I am James Bentley, Ph.D., a semi-retired health policy analyst currently consulting with hospitals and state hospital association on the implications of health reform for their operations. I was employed by the American Hospital Association from 1991 through 2009 and by the Association of American Medical Colleges from 1976 through 1991. I also am a member of the Board of Directors of Trinity Health. The observations I offer the committee today are my personal observations and do not necessarily reflect the view of Trinity Health, the American Hospital Association, or the Association of American Medical Colleges.

During the early 1980s, I served as a member of an external task force convened by the Administrator of the Health Care Financing Administration to advise her on the development of a prospective payment system for Medicare’s inpatient hospital payments.

The payment limitations imposed under Section 223 of P.L. 92-603 and TEFRA demonstrated that a workable prospective payment system needed to address variations in hospital costs. Thus, the prospective payment system developed included from its beginning, or shortly thereafter, adjustments to recognize five sources of variation in hospital costs:

- Patient case mix
- Outlier payments for patients with atypically long stays
- A geographic wage index
- Participation in graduate medical education
- Participation in the care of atypical numbers of low-income patients.

Each of the adjustments was included because variations in cost were beyond the hospital’s control (e.g., case mix) or reflected an expanded mission scope (e.g., graduate medical education).

While each of the adjustments included in PPS has been criticized, I believe the wage index adjustment has historically received the greatest criticism. As you address variations, I offer the following ten observations about the wage index adjustment from listening to hospital CEOs and the presidents of state hospital associations across the past 27 years.

1. Please note that the geographic wage index was the only adjustment accounting for variations that were geographic in nature. Thus, I believe one of the problems with the current wage index from the hospital’s
viewpoint is that wages alone are an inadequate measure of geographic variation.

2. Labor markets do not conform to geographic, governmental, or postal boundaries. Only the most isolated, rural hospitals draw their staffs from a single community. Hospitals ranging from small to large sizes draw staff from a large number of communities. For example, a single hospital in the Washington, DC area may have staff living as far away as West Virginia, Pennsylvania, Maryland’s Eastern Shore, and the greater Richmond area. This makes it difficult to define a single labor market for any hospital.

3. The current use of geographic areas to define wage indices often results in a large difference between adjacent areas and is typically described as the “wage index cliff.” Hospitals in close geographic proximity can have substantial differences in their wage indices and in their PPS payments.

4. I have never heard a CEO say his or her Medicare wage index is too high. This does not reflect greed or avarice. For over a decade, hospitals have faced labor shortages across a wide variety of occupations. The shortages have created pressures to increase wages to attract staff. CEOs and human resource directors are pressed to increase wages. Even in high index areas, the current system constrains revenues from the hospital’s largest payer.

5. Hospital leaders in areas with low Medicare wage indices feel they are at a perpetual disadvantage. In order for a higher index to prevail, hospitals throughout the area would have to fund internally a disproportionate increase in wages for several years before the present wage index system would provide them with a higher index. Given their current low wage index, the hospitals lack the resources to fund such a change internally.

6. Hospitals are frustrated that annual wage index adjustments are budget neutral. As a result, when a hospital increases its wages less than the national average, the hospital’s wage index goes down.

7. The current wage index system is vulnerable to variations in staffing arrangements. Hospitals that outsource low wage services are able to report higher average wages while those that outsource high wage services report low average wages. There is a need to develop a more inclusive or consistent way of capturing data on compensation.

8. I believe most hospital leaders do not think in index terms; they think in terms of wage rates. Thus, they are highly suspicious of any index that uses a proxy for hospital wage differences, even if the proxy has a perfect statistical correlation with hospital wage differences.
9. Hospital leaders are highly suspicious of any data used to set wage indices that is not completely transparent and auditable. Proposals in past years to use Bureau of Labor Statistics data are opposed because BLS, for its own good reasons of sampling and to avoid manipulation, keeps the identification of firms included in the data confidential.

10. The Katrina hurricane demonstrated to hospitals the importance of a timely exception process when time-lagged data is used to determine an index. Following Katrina, New Orleans area hospitals experienced wage levels that were not representative of those before the storm. Similarly, when California imposed mandatory nurse staffing standards, hospital compensation costs increased but were not reflected in the Medicare wage index for several years.