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Geographic Adjustment in Medicare Payment

Phase I: Improving Accuracy

Medicare is the largest health insurer in the United States, providing coverage for 39 million people aged 65 and older and eight million people with disabilities. In 2010, the program made up approximately 15 percent of the federal budget, at an estimated cost of $500 billion.

Although Medicare is a national program, it adjusts fee-for-service payments to hospitals, physicians, and other clinical practitioners according to the geographic locations in which they practice. This adjustment accounts for differences in the price of doing business, such as staff compensation and rent, that vary between urban and rural areas and by region.

There are disagreements about how best to adjust payments based on geographic location, largely because of the financial impact of the payment adjustments and differences of opinion on how to make the adjustments most accurate. Among other issues, critics cite inconsistencies in the definitions of payment areas and labor markets, concerns about the appropriateness of data used to calculate adjustments, and lack of transparency of the methods for making the adjustments.

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After the U.S. House of Representatives called for a study by the Institute of Medicine (IOM) in Section 1157 of *The Affordable Health Care for America Act*, the Department of Health and Human Services and Congress sought advice from the IOM on how to improve the accuracy of the data sources and methods used for making the geographic adjustments in payments to providers. The IOM convened a committee of experts to assess the impact of geographic adjustment on the urban and rural workforce, beneficiaries' access to care, and the ability of providers to give high-value, high-quality care.

Geographic Adjustment in Medicare Payment is a technical assessment of the data sources, methods, and payment areas used for the hospital wage

index and the geographic practice cost indexes. The hospital wage index and the geographic practice cost indexes were created separately and have evolved independently over several years, but the IOM recommends an integrated approach that includes moving to a single source of wage and benefits data for both indexes, changing to one set of payment areas and labor markets, and expanding the range of occupations included in the index calculations.

The IOM also recommends developing a new source of data on the cost of office rent and applying the hospital wage index for facilities other than acute-care hospitals—for example, skilled nursing facilities and home health agencies—taking into account differences in patient mix and staffing.

Taken together, these recommendations will lead to improvements in payment accuracy, including a more streamlined and consistent payment process for a broader range of providers, and cost reporting will be less burdensome. Implementation will require a phased-in process that combines legislative, rule-making, and administrative actions as well as a period of public comment.

In April 2012, a second report from the same committee will address the impact of geographic adjustment on workforce distribution in urban and rural areas, along with policy adjustments used to promote and preserve access to quality care for Medicare beneficiaries. That report also will consider the larger context of fee-for-service clinical practice, including a broad range of clinical practitioners.

Guiding Principles

The IOM committee focused on the technical accuracy of the current data sources and methods used for geographic adjustment, defining accuracy as the degree of closeness of measurement to the true value of whatever is being measured. The following general principles guided the committee's discussions and analytic process for statistical comparisons and simulations:

Accuracy. Geographic adjustment for input price differences is intended to reflect the input prices faced by providers, not the costs incurred by providers.

Evidence for Adjustment. The continued use of geographic adjustment factors in Medicare payment is warranted.

Local Labor Markets. Geographic adjustment should reflect area-wide input prices for labor faced by employers operating in the same local market and should not be drawn exclusively from data on the wages paid by hospitals or health care practitioners.

Consistency. Consistent criteria should be used for determining the payment areas, data sources, and methods that are used in making the geographic adjustment for hospitals and practitioners.

Transparency. The geographic adjustment process should allow empirical review of the data and methods used to make the adjustments.

Separate Policy Adjustments. Medicare payment adjustments related to national policy goals should only be made through a separate and distinct adjustment mechanism, and not through geographic adjustment.

Moving to a Single Set of Labor Markets and Payment Areas

The current system of geographic adjustment for hospitals uses one set of 441 markets based on Metropolitan Statistical Areas (MSAs). MSAs represent local labor markets where people live, work, and commute.

The geographic adjustment system for physician payment uses a different set of 89 payment areas to represent labor markets. These include 55 large metropolitan areas and 34 statewide areas that combine urban and rural areas. This inconsistency raised questions among committee members about whether defining entire states as labor markets was accurate.

. . . rather than using two separate sets of payment areas, the committee recommends using the same payment areas for geographic adjustments to Medicare payment for hospitals and physicians.

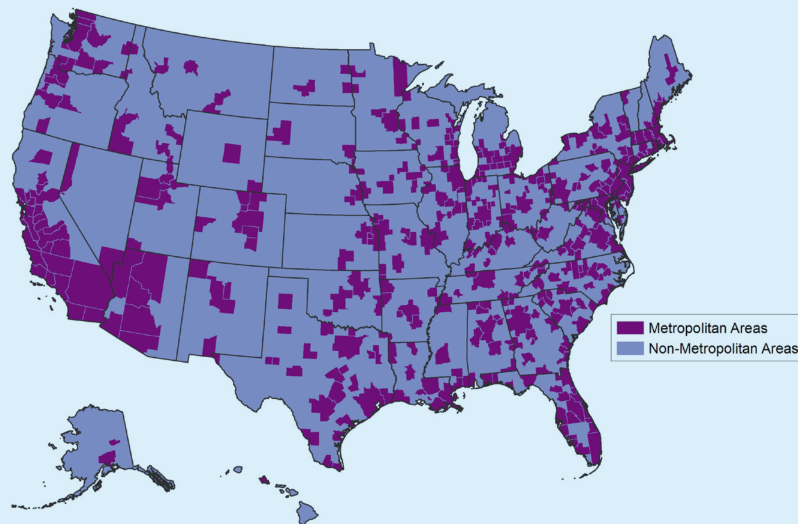
Providers in a given geographic area tend to function within the same local labor markets. Therefore, rather than using two separate sets of payment areas, the committee recommends using the same payment areas for geographic adjustments to Medicare payment for hospitals and physicians.

The payment areas should be defined using MSAs and statewide non-MSAs. When there are significant differences in the indexes near the MSA boundaries, the adjustments should take into account commuting patterns of healthcare workers. The committee believes that smoothing the boundaries will decrease the need for reclassification, a process that currently allows almost 40 percent of eligible hospitals to be paid according to a wage index from a labor market outside of their physical location.

Using a Single Source of Wage Data

The current geographic adjustments use wage data from different sources, some directly from providers (for example, hospital cost reports, physician surveys) and others that are more independent, such as Census data. While no data source is perfect, the committee recommends using Bureau of Labor Statistics (BLS) health care industry wage data to allow the adjustments to reflect the actual price of labor, indicated by the prevailing wage in each labor market for each occupation. From the perspective of the committee, BLS wage data is considered more accurate than Medicare provider data on labor costs, because Medicare data reflect business decisions about the occupational mix of employees and their compensation packages.

Metropolitan Statistical Areas (MSAs) in the United States



SOURCE: RTI Analysis of FY 2011 Wage Index Files, Centers for Medicare and Medicaid Services

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Expanding the Range of Occupations Used in Computing the Indexes

Currently, a limited number of occupations are included in the computation of the physician practice expense for administrative and clinical staff compensation and the hospital wage index. The committee recommends using BLS data from all occupations in the healthcare workforce because these data will more accurately reflect the geographic variations in labor markets, staffing patterns, and occupational mix. The expansion of occupations also will reflect the increasing integration of care in hospitals, outpatient clinics, office-based practices, and other clinical settings.

Conclusion

Taken as a whole, the committee's recommendations are intended to improve accuracy of geographic adjustments to Medicare payment. Implementation will involve changes in the calculations of the indexes, but in the long run, it will bring the advantages of improved accuracy and greater consistency within the Medicare program. Any major transition should be managed strategically by phasing it in over time and communicating clearly with stakeholders at every step. Only then can the long-term policy goal of helping to create an equitable payment system that rewards high-value and high-quality health care be met.

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Revised September 2011

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