

Background on the wage-related portion of the Medicare DRG payments

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- ***What makes up the DRG Payment?***

Most PPS hospitals are paid based on the sum of two fixed amounts per Medicare discharge, that are called the standardized payment amounts. Each case receives both an operating payment and a capital payment. The operating standardized amount is separately computed for hospitals located in large urban areas, and for those located in all other areas (i.e. smaller urban and rural combined).

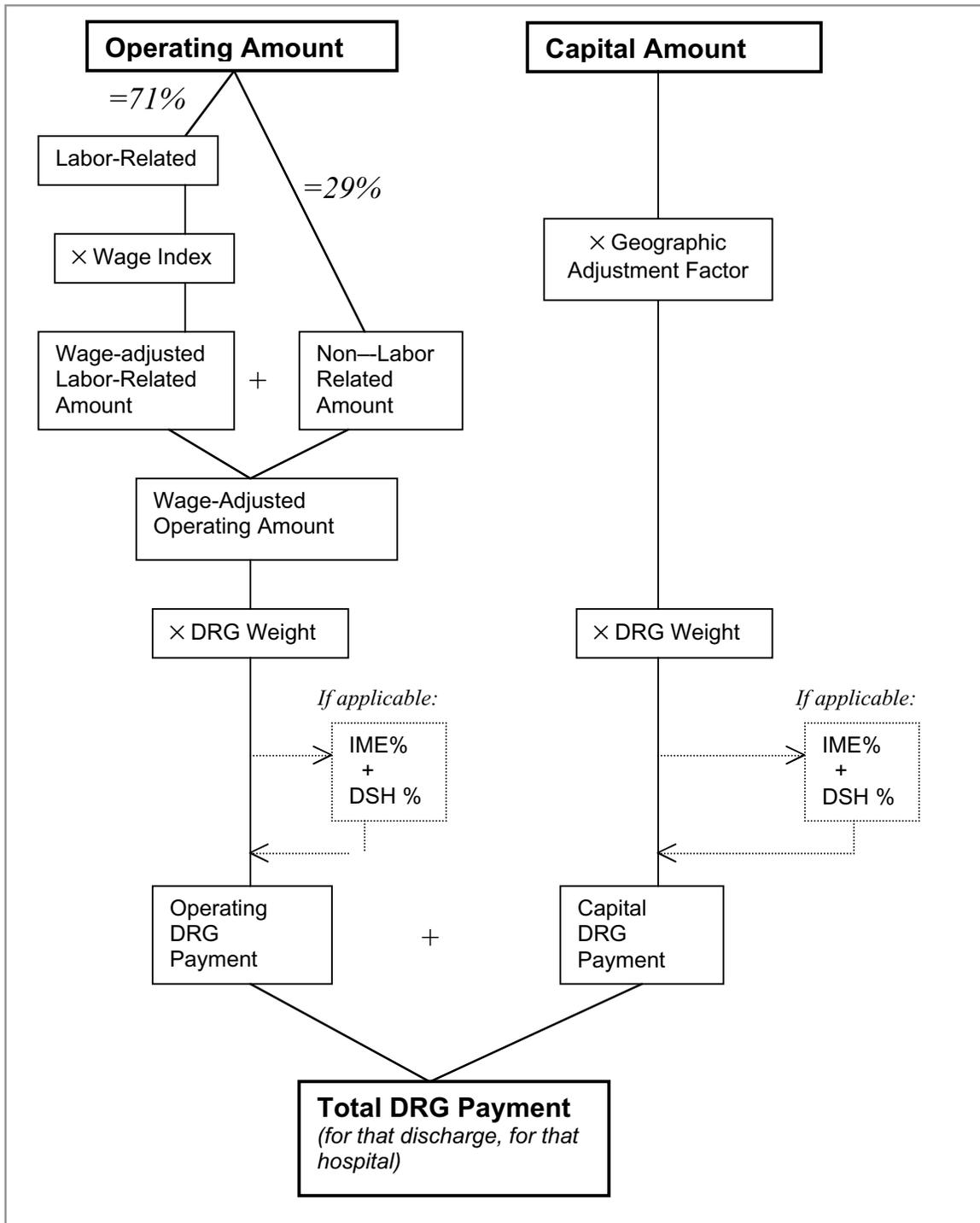
Both the operating and the capital standardized payment amounts are multiplied by a resource weight according to the diagnosis-related group (DRG) that is assigned to each discharge. Other special adjustments are made to the standardized amounts for teaching hospitals (the IME percent add-on) and hospitals serving a “disproportionate share” of indigent patients (the DSH percent add-on).

- ***How Does the Wage Index Affect the Payment?***

The standardized amount for *operating costs* is itself made up of *two components*. One is considered “labor related”, and the other is “non-labor related”. The labor-related component is multiplied by the hospital wage index; the non-labor related component is not. The wage index ranges in value from about 0.70 to 1.30. It is intended to adjust for relative wage differences across different regions of the country.

The portion of the standardized operating amount that has been identified as labor-related has been as high as 75% (during the 1980's) but it is now about 71%. By law, the Secretary of HHS sets this amount and is required to update it periodically. The labor-related portion is always the same for all hospitals.

- Here is a simplified schematic of how to calculate the DRG payment:



- **How does it work in practice?**

The table below walks through two actual payment calculations using the rates that were published in the proposed PPS rules for FY 2001. For simplicity, we assume a DRG weight of 1.000 and no teaching, disproportionate share or other special PPS adjustments. We assume a wage index of 1.200 for Hospital 1 and 0.800 for Hospital 2, and that both hospitals are located in a rural or “other urban” areas.

Sample Calculation:

	Hospital 1		Hospital 2	
	Labor-related	Non labor-related	Labor-related	Non labor-related
National Adjusted Operating Standardized Amount	\$2,811.49	\$1,142.79	\$2,811.49	\$1,142.79
× Wage Index Adjustment	<u>1.200</u>	<i>Not applicable</i>	<u>0.800</u>	<i>Not applicable</i>
= Wage-adjusted Operating Standardized Amount	\$3,373.79	\$1,142.79	\$2,249.19	\$1,142.79
Combined Operating Standardized Amount	\$4,516.58		\$3,391.98	
Capital Standard Federal Payment Rate	<u>\$383.06</u>		<u>\$383.06</u>	
Total Payment, for a case with a DRG weight of 1.00	\$4,899.64		\$3,775.04	

- **Why would the percent identified as the “Labor-Related Portion” be important?**

As can be seen from the table, if you are a hospital located in an area where the wage index is less than 1.00 then your payment will be reduced. If your index value is greater than 1.00, it will be increased. The higher the percent representing the labor-related portion, the stronger will be the effect of the wage index.

With the exception of a few states in New England, all rural wage index values are less than 1.00. It would therefore be advantageous to rural hospitals if the labor-related portion of the standardized operating payment amount were lower.

- **What Does HCFA Consider to be “Labor-Related”?**

HCFA derives the “labor-related” figure from the PPS Hospital Input Price Index (also called the hospital market basket). It is computed from the sum of the weights for all labor-related components of the price index. The weights used in their hospital market basket are derived from national data from all types of acute, short-stay hospitals and across all regions. The most recent revision was in 1997, and it was based on data from 1992. There are five components of the market basket that are identified as labor-related. These are:

1. Wages & salaries	50.244%
2. Employee Benefits	11.146%
3. Non-Medical Professional Fees	2.124%
4. Postal Services	0.272%
5. “All Other” Labor-Related	<u>7.277%</u>
	71.066%

The “all other” category includes items such as business, computer and data processing services. Some of the source data are taken from filed cost reports, and some are taken from surveys conducted by the Bureau of the Census.

There is a perception among hospital administrators that the labor-related portion is too high. This may be due to the inclusion of the fourth and fifth categories, which are not likely to be identified as wage-related costs in hospital accounting records.

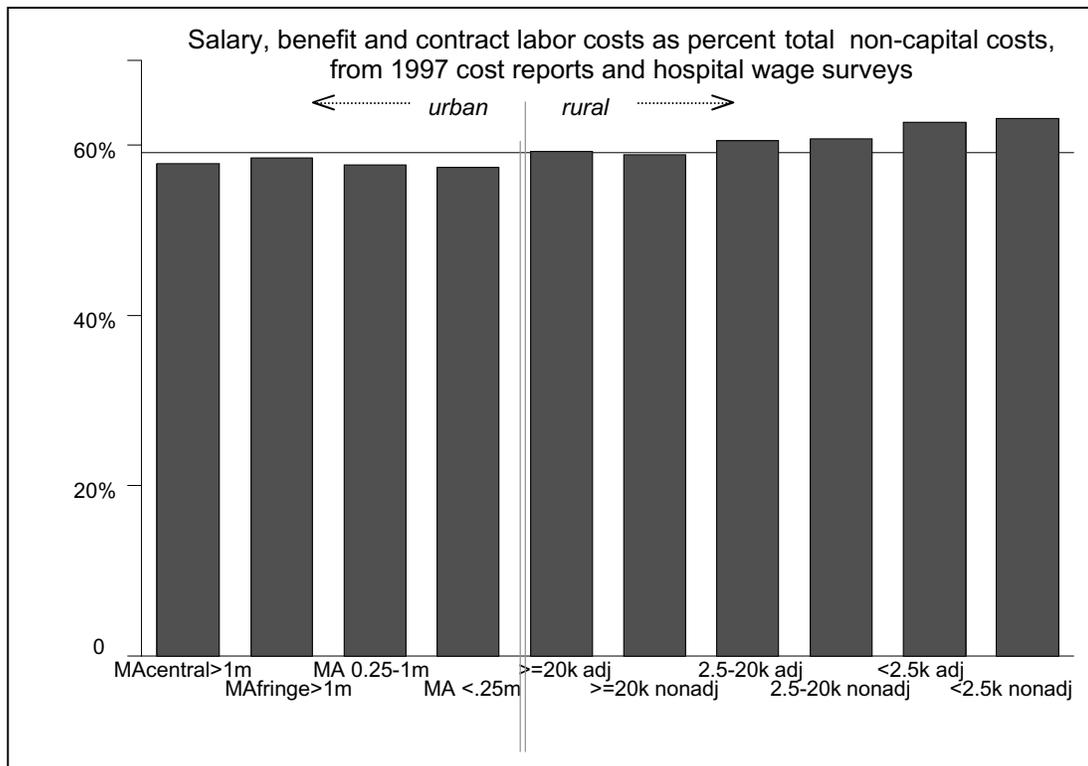
To gain a better understanding of this perception, we attempted to identify the first three categories of labor-related expenses as they appeared in the FY 1997 Medicare cost reports and hospital wage surveys. We divided total

wages, benefits and reported professional contract costs by the reported total expenses (excluding depreciation and interest) for each hospital. From the 4,439 PPS hospitals that had usable data in the HCFA public use files, salaries, benefits and contract costs averaged 59.1% of non-capital expenses, compared to the 63.5% in the market basket. This difference may be due to measurement and/or sampling differences, or it may be due to changes in hospital cost structure that have occurred since 1992.

- ***How Much Difference in the Labor-Related Expense Portion Can Be Measured Between Rural and Urban Areas?***

Labor-related costs tend to be a higher proportion of total costs in rural than in urban hospitals. This is probably because they are smaller, and have lower technology, medical supplies and pharmaceutical costs per bed. If the labor-related portion were based on a hospital-specific computation, instead of the single national number that is now used, rural hospitals would not be at an advantage.

The bar graph below shows averages of our FY1997 labor-related percent figures, computed across hospitals grouped by the ten levels of rural-urban continuum codes. This chart confirms that rural hospitals tend to have higher labor-related cost structures.



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