MedPAC’s Approach to the Wage Index and Geographic Practice Cost Indexes

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September 16, 2010
Medicare Payment Advisory Commission

- Congressional support agency
  - established in 1997
  - advises the U.S. Congress on Medicare issues
- 17 Commissioners
- Meets publicly to discuss issues and make recommendations
- Two reports, issued in March and June
- www.medpac.gov
Principles of Medicare payment

- Ensure beneficiary access to high quality care in an appropriate setting
- Give providers an incentive to supply effective, appropriate care and pay equitably
- Assure best use of taxpayer dollars
Total Medicare program spending in 2009 = $491 billion

- Part D: 12%
- Managed care: 22%
- Hospice: 2%
- DME: 2%
- Home health: 4%
- Skilled nursing facility: 5%
- Physician: 13%
- Other: 8%
- Hospital inpatient: 27%
- Other hospital: 5%

Over 40% of dollars adjusted by hospital wage index.

Source: President’s Budget, 2011.
Principles of input price adjustment

- Adjust for prices beyond providers control
- Avoid circularity
- Budget neutrality
- Wage indexes based on where people work versus where employees live
Other policy goals should be addressed through targeted policies

- Specific policies address issues such as:
  - Access
  - Workforce
  - Supplier mix
  - Low-volume providers

- Dangers of addressing other goals through input price adjustments
  - Will not be well targeted
  - Will lead to pricing inaccuracy
Prior MedPAC Work on Geographic Adjustment Factors

- Hospital
  - Alternative method for computing the wage index (2007)
- Physician
  - Options for reconfiguring payment localities
  - Alternative practice expense GPCI that excludes equipment and supplies (2007)
Hospital wage index: Exceptions draw current system into question

- In 2007, 37 percent of hospitals had an exception to their initial wage index
  - In Connecticut, 27 out of 32 hospitals had an exception

- Exceptions create inequities
  - Some hospitals can get exceptions and others cannot
  - Providers in other sectors (e.g., SNF) do not get an exception even if a nearby hospital that does
Hospital wage index: Limitations to current approach

- Average hourly wage, requires adjustment for occupational mix
- Data from hospital cost reports only, not all employers in market—circularity
- Market areas (MSAs, non-MSA rest of state) may be too large
  - May contain multiple labor markets
  - Large changes at boundaries
- Resulting index can be volatile
Hospital wage index: MedPAC approach

- Use BLS data to calculate relative wages for each market area (MSA)
- Data from all employers in area
  - Fixed occupational weight technique
  - Use cost report data to adjust for benefits
- Use Census county level data to further adjust within market areas to county level
- Smooth between adjacent counties to reach target difference
Most hospitals would have higher wage index under MedPAC proposal

<table>
<thead>
<tr>
<th>Exception status</th>
<th># of hospitals</th>
<th>Current</th>
<th>MedPAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>No exception</td>
<td>2,096</td>
<td>0.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Outcommuting only</td>
<td>224</td>
<td>4.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Reclassification</td>
<td>758</td>
<td>8.3</td>
<td>4.8</td>
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<tr>
<td>Special exception</td>
<td>18</td>
<td>7.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Other hospitals</td>
<td>429</td>
<td>3.9</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Percent increase (from pre-reclassification index)

CMS post reclassification wage index (no 508)

Rural and urban hospital impacts depend on exception status

<table>
<thead>
<tr>
<th>Providers</th>
<th># of hospitals</th>
<th>Medicare payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban hospitals</td>
<td>2,534</td>
<td>0.1</td>
</tr>
<tr>
<td>reclassified</td>
<td>359</td>
<td>-1.0</td>
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<tr>
<td>not reclassified</td>
<td>2,175</td>
<td>0.3</td>
</tr>
<tr>
<td>Rural hospitals</td>
<td>998</td>
<td>-0.7</td>
</tr>
<tr>
<td>reclassified</td>
<td>415</td>
<td>-1.7</td>
</tr>
<tr>
<td>not reclassified</td>
<td>583</td>
<td>1.0</td>
</tr>
<tr>
<td>Critical access hospitals</td>
<td>~1,300</td>
<td>Paid on costs</td>
</tr>
</tbody>
</table>

CMS post reclassification wage index (no 508)
Reclassified through geographic reclassification or special exception
Advantages of MedPAC Approach

- Data represents entire market (reduces circularity)
- Less volatile over time
- Automatically adjusts for occupational mix
- Smaller differences across borders—reduce exceptions
- Can be tailored to other types of providers
- Less data burden on hospitals
- Less sensitive to imprecision in reported wages
Critiques of MedPAC approach

- Some hospitals prefer to provide their own data
- Cannot require compliance with BLS survey
- Maintains county level cliffs
- Redistribution results in reductions to some facilities’ wage indexes
- Phase in period may be needed
Alternative methods for reconfiguring physician payment areas

- **Locality option**
  - In each locality, determine geographic adjustment factor (GAF) for each county
  - Rank counties in descending GAF order
  - If a county’s GAF exceeds average among lower-cost counties by pre-set threshold (e.g., 5 percent), it becomes separate locality

- **MSA option**
  - In each state, determine GAF for each MSA and “rest of state”
  - Rank areas in descending GAF order
  - If area has GAF that exceeds average among lower-cost areas by pre-set threshold, it becomes separate locality
Both options increase number of localities

- Currently, 89 payment localities
- Locality option would increase number to 186; many would be single counties
- MSA option would increase number to 119; most would have more than one county
But changes in payments relative to current policy would tend to be small

- Under both options, 95 percent of counties would have a change in payments of 5 percent or less.

- However, small percentages of counties (0.5-0.7 percent) would see changes of 10 percent or more.
Issues

- Statewide localities
- Budget neutrality within each state
Alternative method for determining the practice expense GPCI

- **Issue**
  - Prices for equipment and supplies do not differ significantly across the nation.
  - Some services have proportionally high (or low) equipment and supply costs.
  - PE GPCI does not recognize such differences.

- **Different approach**
  - Omit equipment and supplies from PE GPCI.
  - Apply revised GPCI to input-price varying portion of PE RVU only.