Make the Most of Your Wage Index Opportunity

HFS Hospital Provider User Meeting

October 14, 2016

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- Wage Index Services
  - Industry leader in wage index opportunities;
  - We model all releases of the Public Use File (PUF) data
  - Recently we modeled the release of the 10/3/16 correction notice
- Audit of individual Hospital data and specific CBSAs
- Individual and Group (County) Reclassifications
  - Over $700M in various reclassifications (years 2005-2017)
- 508 reclassifications
  - Out-of-the-box opportunity for our 4 client hospitals to receive over $150M during the duration of special provision

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Benefits of BESLER Wage Index Service

- Our team of professionals continue to monitor developments in wage index regulations;
- Innovative approach to our wage index modeling is unmatched in the industry;
- Members of our team have been speakers to the industry and tutors to the MAC on various wage index topics;
- Model each release of Pubic Use File information and keep our clients informed of each potential opportunity;
- Relationships with CMS and various Medicare Administrative Contactors (MACs) allow for smooth audit process;
- Responsiveness to our clients – we keep you informed throughout the entire process and also present opportunities to increase your overall average hourly wage

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Wage Index Update: Table of Contents

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Wage Index Update: Overview

- Purpose of Wage Index
- Cost Reporting of Hospital Wage Index Information
- Calculation of Wage Index
- Time Table Deadlines
- Recent Changes in Regulations
- How does your CBSA Compare?
- What Can You Do Today?
- What is on the Horizon for Wage Index?

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Wage Index Update: Overview

The Wage Index is used for the following types of payments:

- Hospital Inpatient Prospective Payment System (IPPS) DRG payments
- Rehab PPS payments
- Psychiatric PPS payments
- Skilled Nursing PPS payments
- Home Health Agency PPS payments
- Hospital Outpatient Prospective Payment System (OPPS) APC Payments
- Hospice Payment Caps

CMS Methodology

- Section 1886(d)(3)(E) of the Social Security Act requires the Secretary to:

"Adjust standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

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Recent Changes to Wage Index

Time Table

- MACs are strict with these deadlines!
- Deadline to submit adjustments for FFY 2018 was September 2nd.

- **Cost Report Changes – Not new but still finding errors when reviewing the data**
- 5 plus years into FORM CMS-2552-10
- Home Office/Overhead Salaries – Potential for Upcoming Changes
- Pension
- Attestations
- Capitalized Salaries
- Wage Related Costs

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Recent and Upcoming Deadlines

- **September 2, 2016**- Deadline for hospitals to request revisions to their Worksheet S-3 wage data and CY 2013 occupational mix data as included in the May 16, 2016 preliminary PUFs and to provide documentation to support the request. MACs must receive the revision requests and supporting documentation by this date. MACs will have approximately 10 weeks to complete their reviews, make determinations, and transmit revised data to CMS's Division of Acute Care (DAC).
- **November 2, 2016 -** Deadline for MACs to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk reviews. The purpose of the letter is to inform the State association and its member hospitals that a hospital's failure to respond to matters raised by the MAC can result in lowering an area's wage index value and, therefore, lower Medicare payments for all hospitals in the area.
- **November 15, 2016** - Deadline for MACs to complete all desk reviews for hospital wage data and transmit revised Worksheet S-3 wage data and occupational mix data to DAC. Worksheet S-3 wage data must be sent to DAC in electronic format (HCRIS hdt format. Occupational mix data must be sent to DAC on the electronic Excel spreadsheet provided by DAC for specific use by MACs.

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-WI-Time-Table.pdf

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CMS Methodology

Providers submit the following wage index data to CMS from Cost Report work-sheet S-3 PT. II, III, IV and V:

- **Salaries and Wage Related Costs (Trial Balance)**
  - Hospital Employees
  - Home Office and Related Party Employees
- **Hours Related to Paid Salaries (Payroll)**

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CMS Methodology

CMS uses the provided wage index data to adjust salaries, hours, wage related costs, and contract labor by:

- **Overhead Excluded Ratio Calculation** – Allocates a portion of overhead salaries, wage related costs, and hours to excluded units
- **Cost Report Mid-Point Mark Up Factor** –Inflates hospital salaries from the cost report year to the current federal year
- **Occupational Mix Factor** – Survey collected from CMS every three years applied against the nursing portion of hospital salaries. This adjustment is used to account for labor pools available to providers in various geographic areas

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Medicare Occupational Mix Adjustment

- Section 304(c) of Public Law 106-544 which amended section 1886(d)(3)(E) of the Social Security Act requires Centers of Medicare and Medicaid (CMS) to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program.
- Purpose is to adjust the Average Hourly Wage (AHW) by accounting for differences in management "choices" of staffing.
- MOMA is used to "level" the playing field & exclude mgt. decisions on staffing
- Providers with a higher mix of lower paid personnel (i.e. medical assistants and nursing aides) receive higher occupational mix factor.
- Markets with an expensive mix of employees and contract labor have a reduced AHW - ?
- The most important factor is RN hours to total nursing hours. The national percent for FFY 2017 is 71.52%.
- So, if the Hospital RN % > 71.52% = negative MOMA; if the Hospital RN % <= positive MOMA

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Medicare Occupational Mix Adjustment

- The MOMA is an important part of a hospital's and subsequently, CBSA's AHW.
- FFY 2017 survey was submitted in 2014 (July 2014) and will be for FFY 2016, FFY 2017 and FFY 2018.
- New Survey will be (should be) due this July 1, 2017. (FFY 2019-FFY 2021)
- More than likely it will be similar to previous years as the form was in Excel format and must be submitted to your MAC/FI.
- FFY 2017 survey utilizes data from CY 2013 as will FFY 2018.
- CMS requests data for 26 pay periods with no accruals or adjustments.
- MOMA Survey very important – its impact will last 3 years
- Focus on RN and other nursing categories – DO NOT OVERLOOK "All Other" category

Medicare Occupational Mix Adjustment

Know your Nursing Staff and Categories

- RNs – direct patient health needs – patient contact, and supervise others that do patient care
- LPNs – Care for patients that are ill, injured, or disabled
- Surgical Technologists – assist in patient care operations under supervision of physicians (surgeons), RNs and other surgical positions.
- Aides – nursing staff providing basic nursing care
- Medical Assistants – perform more general or administrative functions – usually under the direct supervision of a physician
- All Other – not involved with any type of patient care, mostly administrative

Tip: All categories that are excluded from the wage index are not to be reported on the MOMA Survey

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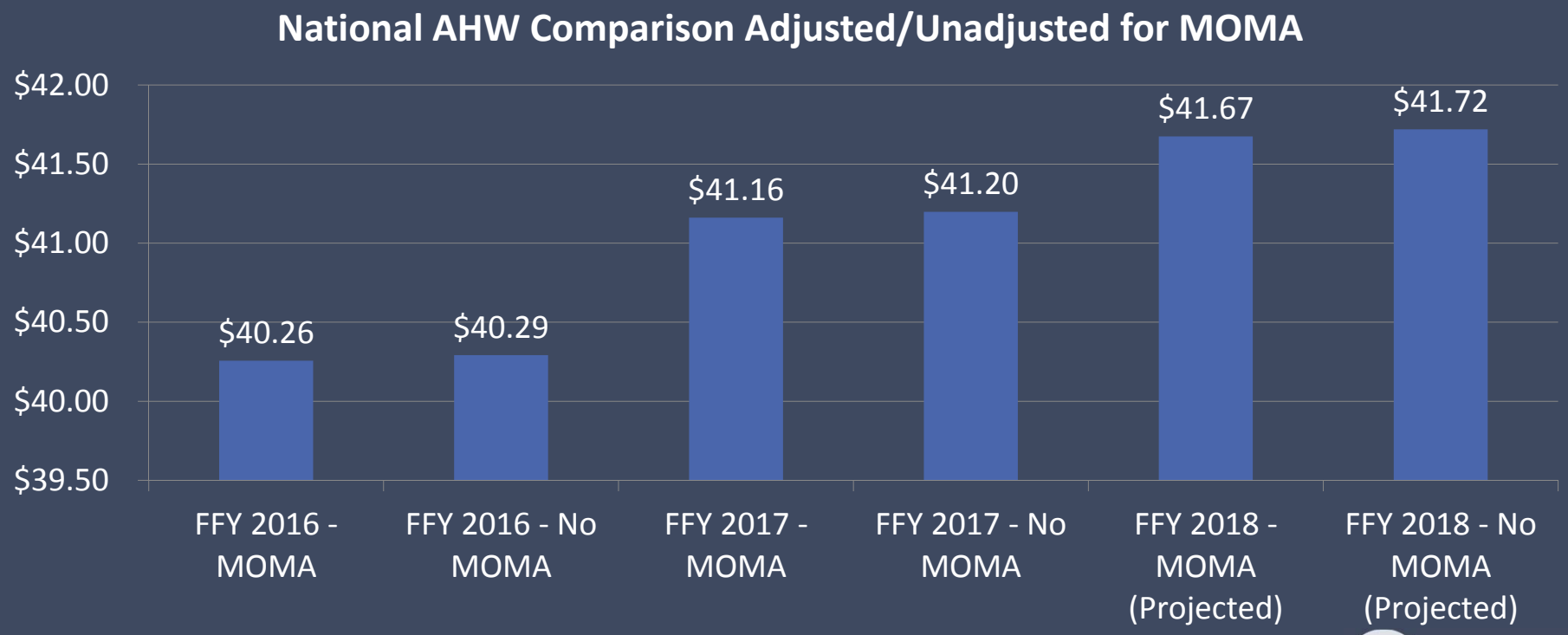
National AHW Analysis



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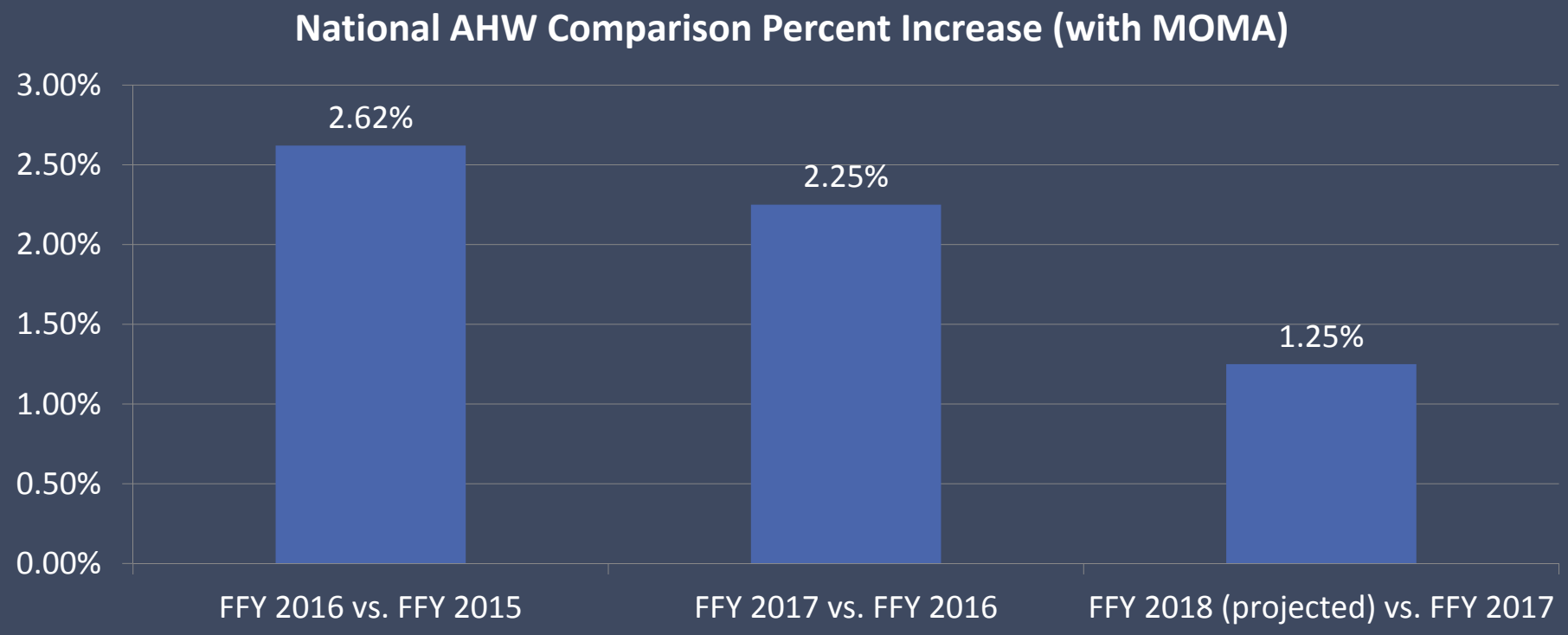
National AHW Analysis



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Top 11 CBSA Wage Index Values

CBSA #	CBSA Description	FFY 2017	FFY 2017 CN
42100	Santa Cruz-Watsonville, CA	1.8039	1.8017
42034	San Rafael, CA	1.7577	1.7555
41940	San Jose-Sunnyvale-Santa Clara, CA	1.7395	1.7374
36084	Oakland-Hayward-Berkeley, CA	1.7227	1.7206
41884	San Francisco-Redwood City-So San Francisco, CA	1.7163	1.7143
46700	Vallejo-Fairfield, CA	1.6993	1.6972
41500	Salinas, CA	1.6983	1.6962
40900	Sacramento-Roseville-Arden-Arcade, CA	1.5977	1.5957
42220	Santa Rosa, CA	1.5957	1.5937
34900	Napa, CA	1.5374	1.5355
39820	Redding, CA	1.4503	1.4485

Top 11 CBSA AHW Increases

CBSA #	CBSA Description	FFY 2016 AHW	FFY 2017 AHW	% Incr
43340	Shreveport-Bossier City, LA	$33.01	$38.14	15.55%
13900	Bismarck, ND	$29.85	$33.68	12.83%
17820	Colorado Springs, CO	$36.79	$41.42	12.61%
30020	Lawton, OK	$29.76	$33.23	11.65%
17660	Coeur d'Alene, ID	$36.04	$40.16	11.43%
44700	Stockton-Lodi, CA	$52.24	$58.12	11.25%
15804	Camden, NJ	$40.78	$45.36	11.23%
02	ALASKA	$53.00	$58.90	11.12%
34620	Muncie, IN	$37.36	$41.40	10.80%
13	IDAHO	$28.22	$31.00	9.86%
39740	Reading, PA	$36.57	$39.97	9.30%
	National AHW	**$40.26**	**$41.16**	**2.25%**

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AHW and Wage Index Analysis

CBSA Comparison

- Of the Top 11 AHW increases only 3 had more than 3 hospitals that comprised their CBSA
- 210 CBSAs had an AHW increase greater than the national AHW
- 164 CBSAs had an AHW increase less than the national AHW but greater than 0%
- 3 CBSAs were at 0%
- 78 CBSAs had AHW decrease less than -0.01 %
- Hospitals should know the drivers in their own CBSA
- Hospitals that drive the wage usually drive the occupational mix adjustment
- CMS' public use files are a great tool to compare your hospital to your CBSA

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Top 11 CBSA AHW Increases >20 Providers

CBSA #	CBSA Description	FFY 2016 AHW	FFY 2017 AHW	% Incr
36420	Oklahoma City, OK	$35.18	$37.18	5.70%
37	OKLAHOMA	$30.86	$32.46	5.18%
11244	Anaheim-Santa Ana-Irvine, CA	$46.69	$49.07	5.10%
18	KENTUCKY	$31.26	$32.62	4.36%
33	NEW YORK	$34.05	$35.52	4.31%
26900	Indianapolis-Carmel-Anderson, IN	$40.21	$41.88	4.15%
19	LOUISIANA	$28.64	$29.66	3.58%
38300	Pittsburgh, PA	$34.57	$35.74	3.36%
25	MISSISSIPPI	$29.73	$30.68	3.21%
40140	Riverside-San Bernardino-Ontario, CA	$45.86	$47.29	3.13%
04	ARKANSAS	$29.69	$30.56	2.93%
	National AHW	**$40.26**	**$41.16**	**2.25%**

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OMB bulletins

- February 28th, 2013 OMB bulletin no. 13-01 is released.

The document revised delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas (CSA).

- This document impacted the entire country and was ready to be used for FFY 2014, but CMS chose not to;
- July 15th, 2015 OMB bulletin no. 15-01 is released.
- Not as many changes as the previous bulletin but hospitals should review this as it is the most recent document.

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FFY 2015 Transition Period

- Urban hospitals that experienced a decrease in their FFY 2015 wage index as a result of the new delineations;
- CMS utilized a blended methodology to determine their wage index amount;
- This blend was the sum of 50 percent of their WI value under the new FFY 2015 wage index delineations and 50 percent of their WI value under the old wage index delineations that were used for the FFY 2014 wage index;

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Out Migration Adjustment

Section 1886(d) (13) of the Act established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees

- Adjustment for hospitals in counties where hospital employees commute to adjacent counties with a higher wage index;
- For FFY 2016 – FFY 2018 Out Migration adjustments were updated from the new delineations.

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Wage Index Exemptions

Providers are eligible to receive a wage index factor outside of their respective CBSA.

- **Rural Floor** – No hospital can receive a wage index less than its statewide rural wage index 397 Hospitals are impacted by the rural floor (see table in Final Rule page 57320)

- **Frontier States (Per Affordable Care Act)** – No hospital in a county with less than six people per square mile can receive a wage index less than 1.00 (Alaska and Hawaii excluded); 50 hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming are impacted by this rule.

- **Out-Migration Adjustment** – Increase to the wage index for hospitals in counties that have a relatively high percentage of employees that reside in the county, but work in a different county with a higher wage index; 373 hospitals will receive an adjustment for out-migration For FY 2017, 700 hospitals are eligible for out-migration but because of their reclassification application, waive this adjustment.

- **Geographic Reclassification** – Increase to the wage index for hospitals (individual, county, or statewide) by receiving a neighboring CBSA wage index factor (full wage index or blended, “diluted”, wage index). Providers must apply and pass reclassification criteria to qualify

Wage Index Exemptions – Individual Provider

Geographic Reclassification Criteria for an Individual Hospital per CFR §412.230 –

- - The pre-classified average hourly wage (AHW) of the desired CBSA is greater than the hospital's AHW and the Standardized amount in the desired CBSA is greater than the hospital's standardized CBSA;
- - The hospital may not be re-designated to more than one area;
- - The distance from the hospital to the desired CBSA is no more than a) **15 miles for urban hospitals** or b) 35 miles for rural hospitals OR at least 50% of the hospital's employee's reside in the target CBSA.
- - The hospital's 3 year AHW is a) for Rural hospitals, at least 106% of its current location's 3 year AHW **b) for Urban hospitals at lease 108% of its current location's 3 year AHW (CBSA)**;
- - The hospital's 3 year AHW is a) for Rural hospitals, at least 82% of the desired location's 3 year AHW b**) for Urban hospitals, at least 84% of the desired location's 3 year AHW (CBSA)**.

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Wage Index Exemptions – Group (County)

Geographic Reclassification Criteria for a Group/County per CFR §412.234 –

- - The county 3 year AHW (Wages/Hours) is at least 85% of the target CBSA 3 year AHW (Rounding is not permitted);
- - All hospitals in the county must apply for the reclass;
- - The county must be adjacent to the target CBSA;
- - Urban counties must be in the same Combined Statistical Area (CSA) as the target CBSA;
- - Rural counties (reclassifying to urban CBSAs) must demonstrate that the county in which the hospitals are located meets the Metropolitan Test standards for redesignation using Census Data.
- - The pre-classified AHW of the target CBSA is greater than the county's AHW.

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Reclassification Implications

- Reclassified hospital cannot negatively impact geographically located hospitals
- Reclassified hospitals can create a positive or negative dilutive effect (also called “blend’)
- If the addition of the reclassified wages and hours result in a decrease of 1.00% or greater, reclassified hospitals receive that amount
- All hospitals (geographic and reclassed) benefit from positive blend
- Only reclassed hospitals are impacted by negative blend

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Special Reclasses

- ***Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services***, 794 F.3d 383 (3d Cir. 2015);
- ***Lawrence + Memorial Hospital v. Burwell, No. 15– 164***, 2016 WL 423702 (2d Cir. February 4, 2015)
- Urban to Rural Status and Reclassifications
- ‘‘the Secretary shall treat the hospital as being located in the rural area,’’ inclusive of MGCRB reclassification purposes, thus invalidating the regulation at § 412.230(a)(5)(iii)

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Wage Index Audit Process
Review of Worksheet S-3, Part II

- **Trial Balance Review of Accounts**
- Identify all possible accounts that may be eligible for wage index reporting; for example:
  - Patient Care Contract Labor (Line 11)
  - Management Contract Labor (Line 12)
  - Contract Labor – Physician Part A (Line 13)
  - A&G Contract Labor (Line 28)
  - Housekeeping Contract Labor (Line 33)
  - Dietary Contract Labor (Line 35)
  - Wage Related Costs (Lines 17 – 25)

  Tip: Total Salaries should reconcile to CMS 2252-10: worksheet A, column 1, line 200 and include vacation, holiday, sick, paid time off, severance and bonus pay.

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Wage Index Audit Process
Review of Worksheet S-3, Part II

- **Trial Balance Review of Accounts (cont'd)**
- Review accounts payable "drill down" information for identified wage index accounts.
- Determine if the expense is allowable for wage index reporting.
- For contract labor, ensure that professional fees and hours are supported on the contract and/or invoice.

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Wage Index Audit Process
Review of Worksheet S-3, Part II

- **Hours Related to Paid Salaries**
- The following hours should be removed from the payroll file for wage index reporting:
  - Differential OT hours that are recorded (i.e. if an employee works 1 hour, but the time is recorded at 1.5, then .5 hours can be removed)
  - Bonus Hours
  - On-Call Hours (report hours for contractors that are hired solely for the purpose of being on call)
  - Shift Differential Hours
  - PTO Paid Out At Employee Termination
  - Buy/Sell back PTO
  - Buy/Sell back vacation
  - Missed meals and breaks
  - Unpaid Family Medical Leave
  - Unpaid Disability

TIP: Hours associated with earn codes that represent "time" paid are to be reported (for instance, report PTO hours as they represent time, and do not report PTO cash-out hours, as they do not represent time).

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Wage Index Audit Process
Review of Worksheet S-3, Part II

- **Hours Related to Paid Salaries**
- The following hours should be removed from the payroll file for wage index reporting (cont'd):
  - Unpaid Leave of Absence
  - Hours related to capitalized salaries
  - Hours associated with current year are reported hours – any hours that are accrued, do not have to be reported
  - Baylor Plan: employees work 36 hours, but get paid for 40 hours – remove 4 hour difference
  - Seasonal Plan; employees work certain months of the year, but get paid for 52 weeks – remove the time not actually employed
  - Severance Hours; General rule: if severance is booked as a "salary" expense then include hours. If severance is booked as a non-salary expense, do not include hours
  - Disability Hours; If disability hours are reduced on the payroll report , they need gross up to 100%
  - Holiday Pay for Nurses who work a paid holiday. The Nurses may get paid regular pay + holiday pay + overtime; ensure that hours are not being double-counted

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Wage Index Audit Process
Review of Worksheet S-3, Part II

Contracted Labor

Appropriate supporting documentation for ALL contract labor (Per CMSTransmittal 20):

- The minimum requirement for supporting documentation is the contract itself;
- Many MACs require that the contract has an "access clause" as defined at 42 CFR 420.302;
- If the wage costs, hours, and non-labor costs are not clearly specified in the contract, then other documentation is necessary, such as a representative sample of invoices or a signed declaration from the vendor in conjunction with a sample of invoices;
- Contracts or invoices must specify professional fees apart from non-labor fees (i.e., travel, meals, supplies).

TIP: Patient care contract labor is primarily found in registry accounts as well as therapies, perfusion, dialysis and temporary labor accounts in the hospital's trial balance. Administrative and General contract labor is primarily found in audit and legal fees, consulting and management accounts in T/B.

Wage Index Audit Process
Review of Worksheet S-3, Part IV

CORE Related Costs

- 401(k) Employer Contributions
- Tax Sheltered Annuity (TSA) Employer Contributions
- Qualified and Non-Qualified Pension Plan Cost
- Prior Year Pension Service Cost
- 401(k)/TSA Plan Administration Fees
- Legal/Accounting/Management Fees – Pension Plan
- Employee Managed Care Program Administration Fees
- Health Insurance (Purchased or Self-Funded)
- Prescription Drug Plan
- Dental, Hearing, & Vision Plans
- Life Insurance (If employee is owner or beneficiary)

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Wage Index Audit Process
Review of Worksheet S-3, Part IV

CORE Related Costs (cont'd)

- Accident Insurance (if employee is owner or beneficiary)
- Disability Insurance (if employee is owner or beneficiary)
- Long-term Care Insurance (if employee is owner or beneficiary)
- Worker's Compensation Insurance Retiree Health Care Cost (only current year)
- FICA – Employer's Portion Only
- Medicare Taxes – Employer's Portion Only
- Unemployment Insurance
- State or Federal Unemployment Taxes
- Executive Deferred Compensation
- Day Care Cost and Allowances
- Tuition Reimbursement (can include Licensing Fees for Nurses, Techs, etc.)

TIP : Lines 17, 18 and 22 are the ONLY lines included in the hospital's average hourly wage calculation. Also it is more accurate to allocate (Core, Exclude, Physicians, etc) some wage related costs using FTEs as the statistic (i.e., for health insurance) as opposed to salaries (i.e., pension).

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Wage Index Audit Process
Review of Worksheet S-3, Part IV

Other Wage Related Costs

- Parking Subsidy / Cafeteria Subsidy / Transportation Subsidy
- Employee Wellness Program / Employee Assistance Program
- Salaried Physician Malpractice
- Employee Relocation Reimbursement
- Employee Service Awards / Employee Banquets
  - Any other employee benefit that is reported on the G/L and to the IRS as a fringe benefit, and which has not been furnished for the convenience of the hospital.
- Must meet the "1% Test"
  - Each individual "other" wage related cost must exceed 1% of Worksheet S-3, Part III, Line 3, Column 3 in order to be reported on Worksheet S-3, Part II, Line 18.
- Other wage related costs must also be allocated between allowable and excluded areas (e.g., based on salaries, FTEs, etc.).

Healthcare Reform – Wage Index

- CMS and its decision on wage index reform.
- The rural floor budget neutrality factor was again applied at a national level (rather than state specific level).
- Three year average hourly wage thresholds for geographic reclassifications

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Healthcare Reform – Wage Index

- Started back in 2006.
- Tax Relief and Health Care Act (TRHCA) allowed congress to order Medicare Payment Advisory Commission's (MedPAC) to develop recommendations for revising the current wage index system.
- There are 3 core areas of concern with the current wage index system:
  - Circularity (area's ability to maintain AHW with national AHW)
  - Volatility
  - Geographic Boundaries
- CMS engaged with Acumen, LLC to execute an impact analysis between MedPAC's recommendations and the current system.

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Healthcare Reform – Wage Index

- U.S. Rep. Kevin Brady (R-Texas) put forth a bill on the House The Medicare Hospital Wage Index Equity Act of 2013 would effectively overwrite the rural floor provision of the hospital wage index

- In a release, Rep. Brady slammed the so-called "Bay State Boondoggle," a controversy uncovered earlier this year regarding a situation in Massachusetts in which the state's only rural hospital — located in the affluent Nantucket region — helped drive all other Massachusetts hospitals' Medicare wage reimbursements up. "Last year local hospitals in 40 states lost $471 million," Rep. Brady said in the release. "It's time to stop rewarding one state at the expense of all the others."

- Twenty state hospital associations and the National Rural Health Association have opposed the index payment change under the PPACA, and U.S. Sens. Claire McCaskill (D-Mo.) and Tom Coburn, MD (R-Okla.), passed an amendment to the Senate budget that would undo the change if approved in both chambers.

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Previous Wage Index Proposed Changes

- Data Sources: Bureau of Labor Statistics (BLS) Occupational Employee Statistics (OES) Survey, 2000 Census, and benefit data from Worksheet A of the Medicare Cost Report.

- Bureau of Labor Statistic data (Released every May & November)
  - Include hospital and non-hospital data
  - Over 1 million businesses and collected every three years
  - By occupation (eliminate need for Occupational Mix?)

- Adjustment (RNs, LPNs, physical therapist, etc)
  - By county within and outside CBSAs
  - Determine wage index for each CBSA (metro division)

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Previous Wage Index Proposed Changes

- Smoothing - Wage data is adjusted at the county level "smoothing," large differences between counties, and implemented so that large changes in wage index values are phased in over a transition period.
- High cost county/counties may be increased up to 105% of CBSA average; Lower cost counties (generally outlying counties) can be reduced to 95%.
- Maximum "cliff" at county boundary is set at 10%
- Rural counties (outside Metropolitan Statistical Areas) county by county determination; 10% maximum cliff.
- Eliminate geographic reclassification

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Previous Wage Index Proposed Changes

- Acumen Report Part I - Source Data for the Wage Index
  - Recommends the use of BLS data, but acknowledges there are many issues with the data.
  - Recommends that CMS works with BLS to produce a more reliable manner of capturing wage related cost data.
  - Recommends a clear set of rules for construction of 30 occupational fixed weights.
- Acumen Report Part II – Wage Index Geographic Areas
  - Acumen does not recommend MedPAC proposed methods of smoothed county indices.
  - Acumen recommends that CMS explore the use of labor market definitions as geographic areas used to develop wage index.
  - Labor market definitions would use specific characteristics (i.e. commuting patterns or the proximity of one hospital to another).
- Commuter Based Wage Index

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Wage Index Task Force

- Created in 2011 by the American Hospital Association to serve the following purposes:
  - identify and evaluate the strengths and weaknesses of the current hospital area wage index
  - develop a set of principles by which to evaluate various proposals to modify the hospital area wage index
  - evaluate proposals and studies to change the hospital area wage index
  - make recommendations to improve the accuracy, fairness and effectiveness of the hospital area wage index
- Task Force has met periodically since November 2011 (most recently July 2013).
- Any substantial change would require statutory and regulatory change - Never easy – let alone in an election year (nothing happened in ‘12)

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Wage Index Task Force

Wage Index Principles

- Wage index reform is absolutely necessary
- Must be a transition period and budget neutral
- Should reflect relative differences in labor markets
- Must be transparent and easy to understand and administer
- Must minimize large swings from year-to-year
- Eliminate large differences across areas
- Minimize or if possible, eliminate need for any exceptions
- No hard boundaries
- Broadly define wage areas but not so much to dilute overall value

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What should Hospitals be doing?

- Submit accurate Wage Index data on Medicare Cost Reports
- Monitor the Wage Index Timetable deadlines
- Identify potential opportunities to obtain a higher WI value:
  - Where does the greatest benefit lie?
- Re-evaluate the benefit of current/potential reclassifications (if reclassifying is an option)
- Compare reclass WI value to Geographic WI value
- Understand the driving factors of your Wage Index

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What Can Hospitals Do?

- Nothing
  - Leave changes in the hands of CMS
  - Allow Acumen or another consultant to publish another proposal
- Develop a solution and frame it for CMS
  - Should minimize redistribution
  - Majority rules – need support from most of industry
  - Must satisfy the objectives of the Affordable Care Act
- Industry needs to challenge the BLS
  - Audit or lack of it
  - No contracted labor
  - Inaccuracies among those that file report
  - No fringe benefits

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