients (i.e., patients with the same conditions, as reflected by the same Medicare Severity-Diagnosis Related Groups, or MS-DRGs). Whereas Hospital A chooses to employ a relatively higher proportion of registered nurses (RNs), Hospital B employs a relatively higher proportion of licensed practical nurses (LPNs). (RN credentials and training are more advanced than LPNs; therefore, salaries are typically greater for RNs than for LPNs.) To eliminate the

[23] Salaries and hours of physicians and certain nonphysician practitioners whose services are billable to Medicare Part B are excluded from the wage index calculation. For example, certified nurse midwife, certified nurse anesthetist, among other practitioners, are allowed to bill Medicare Part B for their services. Salaries and hours worked in administrative or supervisory roles by physicians and nonphysician practitioners are included for the wage index.

effect of these management hiring decisions on the wage index, a hospital's AHW is adjusted up or down based on *occupational mix*—the proportion of nursing and other occupations the hospital employs relative to the proportion employed at hospitals nationally. According to CMS, "the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor."[24]

The *occupational mix adjustment* (OMA) is applied only to the nursing occupational category—RN, LPN, surgical technologist, nurse assistant, orderly, and medical assistant.[25] Occupational mix information for all other hospital occupations, including some physicians, is categorized as "all other occupations," and the OMA is not applied to these occupations.[26]

Table 2. Hospital Occupations Subject to the Occupational Mix Adjustment

Applicable Hospital Occupations[a]	Non-applicable Hospital Occupations
Registered Nurses	All Other Occupations
Licensed Practical Nurses	
Surgical Technologists	
Nursing Assistants	
Orderlies	
Medical Assistants	

Source: CMS, Medicare Wage Index Occupational Mix Survey, "2019 Occupational Mix Survey Hospital Reporting Form CMS-10079 for the Wage Index Beginning FY2022," at https://www.cms.gov/medicaremedicare-fee-service-paymentacuteinpatientppswage-index-files/2019-occupational-mix-survey-hospital-reporting-form-cms-10079-wage-index-beginning-fy-2022.

Note:

a. These hospital occupations are collectively the "nursing" occupational category. Only the nursing occupational category is subject to the Occupational Mix Adjustment.

The OMA reduces the total wages of the nursing occupational category for hospitals with a higher nursing skill mix than the national average and increases the total wages of the nursing occupational category for hospitals with a lower skill mix than the national average. This exercise determines the occupationally adjusted wages for each hospital.

Medicare collects data used to calculate the OMA through a survey of hospitals every three years.[27] The occupational mix survey conducted in 2016 is used to calculate the OMA of IPPS payments for hospital patient discharges in FY2019-FY2021. CMS is currently analyzing the 2019 survey data, which it is to use to apply the OMA for Medicare IPPS payments in FY2022-FY2024.

[24] CMS, 85 *Federal Register* 58432, September 18, 2020.

[25] CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment; Final Rule," 76 *Federal Register* 51475, August 18, 2011, at https://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf (see p. 51583). Hereinafter, CMS, 76 *Federal Register* 51475.

[26] As noted earlier, only physicians in administrative or supervisory roles are included in the wage index.

[27] 42 U.S.C. §1395ww(d)(3)(E)(i).

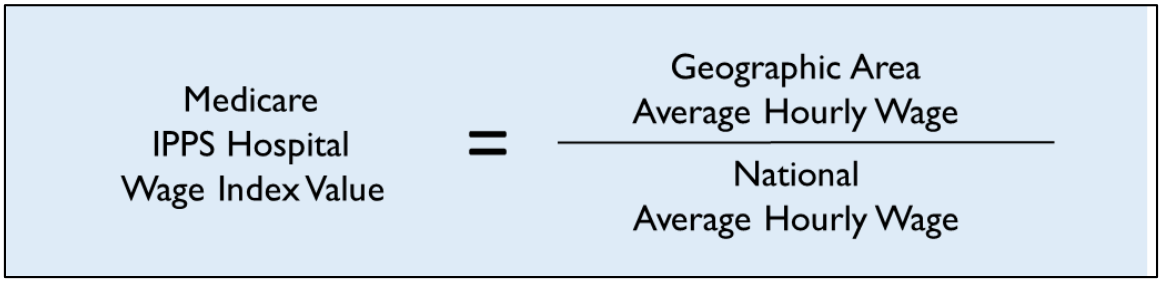
Calculating Geographic Area Wage Index Values

After adjusting hospital wages for occupational mix, CMS aggregates the hospital data to calculate the wage index value for each geographic area. The Institute of Medicine (now the National Academies of Sciences, Engineering, and Medicine, or NASEM) defines an *index* as "A statistic that is designed to compare how the price for a defined group of goods and services varies as a whole over time or *between geographic areas compared with an average* [emphasis added]. This is distinct from a cost index, which measures variation in actual expenditures, such as wages and benefits."[28]

Using the wage data reported by hospitals, including occupational mix information, CMS calculates each geographic area's AHW and a national AHW. A geographic area's AHW is equal to the occupation-adjusted wages of all hospitals in the area divided by the total number of labor hours of all hospitals in the area. The national AHW is equal to the total adjusted wages for IPPS hospitals in the 50 states, DC, and Puerto Rico divided by the total labor hours for these hospitals.

CMS then uses these figures—the geographic area AHW and the national AHW—to calculate each geographic area's wage index value. The wage index value for a geographic area is the AHW of the geographic area divided by the national AHW, as illustrated in **Figure 3**.

Figure 3. Medicare IPPS Wage Index Calculation



Source: CRS.

A wage index value of 1.0 represents the national AHW. Therefore, geographic areas with an AHW higher than the national average will have a wage index value above 1.0; areas with an AHW lower than the national average will have a wage index value below 1.0. CMS publishes the wage index values for each geographic area and for individual hospitals with the annual hospital IPPS payment update final rule.[29] Wage index values, as well as the IPPS base rate and other IPPS payment adjustments, change annually.

Wage Index Effect on Medicare Payment

Figure 4, below, illustrates how variation in the wage index value across geographic areas affects the Medicare IPPS payment. As noted, for areas with a wage index value greater than 1.0 (the national average wage index value), 68.3% of the base payment (or $4,653.91, given the FY2021 operating base payment amount of $5,961.19) is adjusted by the wage index.[30] Las Vegas, NV, is an example of an area whose wage index value is greater than 1.0—it is 1.1430. For areas with

[28] Institute of Medicine, *Geographic Adjustment*. See Glossary, p. XXV.

[29] For example, see CMS, 85 *Federal Register* 58432, September 18, 2020. Wage index data are generally contained in Tables 2, 3, and 4 at the CMS "IPPS Final Rule Home Page." For example, the FY2021 wage index data are at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page.

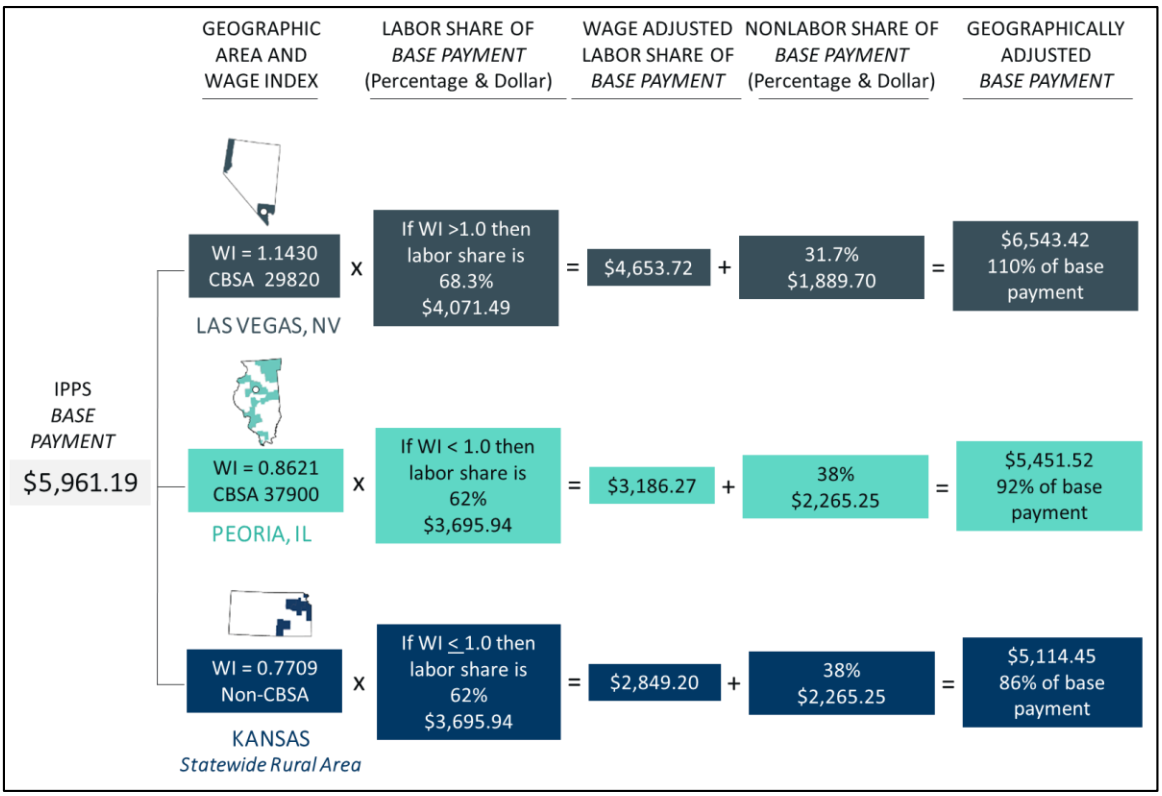
[30] The 68.3% is the *labor share* of the IPPS operating base payment.

wage index values that are equal to or less than 1.0, 62% (or $3,186.27 in FY2021) of the base payment is adjusted by the wage index. Peoria, IL, which has a wage index value of 0.8621, is one example of an area that has a wage index value that is equal to or less than 1.0. Rural Kansas (i.e., the non-MSA areas), with a wage index value of 0.7709, is another such example.

Figure 4 illustrates how variation in the wage index value affects the Medicare IPPS payment in three geographic areas—Las Vegas, Peoria, and rural Kansas. In the examples included, the IPPS operating base rate is $5,961.19. The higher wage index value in Las Vegas results in a higher Medicare IPPS payment—not withstanding all other Medicare IPPS adjustments illustrated in **Appendix A**—than in either Peoria or rural Kansas. In other words, although all geographic areas start out with the same IPPS base payment amount, the wage index adjustment effectively varies IPPS payments across geographic areas. The variation reflects the difference in wages across these areas.

The same steps apply to the other two examples illustrated in **Figure 4**. The labor share that is subject to the wage index adjustment changes depending on whether the wage index is greater than or less than/equal to 1.0 (refer to **Figure 1**). In the examples in **Figure 4**, the geographically adjusted (i.e., wage index-adjusted) IPPS base payments differ—ranging from a low of $5,114.45 to a high of $6,543.41—due to the application of the different wage index values and applicable percentage of the labor-related portion subject to the adjustment.

Figure 4. Effect of the Wage Index on Medicare IPPS Operating Base Payment in Three Geographic Areas



Source: CRS analysis of Tables 2, 3, 4A, and 4B in CMS, 85 *Federal Register* 58432, September 18, 2020, at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page#Tables.

Notes: CBSA = core-based statistical area; IL = Illinois; IPPS = inpatient prospective payment system; NV = Nevada; WI = wage index.

Wage Index Geographic Reclassifications and Adjustments

As noted, a hospital is assigned the wage index value of the geographic area in which it is physically located. However, since the implementation of the IPPS, Congress has created options for qualifying hospitals to obtain wage index values different from the value assigned to the geographic area in which the hospital is physically located. These options involve reclassifying a hospital into a neighboring geographic area or adjusting a hospital's wage index value. Congress has established these exceptions to address concerns about the wage index; for example, some hospital industry representatives have suggested these reclassifications and adjustments are necessary to ensure hospitals receive fair compensation under the current wage index formula.[31] Despite this, an American Hospital Association (AHA) Medicare Area Wage Index Task Force also acknowledged concerns with both the current wage index and reclassifications.[32] (See **Appendix B** for a legislative history of the hospital wage index.)

Qualifying hospitals may use these congressionally established exceptions to change or receive an adjustment to their wage index values. (See the hospital wage index reclassifications and adjustments listed in **Table 3**.)[33] Generally, these exceptions permit eligible hospitals to reclassify into a different geographic area—usually to a neighboring area—or to adjust their wage index values. For example, a qualifying hospital may receive a wage index value different from the wage index corresponding to the geographic area in which it is physically located through a Medicare Geographic Classification Review Board (MGCRB) reclassification.[34] The MGCRB allows a hospital three reclassifications:[35]

1. Rural to urban
2. Rural to rural
3. Urban to urban

To qualify for MGCRB reclassification, a hospital must have an AHW similar to the geographic area to which it seeks reclassification and be proximately located to that area. Proximity is determined either by the distance from the area (i.e., no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital) or by having at least 50% of the hospital's employees reside in the area.[36] **Figure 5** illustrates an example of each of the three types of MGCRB reclassifications.

The first example in **Figure 5** illustrates an MGCRB rural-to-urban reclassification. A hospital geographically located in rural Rio Arriba County, NM, reclassified into the Santa Fe, NM, urban (MSA) area. The reclassification resulted in the hospital obtaining a new, higher wage index—0.8845 instead of 0.8670. The second example illustrates an MGCRB rural-to-rural reclassification. In this case, a hospital geographically located in rural Franklin County, AL, along

[31] American Hospital Association (AHA), "Letter to Centers for Medicare & Medicaid Services," April 20, 2011, at http://www.aha.org/advocacy-issues/letter/2011/110420-cl-wageindexrep.pdf.

[32] See slides by AHA, Medicare Area Wage Index Task Force, 2013, at https://www.ahe.org/system/files/2018-04/13juneawicallslides.pdf.

[33] CMS, 76 *Federal Register* 51475.

[34] A qualifying individual hospital or a group of hospitals may reclassify through the Medicare Geographic Classification Review Board.

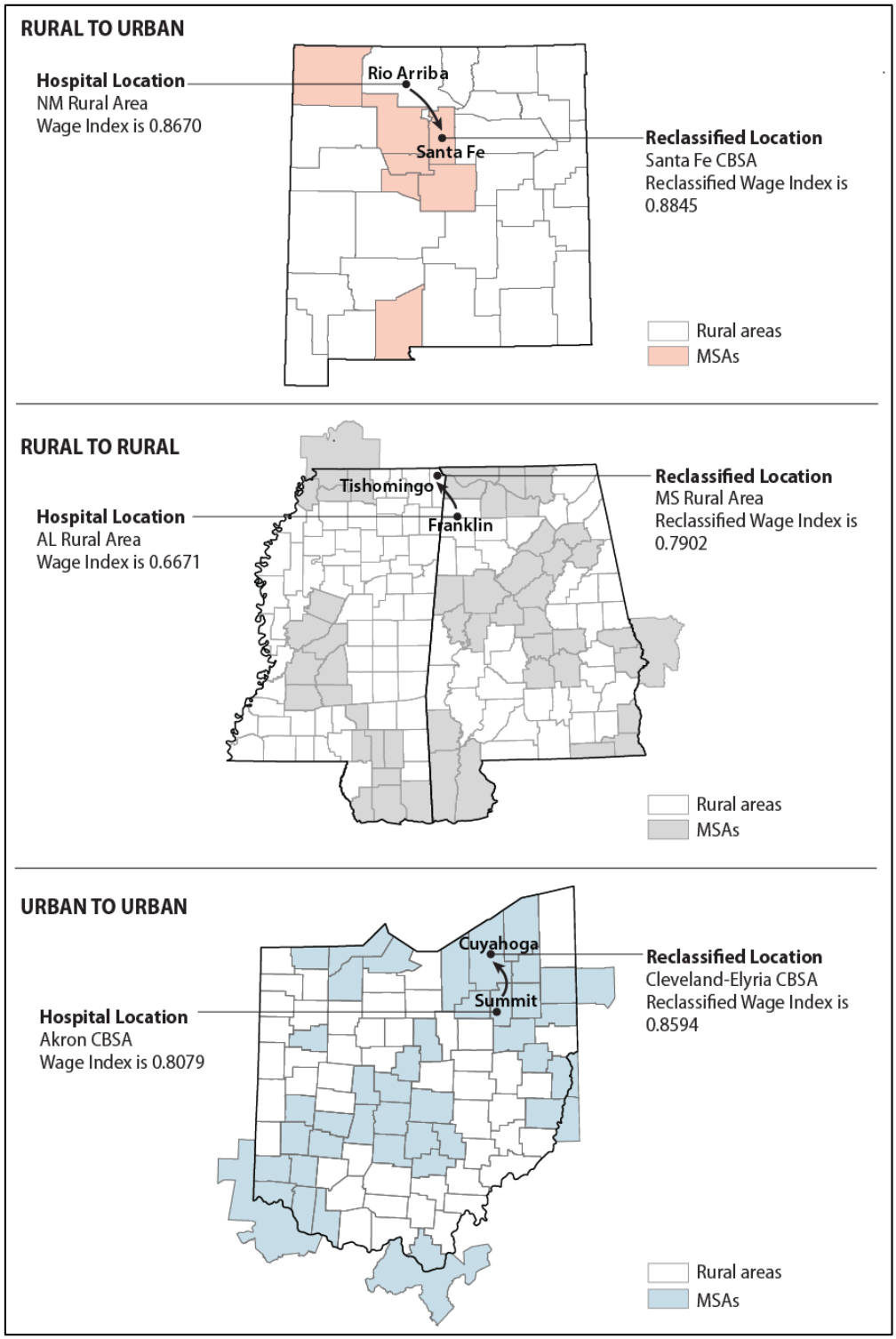
[35] 42 C.F.R. §412.230(a)(1).

[36] 42 C.F.R. §412.230(b).

the Alabama-Mississippi state line, reclassified to the Mississippi rural area. The reclassification resulted in an increase in wage index for this hospital from 0.6671 to 0.7902. The third example in **Figure 5** is an MGCRB urban-to-urban reclassification. In this example, a hospital geographically located in the Akron, OH, urban (MSA) area reclassified into the neighboring Cleveland-Elyria, OH, urban (MSA) area, resulting in a wage index change from 0.8079 to 0.8594.

Figure 5. Examples of Medicare MGCRB Reclassifications

(rural-urban, rural-rural, and urban-urban reclassifications, FY2021)



Source: CRS analysis of Table 3: "Wage Index Table by CBSA—FY2021" in CMS, 85 *Federal Register* 58432, September 18, 2020, at https://www.cms.gov/files/zip/tables-2-3-4a-and-4b-fy-2021-wage-index-tables-final-rule-and-correction-notice.zip.

Notes: AL = Alabama; CBSA = core-based statistical area; MGCRB = Medicare Geographic Classification Review Board; MS = Mississippi; MSA = metropolitan statistical area; WI = wage index.

Although most reclassifications are through the MGCRB, there are other reclassification methods for qualified hospitals.[37] For example, a hospital may choose to receive an out-commuting adjustment based on the percentage of hospital-employed residents of the hospital's county that commute to work in a higher wage index area. Another example is the rural floor adjustment, which sets the wage index value of certain urban hospitals at no less than the state's rural wage index value. These and other wage index reclassification and adjustment methods are described in **Table 3**.

Most wage index reclassifications are implemented in a budget-neutral manner—generally meaning the IPPS payment to some or all IPPS hospitals is reduced to "offset" an increase in the wage index of hospitals that have reclassified.[38] This is done so the aggregate amount of Medicare IPPS spending is not greater than it otherwise would be if hospitals did not reclassify. This means some or all hospitals pay for the increase in Medicare payments to those hospitals that have a reclassification.[39] CMS applied a budget-neutrality factor of 0.986583 to the IPPS base rate of all hospitals to offset MGCRB, rural-to-urban, and urban-to-rural reclassifications and a budget-neutrality factor of 0.993433 to the wage index to offset for the rural floor adjustment.[40] Reclassifications and related budget-neutrality adjustments affect hospitals differently. For example, MGCRB reclassifications and related budget neutrality is expected to result in a -0.1% IPPS payment reduction for urban hospitals and a 1.1% payment increase for rural hospitals in FY2021.[41] **Table 3** contains a summary of wage index reclassifications and adjustments.

[37] Not all wage index reclassifications are mutually exclusive. These are addressed briefly in section "Concerns About the Hospital Wage Index."

[38] CMS applies budget neutrality to IPPS payment adjustments other than wage index reclassifications. For example, to offset recalibration of the MS-DRGs.

[39] AHA, "Wage Index Chartpack" November 2011, at https://www.aha.org/system/files/content/11/11nov-wgindexchartpk.pdf. AHA estimated that approximately 1% of total IPPS payments, or $633 million, in FY2012 were redistributed due to wage index reclassification budget neutrality. See slide 16. This is the most recent publicly available estimate of the dollar effect of wage index reclassification budget-neutrality policy.

[40] CMS, 76 *Federal Register* 51475, see table "Summary of FY2021 Budget Neutrality Factors," p. 59034.

[41] CMS, 85 *Federal Register* 58432, see "Table I – Impact Analysis of Changes to the IPPS for Operating Costs for FY2021," p. 59065, for additional information about the payment effects of other FY2021 IPPS payment policies, including other reclassifications and their respective budget neutrality factors.

Table 3. Medicare IPPS Hospital Wage Index Reclassifications and Adjustments

Wage Index Reclassification or Adjustment	Effect on Hospital Wage Index	Eligibility	Duration	Budget Neutral?	Number (Percentage) of IPPS Hospitals with Wage Index Reclassification or Adjustment in FY2021[a]
MGCRB[b]	Reclassifies a hospital (or group of hospitals) into a different (generally higher) wage index area	Hospital (or group of all hospitals in a county) meet specified requirements related to geographic proximity and AHW relative to another geographic area	3 years after approval	Yes	906 (26.4%)
Out-Commuting Adjustment[c]	Increases a hospital's wage index value via a county-based add-on payment determined by blending the assigned wage index value for hospitals in a county with the higher wage index value(s) of a nearby area(s) by the proportion of hospital workers who commute to those higher wage index area(s)	At least 10% of a county's hospital-employed residents commute to work in higher wage index areas. The hospital in a qualifying county cannot also hold another type of reclassification (i.e., MGCRB, or rural to urban, or urban to rural both are addressed later in this table)	Assessed annually and assigned values are fixed for 3 years periods	No	245 (7.1%)
Rural Floor[d]	Increases urban area's wage index value so it is not less than the state's rural area's wage index value	An urban area's wage index is less than the state's rural area wage index	CMS publishes rural floor values annually	Yes	285 (8.3%)

Wage Index Reclassification or Adjustment	Effect on Hospital Wage Index	Eligibility	Duration	Budget Neutral?	Number (Percentage) of IPPS Hospitals with Wage Index Reclassification or Adjustment in FY2021[a]
Rural to Urban[e]	Reclassifies hospital from a rural wage index area to a higher urban wage index area	Substantial commuting of workers (hospital and nonhospital employees) between a hospital's county and adjacent urban area(s)	CMS updates periodically using revised OMB geographic delineations and U.S. Census Bureau commuting data	Yes	64 (1.9%)
Urban to Rural[f]	Reclassifies hospital from an urban wage index area to its state's rural area	Hospital would qualify, but for its urban location, as a rural referral center or a sole community hospital; or the hospital is deemed by state law or regulation to be rural; or is located in a rural RUCA census tract[g]	Until canceled by the hospital or the hospital's eligibility changes	Yes	466 (13.6%)
Frontier[h]	Sets a wage index floor of 1.0 (the national average wage index) for hospitals located in a qualifying state	At least 50% of the state's counties have a population density of less than six persons per square mile	CMS reassesses periodically	No	44 (1.3%)

Source: CRS analysis of Table 2-Final Case Mix Index and Wage Index Table by CMS Certification Number (CCN), CMS, 85 *Federal Register* 58432, September 18, 2020, at https://www.cms.gov/files/zip/fy-2021-ipps-fr-tables-2-3-4a-4b.zip,.

Notes: AHW = average hourly wage; CMS = Centers for Medicare & Medicaid Services; IPPS = inpatient prospective payment system; MGCRB = Medicare Geographic Classification Review Board; OMB = Office of Management and Budget; RUCA = Rural-Urban Commuting Area. Some reclassifications are not mutually exclusive. For example, a hospital may have two reclassifications simultaneously—an urban-to-rural reclassification and an MGCRB reclassification to an urban area.

a. N = 3,435, from Table 2-Final Case Mix Index and Wage Index Table by CCN - FY2021, CMS, 85 *Federal Register* 58432, September 18, 2020, at https://www.cms.gov/files/zip/fy-2021-ipps-fr-tables-2-3-4a-4b.zip. This column contains figures for FY2021; FY2021 is used to illustrate the scope of reclassifications in a given year. These figures may fluctuate from year to year.

b. **MGCRB**: Process and eligibility criteria from 42 C.F.R. §412.230-412.280. The proximity requirement for MGCRB reclassification is waived for rural referral centers and sole community hospitals (special payment designations under Medicare IPPS for qualified hospitals that modify these hospitals' IPPS base payment rates). MGCRB is located in statute at 42 U.S.C. §1395ww(d)(10).

c. **Out-commuting adjustment**: Process and eligibility criteria from 42 C.F.R. §412.64(i). Out-migration adjustment is located in statute at 42 U.S.C. §1395ww(d)(13).

d. **Rural floor**: Process and eligibility criteria from CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices," 82 *Federal Register* 19796, April 28, 2018. Rural floor is located in statute at 42 U.S.C. §1395ww Note – Floor on Area Wage Index. Previously enacted provisions at 42 U.S.C. §1395ww(d)(8)(C)(iii) and (iv) provide duplicative wage index floors for certain hospitals though are technically separate from the rural floor.

e. **Rural-to-urban reclassification**: Process and eligibility criteria from 42 C.F.R. §412.64(b)(3). Rural-to-urban reclassification is located in statute at 42 U.S.C. §1395ww(d)(8)(B).

f. **Urban-to-rural reclassification**: Process and eligibility criteria from 42 C.F.R. §412.103. Urban-to-rural reclassification is located in statute at 42 U.S.C. §1395ww(d)(8)(E).

g. A **Rural-Urban Commuting Area**, or RUCA, is developed by the U.S. Department of Agriculture, Economic Research Service.

h. **Frontier**: Process and eligibility criteria from 42 C.F.R. §412.64(m). According to CMS, Montana, North Dakota, South Dakota, and Wyoming hospitals are receiving frontier adjustments in FY2021. Nevada also qualifies as a frontier state in FY2021; however, its hospitals currently receive a wage index greater than 1.0. The frontier adjustment is located in statute at 42 U.S.C. §1395ww(d)(3)(E).

Reclassification Hold-Harmless Policies

Hospitals reclassifying in and out of geographic areas can change the AHW of those areas (i.e., the numerator in **Figure 3**). Statute requires the HHS Secretary to mitigate the effect of certain reclassifications on geographic areas' wage indexes.[42] In addition to statutory requirements, CMS administratively applies additional policies.[43] Collectively, the statutory and administrative actions are referred to as *hold-harmless policies*. Applicable hold-harmless policies typically are based on (1) the effect a reclassification has on a geographic area (i.e., the originating/geographic area or the destination/reclassified area), (2) the magnitude of the effect, or (3) the type of reclassification. The applicable hold-harmless policies are illustrated in **Table 4**, below.

[42] 42 U.S.C. §1395ww(d)(8)(C).

[43] CMS, 76 *Federal Register* 51475.

Table 4. Reclassification Hold-Harmless Policies

Effect/Type of Reclassification	Hold-Harmless Policy
Statutory Policies	
If *including* the wage data of reclassified hospitals would *reduce* the wage index for a[n urban] *destination* area by ≤1%	Wage index of *all hospitals*—those reclassified into and those physically located in the destination geographic area—is the wage index of the original hospitals.
If *including* the wage data of reclassified hospitals would *reduce* the wage index for a[n urban] *destination* area by >1%	Wage index differs for the reclassified hospitals and the hospitals located in the destination geographic area. For a *reclassified hospital*, the wage index is a blend of (1) its geographic wage index and (2) the reclassified wage index of the destination geographic area. The hospitals physically located in the destination geographic area maintain their wage index without adjusting/including the reclassified hospital's wage index.
If *including* the wage data of reclassified hospitals would *increase* the wage index for an *urban destination area*	Wage index of *all hospitals* in the destination area—hospitals physically located in the area and those reclassified into the area—is a blend of the two (originating and destination) area wage indexes.
If *excluding* the wage data of reclassified rural hospitals would decrease the wage index of the *originating/geographic rural area*	Wage index of the *originating rural area* is calculated by including the wage index of the reclassified hospitals as if there had been no reclassification out of the rural area.
Administrative Policies	
For urban-to-urban reclassifications, regardless of the effect	Subject to the applicable statutory rules listed above, the wage index data of the reclassified hospitals are included for calculating the wage index of both the *destination* and the *originating/geographic* areas.
For reclassifications to a rural area	Wage data of reclassified hospitals are included for calculating the wage index of both the *rural destination* area (unless doing so reduces the wage index of the rural area) and the *urban originating/geographic* area.[a]

Source: CRS analysis of 42 U.S.C. §§1395ww(d)(8)(C), 1395ww(d)(8)(B), 1395ww(d)(10); CMS, 76 *Federal Register* 51476, August 18, 2011; and 84 *Federal Register* 42044.

a. CMS states that the effect of this policy is that

> rural areas may receive a wage index based on the higher of: (1) Wage data from hospitals geographically located in the rural area; (2) wage data from hospitals geographically located in the rural area, but excluding all data associated with hospitals reclassifying out of the rural area under §1886(d)(8)(B) [42 U.S.C. §1395ww(d)(8)(B)-rural to urban reclassification] or §1886(d)(10) [42 U.S.C. §1395ww(d)(10)-MGCRB] of the Act; or (3) wage data associated with hospitals geographically located in the area plus all hospitals reclassified into the rural area.

Also, per CMS policy change effective beginning FY2020 (October 1, 2019), the wage data of an urban hospital reclassified to a rural area are excluded for purposes of calculating the rural floor wage index. The rural floor increases the urban area's wage index value so it is not less than the state's rural area wage index. See **Table 3** in this report for additional information about the rural floor wage index.

The interaction of reclassifications, hold-harmless policies, and budget neutrality leads to a combination of possible increases and decreases in Medicare payments for different hospitals. For example, all hospitals are affected by the budget neutrality to offset payment increases due to reclassifications and hold-harmless policies. Therefore, reclassifying and hold-harmless protected

hospitals "receive a benefit and a detriment, but non-reclassifying, non-protected hospitals receive only a detriment."[44]

Concerns About the Hospital Wage Index

Stakeholders have raised a number of concerns about the hospital wage index. Some of these concerns are summarized below.

- **Labor Market Categorization.** Geographic area delineations can define labor markets too broadly, which can result in a single wage index value for hospitals with different labor costs. Alternatively, labor markets can be set too narrowly, resulting in different wage index values for hospitals with similar labor costs.[45]
- **Wage Index Cliffs.** The wage index formula can result in large differences in wage index values in adjacent geographic areas. Hospitals on either side of a geographic labor market area dividing line may have different wage index values, even if the hospitals are relatively close to each other. For example, one study found 152 cases of hospitals located within 10 miles of each other that had greater than 0.10 differences in wage index values.[46]
- **Volatility.** A geographic area's wage index value can fluctuate from year to year due to circularity (addressed below) and other factors, creating financial uncertainty and complexity for hospitals. These fluctuations may be especially pronounced in geographic areas with few hospitals.[47] For example, a CMS-commissioned analysis found that from one year to the next, wage index values change more than 10% for 1% of hospitals and between 5% and 10% for 8% of hospitals.[48]
- **Circularity.** The current system—built on hospital-only wage information—may give hospitals "undue influence over their own wage indexes."[49] For example, a hospital that moderated its wage increases could reduce the wage index for the geographic area; which could pressure the hospital (and other hospitals in the same geographic area) to further restrain labor costs.[50] Conversely, a hospital that has high labor costs may increase the wage index for its geographic area, potentially creating a disincentive to control labor costs. This influence on an area's wage index is especially evident in areas with few hospitals.

---

[44] HHS, Office of Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, A-01-17-00500, November 2018, p. 11, at https://oig.hhs.gov/oas/reports/region1/11700500.pdf.

[45] Department of Health and Human Services (HHS), *Report to Congress: Wage Index Reform, 2012*, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Wage-Index-Reform-Report-to-Congress-2012.zip.

[46] Institute of Medicine, *Geographic Adjustment*.

[47] AHA, *Statement for the Record of the American Hospital Association for the Institute of Medicine,* September 16, 2010, at http://www.aha.org/advocacy-issues/testimony/2010/100916-statement-wage-index.pdf.

[48] Thomas MaCurdy et al., *Revision of Medicare Wage Index Final Report Part I*, Acumen, LLC, April 2009. Based on FY2005-FY2008 Medicare hospital cost report data that do not take into account reclassifications and other adjustments to wage index values. Hereinafter, MaCurdy et al., *Revision of Medicare Wage Index*.

[49] Institute of Medicine, *Geographic Adjustment*, pp. 50-51.

[50] MedPAC, *Report to Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 130, at http://www.medpac.gov/docs/default-source/reports/Jun07_EntireReport.pdf. Hereinafter, MedPAC, *Report to Congress*, 2007.

- **Limited Labor Mix.** The current OMA is based on differences across hospitals in nursing occupational categories. The OMA does not account for differences in skill levels of other hospital occupations. For example, non-nursing occupations, including physicians—many of whom are now employed by hospitals—are classified in an "All Other Occupations" category.[51]

Although the reclassification and adjustment methods in **Table 3** are intended to address many of the concerns listed above, these methods have raised additional concerns. Some of these additional issues are listed below.

- **Over- and Undercompensating Hospitals.** A Medicare Payment Advisory Commission (MedPAC) study comparing the current Medicare wage index with alternative methodologies concluded that hospitals that reclassify receive wage index values in excess of what would accurately reflect true labor market costs. Conversely, hospitals that do not reclassify are undercompensated by the current wage index.[52]
- **Administrative Complexity.** Adjudicating and navigating the wage index reclassifications, adjustments, and hold-harmless policies is time-consuming and complex for CMS and hospitals.[53]
- **Overlapping Exceptions.** Wage index reclassifications and adjustments can overlap, creating additional complexity. For example, Medicare allows a hospital to hold two reclassifications simultaneously—an urban-to-rural reclassification and an MGCRB reclassification to an urban area. The urban-to-rural reclassification permits a hospital to qualify for IPPS payment adjustments available to rural hospitals. The MGCRB reclassification allows the same hospital to also reclassify to the higher-wage urban area for purposes of obtaining a higher wage index value.[54]
- **Nonintuitive Impacts on Medicare Payment.** A dual reclassification as described above can have nonintuitive impacts on wage index values and Medicare payments. For example, the dual reclassification noted above permits a hospital to be both rural and urban—rural for purposes of qualifying for certain Medicare special rural payment adjustments and urban for purposes of obtaining a higher urban wage index.[55] CMS estimates that in FY2021, 378 (11%) of 3,435

[51] For additional information about the occupational mix survey, see CMS, 85 *Federal Register* 58432, September 18, 2020 beginning on page 58762, and CMS, "2016 Occupational Mix Survey Hospital Reporting Form CMS-10079 for the Wage Index beginning FY2019," at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/2016-Occupational-Mix-Survey-Hospital-Reporting-Form-CMS-10079-for-the-Wage-Index-Beginning-FY-2019.html.

[52] MedPAC, *Report to Congress*, 2007, p. 133-135.

[53] MedPAC, *Report to Congress*, 2007, p. 129.

[54] In an interim final rule published in FY2016, CMS changed its regulations to allow this double reclassification. CMS implemented this change to be consistent with decisions of the U.S. Court of Appeals for the Second and Third Circuits that held that hospitals redesignated as rural also may obtain an urban wage index. See CMS, "Medicare Program; Temporary Exception for Certain Severe Wound Discharges From Certain Long-Term Care Hospitals Required by the Consolidated Appropriations Act, 2016; Modification of Limitations on Redesignation by the Medicare Geographic Classification Review Board," 81 *Federal Register* 23428, April 21, 2016, at https://www.govinfo.gov/content/pkg/FR-2016-04-21/pdf/2016-09219.pdf; or CMS guidance at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3885CP.pdf.

[55] 42 C.F.R. §412.230(a)(5)(ii), at https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol2/CFR-2011-title42-vol2-sec412-230.

IPPS hospitals hold dual urban-to-rural and either MGCRB reclassification or rural-to-urban adjustment.

Notwithstanding concerns with reclassifications, in FY2012, the AHA calculated that reclassifications resulted in an average percentage gain in hospitals' wage index of 1.9% for the out-commuting adjustment, 7.1% for rural floor, 7.3% for MGCRB, 10.1% for rural to urban, and 16.6% for frontier.[56]

Wage Index Reform

Selected Analyses and Recommendations

Congress and other key stakeholders have explored reforms to the Medicare hospital wage index that aim to remove the need for reclassifications and adjustments and to create a wage index that more accurately reflects hospitals' underlying labor costs. Consensus around the various reforms has not materialized. Many of the authoritative analyses and recommendations for reforming the wage index were published between 2007 and 2012 and are briefly described below.

In 2007, MedPAC proposed to Congress a new source—the Bureau of Labor Statistics (BLS)—for wage data to determine MSA and rural area wage indexes.[57] MedPAC also recommended further refining MSA and rural area wage information using more granular geographic units by using county-level census data.[58] Under this change, each county within an MSA and rural area would have its own wage index value. Further, MedPAC proposed incorporating a "smoothing technique" to eliminate large differences in wage index values between adjacent counties (i.e., wage cliffs).[59] MedPAC also recommended using wage data from all employers of hospital-related occupations, such as registered nurses working in skilled nursing facilities or non-IPPS hospitals, such as rehabilitation or psychiatric hospitals.[60] MedPAC concluded these proposed changes would decrease year-to-year wage index volatility and result in smaller differences in wage index values between adjoining geographic areas.[61]

Following the MedPAC analysis, a CMS-commissioned study issued in 2009 concluded that despite some limitations, BLS wage information is more accurate and reliable than the current source of wage information.[62] However, with respect to MedPAC's proposal for smoothing differences in wage index values between adjacent counties, a subsequent CMS-commissioned study, issued in 2010, concluded that MedPAC's methodology would not guarantee a more

[56] AHA, "Wage Index Chartpack" November 2011 at https://www.aha.org/system/files/content/11/11nov-wgindexchartpk.pdf. See slides 14 and 15.

[57] MedPAC, *Report to Congress*, 2007, Table 6-3, p.134.

[58] MedPAC proposes using county-level Census data to supplement, not replace, MSA-level and statewide rural area data from the BLS.

[59] MedPAC, *Report to Congress*, 2007, p.135.

[60] As noted earlier in this report, the Medicare wage index does not include data of health service providers that may be similar to an IPPS hospital such as rehabilitation or psychiatric hospitals with which IPPS hospitals likely compete for labor in a geographic labor market. See MedPAC, *Report to Congress*, 2007, p.132.

[61] MedPAC, *Report to Congress*, June 2007, p. 144.

[62] MaCurdy et al., *Revision of Medicare Wage Index*.

accurate representation of a hospital labor market and likely would not reduce hospitals' desires to seek reclassifications.[63]

In 2012, an Institute of Medicine (now NASEM) study prepared for HHS and Congress supported using BLS data but recommended continuing to use the wage index geographic unit at the MSA level. The study suggested, much as the 2007 MedPAC study had, using wage data from a broader array of health-related occupations beyond just hospitals. It also recommended adjusting the wage index for health care workers' commuting patterns.[64]

HHS submitted its own reform proposal to Congress in 2012, as mandated by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). In the wage index reform proposal, the HHS Secretary proposed using zip codes and census tracts rather than MSAs as the geographic unit for the wage index labor markets. The plan also proposed creating a Commuting-Based Wage Index (CBWI) centered on where hospital workers live instead of where hospitals are located. The report concluded the CBWI method would reduce wage cliffs and more closely reflect hospitals' actual wages than the current CMS method or MedPAC's recommended approach.[65]

Although CMS has made technical changes to aspects of the hospital wage index over time, the proposed reforms noted above have not been implemented. MedPAC, in its comments to CMS on the FY2019 IPPS proposed rule, reiterated its recommendation from 2007 that Congress should "repeal the current wage index system and give the Secretary the authority to create a new system."[66] MedPAC continued to support using wage data from all employers, not just hospitals, available through the BLS; adopting a smoothing technique to reduce large differences in wage index values between adjacent geographic areas; and setting the geographic unit at the county rather than MSA level, among other recommendations.[67]

More recently, the Office of Inspector General for the Department of Health and Human Services (HHS-OIG) identified vulnerabilities in the current hospital wage reporting system. This analysis found accuracy and completeness problems with hospital-reported wage data. These findings reinforce concerns that current wage index data do not reflect local labor prices, which could lead to less accurate wage indexes. The HHS-OIG recommended the HHS Secretary "revisit the plan to comprehensively reform the hospital wage index system, including the previously researched option of a commuting-based wage index."[68] The HHS-OIG also recommended other changes in lieu of comprehensive reform, including seeking legislation that

- repeals the rural floor wage index adjustment;
- gives the HHS Secretary authority to penalize hospitals that submit inaccurate or incomplete wage data in the absence of misrepresentation or falsification; and

[63] MaCurdy et al., *Revision of Medicare Wage Index*.

[64] Institute of Medicine, *Geographic Adjustment*.

[65] HHS, *Report to Congress: Plan to Reform the Medicare Wage Index*, January 25, 2012, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Wage-Index-Reform-Report-to-Congress-2012.zip.

[66] Letter from Francis. J. Crosson, MedPAC chairman, to Seema Verma, CMS Administrator, "RE: File code CMS-1694-P," June 22, 2018, =p. 8, at http://www.medpac.gov/docs/default-source/publications/06222018_medpac_2019_ipps_comment_sec.pdf?sfvrsn=0. Hereinafter, MedPAC letter, June 2018.

[67] MedPAC letter, June 2018.

[68] HHS, Office of Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, A-01-17-00500, November 2018, p. 12, at https://oig.hhs.gov/oas/reports/region1/11700500.pdf.

- repeals the hold-harmless provisions that allow CMS to calculate each area wage index using the wage data of hospitals that reclassify into an area and of hospitals that are physically located in the area and have not reclassified out.

Administrative Policy to Address Wage Index Disparity

In lieu of comprehensive wage index reforms as discussed above—some of which would require the enactment of legislation—beginning in FY2020, CMS implemented a change to address wage index disparity.[69] Specifically, CMS temporarily increased the wage index values of IPPS hospitals with wage index values in the lowest quartile. As a result, the lowest wage index value increased from 0.3711 to 0.6083 between FY2019 and FY2020. The highest wage index value remained the same in FY2020 as in FY2019, 1.9343.[70] (See **Figure 6** for an illustration of the high-low wage index values pre- and post-wage index disparity policy.) The intent of this temporary policy was to narrow the difference between the highest and lowest wage indexes.

As noted earlier, CMS implements most wage index reclassifications and adjustments in a budget-neutral manner. CMS implemented the temporary wage index disparity policy in such a manner. This means CMS applied a 0.998835 budget-neutrality factor to the IPPS base payment of all hospitals to offset increasing the wage index of hospitals in the bottom quartile of wage index values.[71]

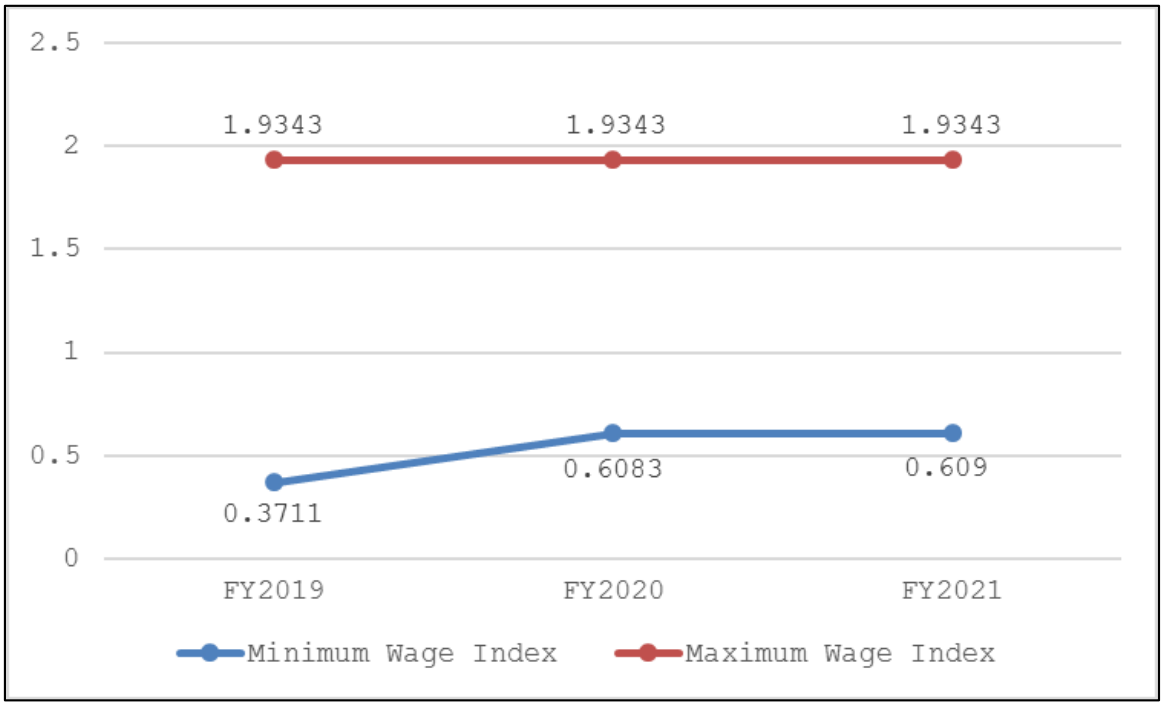
[69] CMS, "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals," 84 *Federal Register* 42044, August 16, 2019 (see p. 42326). Hereinafter, CMS, 84 *Federal Register* 42044.

[70] The wage index disparity policy was implemented in a budget-neutral manner—CMS adjusted the IPPS base rate payment applicable to all IPPS hospitals so that aggregate Medicare IPPS spending does not increase due to the wage index disparity policy. CMS, 84 *Federal Register* 42044 (see p. 42331).

[71] The AHA wrote to CMS opposing budget neutrality for the temporary wage index disparity policy. See, AHA, Letter to Seema Verma, CMS Administrator re "CMS–1716–P, Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospital: Proposed Rule (Vol. 84, No. 86), May 3, 2019," June 24, 2019 at https://www.aha.org/system/files/media/file/2019/06/aha-comments-cms-inpatient-pps-fy-2020-proposed-rule-6-24-2019.pdf.

Figure 6. Effect of the Wage Index Disparity Policy on Minimum and Maximum Hospital Wage Index Values

(temporary policy effective for a minimum of four years, FY2020 through FY2023)



Source: CRS analysis of CMS, "Table 2: Case Mix Index and Wage Index Table by [CMS Certification Number]" for each fiscal year. For FY2019 (Correction Notice), see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2019-CMS-1694-FR-Tables-2-3-4.zip. For FY2020 (Correction Notice), see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2020-FR-Tables-2-3-4.zip. For FY2021, see https://www.cms.gov/files/zip/tables-2-3-4a-and-4b-fy-2021-wage-index-tables-final-rule-and-correction-notice.zip.

Notes: FY2019 is the year prior to implementing the temporary wage index disparity policy; FY2020 is the first year of the temporary wage index disparity policy. The temporary wage index disparity policy is scheduled to be in effect for four years, FY2020 through FY2023.

CMS states that this temporary policy—effective for a minimum of four years, FY2020 through FY2023—is intended to give hospitals with a low wage index an opportunity to use the higher Medicare payments to increase employee compensation. If hospitals do so, the higher wages would be reflected in future hospital wage index reporting and subsequent CMS wage index calculations and adjustments. As a result, the expectation is that, when the temporary policy expires, any increases in hospital-paid wages will be "baked in" to the wage index calculations going forward. However, hospitals receiving increased IPPS payments resulting from the temporary policy are not required to increase employee compensation; therefore, the long-term effects of such a policy are yet to be determined.

Appendix A. Medicare Inpatient Prospective Payment System

Medicare pays for most hospital inpatient services furnished in short-term, acute-care hospitals under the inpatient prospective payment system (IPPS).[72] IPPS prospectively determines a fixed payment amount for each discharge. It accounts for variation in local market conditions (including wages), the patient's diagnosis and associated procedures (often referred to as *case mix*), and other factors for certain qualifying hospitals.[73] (See **Figure A-1**.)

Medicare's per discharge payment starts with a national *base rate*, which is adjusted by (1) a *wage index* for the geographic area in which the hospital is located or to which the hospital has been reclassified and (2) a case mix—the weight associated with the Medicare Severity-Diagnosis Related Group (MS-DRG) to which the patient is assigned.[74] This weight reflects the relative cost of the average patient in that MS-DRG. The base rate is updated annually for inflation.

Additional adjustments are made to the IPPS payment for qualifying hospitals. For example, adjustments are made for extraordinarily costly patients (*outliers*), indirect costs incurred by teaching hospitals for graduate medical education, and disproportionate share hospital payments to those hospitals that serve a certain volume of low-income patients. Some hospitals receive an adjustment to compensate for the higher incremental operating costs due to a low volume of inpatients. Additional payments also may be made for a hospital's use of qualified new medical technologies.

IPPS payments also may be increased or reduced under certain Medicare quality-related programs based on a hospital's performance on quality metrics. These quality-related programs include the Hospital Readmissions Reduction Program, the Hospital-Acquired Condition Reduction Program, and the Hospital Value-Based Purchasing Program.

Certain hospitals or distinct hospital units are exempt from the IPPS and paid under an alternative method. Exempt hospitals or hospital units include (1) inpatient rehabilitation facilities; (2) long-term care hospitals; (3) psychiatric facilities, including hospitals and distinct part units; (4) children's hospitals; (5) cancer hospitals; and (6) critical access hospitals.[75]

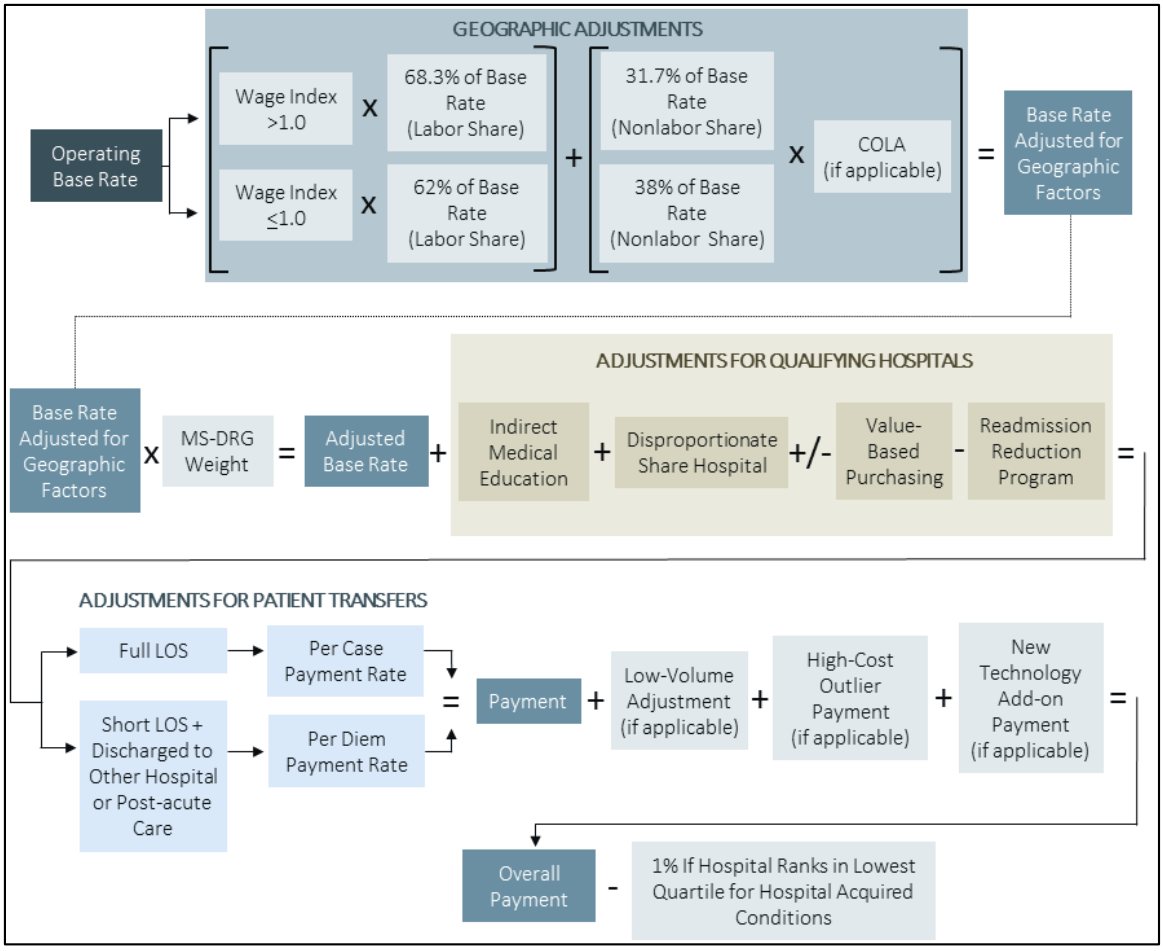
[72] As distinguished from, for example, long-term care hospitals, psychiatric hospitals, or pediatric/children's hospitals.

[73] Prior to the inpatient prospective payment system (IPPS), Medicare paid for hospital inpatient services based on a hospital's reasonable costs, subject to certain limits.

[74] The IPPS *base rate* is calculated using costs reported by hospitals on the Medicare cost report for the cost reporting period that ended during the period October 1, 1982, through September 30, 1983, updated annually. Under the IPPS, a hospital receives two payments, one for *operating* expenses and another for *capital* expenses. This report describes the IPPS operating payment only. For more on Medicare Severity-Diagnosis Related Groups (MS-DRGs), see footnote 9.

[75] Additionally, other hospitals that are exempt from the IPPS and are reimbursed by Medicare under different methods include hospitals in Maryland, hospitals in U.S. territories (with the exception of Puerto Rico), and hospitals of the Indian Health Service.

Figure A-1. Medicare Hospital Inpatient Prospective Payment System (IPPS) for Operating Costs



Sources: Congressional Research Service (CRS), adapted from the Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network, *Acute Care Hospital Inpatient Prospective Payment System*, March 2020, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf; and Medicare Payment Advisory Commission (MedPAC), *Hospital Acute Inpatient Services Payment System*, October 2020, at http://www.medpac.gov/-documents-/payment-basics.

Notes: For illustrative purposes, this schematic addresses the *operating* portion of the IPPS payment; it does not address the *capital* IPPS payment. COLA = cost-of-living adjustment (applicable to the nonlabor portion of the IPPS base payment for IPPS hospitals in Alaska and Hawaii); LOS = length of stay; MS-DRG = Medicare Severity-Diagnosis Related Group.

Appendix B. Legislative History of the Medicare Hospital Wage Index

Table B-1. Legislative History of the Medicare Hospital Wage Index

Public Law	Summary
Social Security Amendments of 1983 (P.L. 98-21)	Section 601 established the hospital IPPS, including a wage index that adjusts the standardized reimbursement amounts for area differences in hospital wage levels "reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." Required the HHS Secretary to determine, and periodically adjust, the proportion of a hospital's costs that are attributable to wages and wage-related costs.
Deficit Reduction Act of 1984 (P.L. 98-369)	Section 2316 directed the HHS Secretary to develop a new wage index that accounts for full- and part-time wages.
Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)	Section 9103 delayed implementation of the wage index to hospital discharges on or after May 1, 1986.
Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203)	Section 4005(a) established "Lugar counties" which are counties adjacent to MSAs meeting certain worker commuting patterns that are deemed urban.[a]
Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647)	Section 8403(a) directed the wage index for Lugar counties to be calculated separately from the adjacent urban area to avoid a reduction of the urban area's wage index values; conversely, it directed the wage index for the rural area(s) to be calculated as if the Lugar hospitals were not Lugar to avoid a reduction of the rural area's wage index value.
Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239)	Section 6003(h) created the MGCRB, specified the general process for consideration of reclassifications by the MGCRB, and required the HHS Secretary to develop guidelines for rendering MGCRB decisions. Limited the negative effect from reclassifications to 1% or less in the geographic area to and from which a facility reclassifies and specified that reclassification may not result in a reduction to any county's wage index to a level below the rural wage index of that state. Required that wage indexes be updated annually beginning FY1994.
Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508)	Section 4002(h) further limited the effect of redesignation on wage index values for non-redesignated facilities in urban areas.
Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)	Section 13501(b) prevented a reduction in the wage index for an urban area where the urban area's index value is below the state rural wage index value.
Balanced Budget Act of 1997 (P.L. 105-33)	Section 4410 established a wage index floor that is not less than the statewide rural wage index value for hospitals located in urban areas.
Balanced Budget Refinement Act of 1999 (P.L. 106-113)	Section 401 permitted an urban hospital to be treated as being located in a rural area (i.e., urban-to-rural reclassification).
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554)	Section 304 mandated occupational mix data collection and implementation of an occupational mix adjustment effective October 1, 2004. Established three-year duration for MGCRB reclassifications. Allowed a statewide entity to apply to have all geographic areas in the state be classified as a single geographic area.

Public Law	Summary
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173)	Section 505 established an "out-migration" adjustment. Section 508 created a one-time appeals process for MGCRB decisions for hospitals that do not qualify for a reclassification based on distance or commuting patterns; *Section 508 reclassifications* allow the temporary reclassification of a hospital from a low Medicare hospital wage index geographic area, for reimbursement purposes, to a nearby geographic area with a higher Medicare hospital wage index, so that the *Section 508 hospital* will receive a higher Medicare inpatient hospital payment rate.
Tax Relief and Health Care Act of 2006 (TRHCA; P.L. 109-432)	Section 106 extended Section 508 hospital reclassifications. Mandated MedPAC study of alternative wage indexes. Directed the HHS Secretary to propose revisions to the wage index, taking into account the mandated MedPAC study.
Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)	Section 117 amended the TRHCA to extend certain Medicare hospital wage index reclassifications through FY2008. Directed the HHS Secretary to extend for discharges occurring through September 30, 2008, the special exception reclassifications made under Medicare and contained in the final rule promulgated by the HHS Secretary in the *Federal Register* on August 11, 2004. Amended the MMA to provide, for purposes of the reclassification of a group of hospitals in a geographic area applicable to discharges occurring during FY2008, that a hospital reclassified under such act shall not be taken into account and shall not prevent the other hospitals in such area from continuing such a group for such purposes. Directed the HHS Secretary, in the case of certain IPPS hospitals, to apply a certain higher wage index in specified circumstances.
Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)	Section 3137, as modified by Section 10317, amended the TRHCA, as modified by other federal law, to extend Section 508 hospital reclassifications until September 30, 2010, with a special rule for FY2010. Directed the HHS Secretary to report to Congress a plan to reform the hospital wage index system. Section 3141 applied the budget-neutrality requirement associated with certain wage index reclassifications and adjustments at the national level rather than at a state-by-state level as proposed by CMS.
Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309)	Section 102 amended the TRHCA, as modified by other federal law, to extend Section 508 hospital reclassifications through FY2011.
Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)	Section 302 amended the TRHCA, as modified by other federal law, to extend Section 508 hospital reclassifications for two months, through November 30, 2011.

Sources: Compiled by CRS from multiple sources, including MedPAC, Congress.gov, amendments to the *United States Code* provided by the U.S. House of Representatives Office of the Law Revision Counsel, and previous CRS reports. Table 1 of "Potential Refinements to Medicare's Wage Indexes for Hospitals and Other Sectors," RTI International for MedPAC, June 2007, at http://www.medpac.gov/docs/default-source/contractor-reports/potential-refinements-to-medicare-s-wage-indexes-for-hospitals-and-other-sectors.pdf?sfvrsn=0, was used as an initial source.

Notes: This section summarizes Medicare wage index legislation enacted into law. Summaries highlight major provisions; this is not a comprehensive list of all amendments. HHS = Department of Health and Human Services; IPPS = inpatient prospective payment system; MedPAC = Medicare Payment Advisory Commission; MGCRB = Medicare Geographic Classification Review Board; MSA = metropolitan statistical area.

a. "Lugar counties" applies to the rural-to-urban wage index reclassification summarized in **Table 3** of this report.

Author Information

Marco A. Villagrana
Analyst in Health Care Financing

Acknowledgments

Steven Weiss made significant contributions to this report as part of a summer internship. Jamie Hutchinson, Visual Information Specialist, and Jim Uzel, Geospatial Information Systems Analyst, designed the figures. Michele Malloy, Research Librarian, prepared the legislative history in **Appendix B**. Isaac Nicchitta, Research Assistant, performed data analysis for **Table 3**.

Disclaimer