

GAO

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**MEDICARE HOSPITAL
AND PHYSICIAN
PAYMENTS**

**Geographic Cost
Adjustments Important to
Preserve Beneficiary
Access to Services**

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Madam Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss how the Medicare program adjusts payments to hospitals and physicians to account for geographic differences in costs. Because Medicare's hospital and physician payment systems are based on national rates, these geographic cost adjustments are essential to account for costs beyond providers' control and to ensure that beneficiaries have adequate access to services. If these adjustments are not adequate, Medicare could financially reward or penalize providers due only to where they are located. Over time, this could affect some providers' financial stability and their ability or willingness to continue serving Medicare patients.

Some providers contend that Medicare's geographic cost adjustments are inadequate. Medicare's payments to hospitals are intended to vary with the average wages paid in a hospital's labor market. Yet, some hospitals believe that the labor cost adjustment applied to their payments does not reflect the average wage they face in their labor market area. Hospitals that meet certain criteria can qualify to have their payments increased through Medicare's reclassification process. But concerns remain about the geographic variation in payments to hospitals and disparities in hospital financial performance under Medicare's hospital payment system. Similarly, physicians have raised concerns about the appropriateness of Medicare's geographic adjustment to their fees.

My comments today are based on our forthcoming report on the Medicare program's labor cost adjustment for hospital services and our preliminary work on the program's physician payment adjustment. I will focus on (1) how Medicare determines the labor cost adjustment for hospitals in an area; (2) whether Medicare's labor cost adjustment accounts appropriately for geographic variation in wages paid by hospitals; (3) the extent to which geographic reclassification addresses potential problems with Medicare's labor cost adjustment for hospitals; and (4) how Medicare determines geographic adjustments to physician fees. My comments are based primarily on our analysis of hospital Medicare cost report data and other information, including that compiled by the Centers for Medicare and Medicaid Services, the agency within the Department of Health and Human Services that oversees the Medicare program.

In summary, Medicare's labor cost adjustment does not adequately account for geographic differences in hospital wages in some areas because a single adjustment is applied to all hospitals in an area even though the area may encompass multiple labor markets or different types

of communities within which hospitals pay significantly different average wages. Geographic reclassification addresses some inequities in Medicare's labor cost adjustments by allowing some hospitals that pay wages enough above the average in their area to receive a higher labor cost adjustment. At the same time, however, some hospitals can reclassify even though they pay wages that are comparable to the average in their area. To help ensure that beneficiaries in all parts of the country have access to services, Medicare adjusts its physician fee schedule based on indexes designed to reflect cost differences among 92 geographic areas. The adjustment is designed to help ensure that the fees paid in a geographic area appropriately reflect the cost of living in that area and the costs of operating a practice. We are beginning an analysis of the methodology and data that Medicare uses to make the adjustment to determine whether it appropriately reflects underlying costs and, if not, whether beneficiary access to physician services has been impaired in certain areas.

A Hospital's Labor Cost Adjustment Is Based On Average Wages Paid in a Geographic Area

Medicare's prospective payment system (PPS) provides incentives for hospitals to operate efficiently by paying them a predetermined, fixed amount for each inpatient hospital stay, regardless of the actual costs incurred in providing the care. Although the fixed, or standardized, amount is based on national average costs, actual hospital payments vary widely across hospitals, primarily because of two payment adjustments in PPS. There is an adjustment that accounts for cost differences across patients due to their care needs, and a labor cost adjustment that accounts for the substantial variation in average hospital wages across the country. The fixed amount is adjusted for these two sources of cost differences because they are largely beyond any individual hospital's ability to control.

The Medicare labor cost adjustment for a geographic area is based on a wage index that is computed using data that hospitals submit to Medicare. The wage index for an area is the ratio of the average hourly hospital wage in the area compared to the national average hourly hospital wage. The wage indexes ranged from roughly 0.74 to 1.5 in 2001.¹ Only the portion of the hospital payment that reflects labor-related expenses (71 percent) is multiplied by the wage index. The rest of the payment, which covers drugs, medical supplies and certain other non-labor-related expenses, is

¹The fiscal year 2001 Medicare wage indexes were based on 1997 data from Medicare cost reports—which hospitals submit annually to Medicare.

uniform nationwide because prices for these items are not perceived as varying significantly from area to area.²

The geographic area for which a wage index is calculated is supposed to represent an area where hospitals pay relatively uniform wages. If it does not, the hospitals in the area may receive a labor cost adjustment that is higher or lower than the wages paid in their area would justify.³

The Medicare program uses the Office of Management and Budget's (OMB) "metropolitan/non-metropolitan" classification system to define the geographic areas used for the labor cost adjustment. Medicare calculates labor cost adjustments for 324 metropolitan areas and 49 "statewide" non-metropolitan areas. Medicare specifies an OMB metropolitan statistical area (MSA) as a distinct region within which wages are assumed to be relatively uniform.⁴ Medicare specifies the rest of a state—all the non-MSA counties⁵—as a single, non-metropolitan area in which hospitals are assumed to face similar average wages. These non-metropolitan areas can be quite large and not contiguous (see fig. 1).

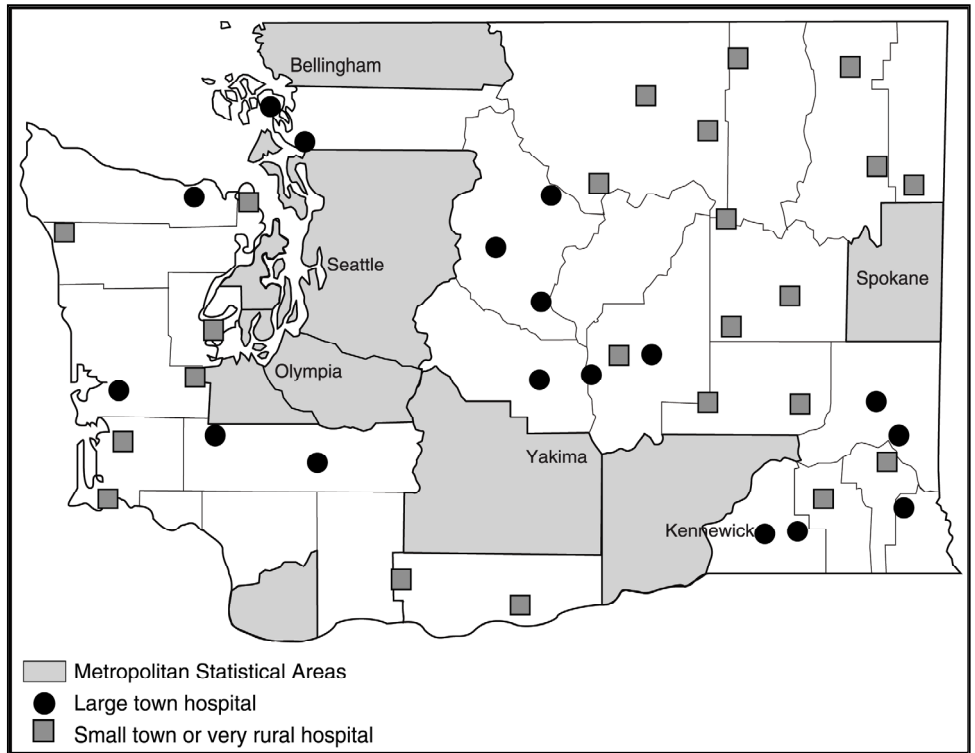
²For hospitals in Alaska and Hawaii, the non-labor portion of the payment is subject to a cost-of-living adjustment.

³In addition to being affected by wage differences, the wage index is affected by differences in the occupational mix of hospital employees across geographic areas: The wage index can be higher in areas with a concentration of hospitals employing a more skilled (and more expensive) mix of staff, and lower in areas where hospitals employ a less skilled mix of staff. The Congress has required the Secretary of Health and Human Services to take into account the effects of occupational mix on the wage index beginning October 1, 2004.

⁴In general, MSAs are groups of counties containing a core population of at least 50,000, together with adjacent areas having a high degree of economic and social integration with that core. OMB defines the central county or counties of an MSA as those containing the largest city or urbanized area. An outlying county or counties qualify for inclusion in a metropolitan area based on commuting ties with the central counties and other specified measures of metropolitan character. The current geographic areas may change when OMB updates MSA boundaries in 2003 using population data from the most recent decennial census and revised OMB standards for including counties in an MSA.

⁵In New England, the MSAs are defined in terms of cities and towns, rather than counties.

Figure 1: Washington State Non-metropolitan Hospitals



Source: GAO analysis of Medicare Provider of Services file, fiscal year 2001.

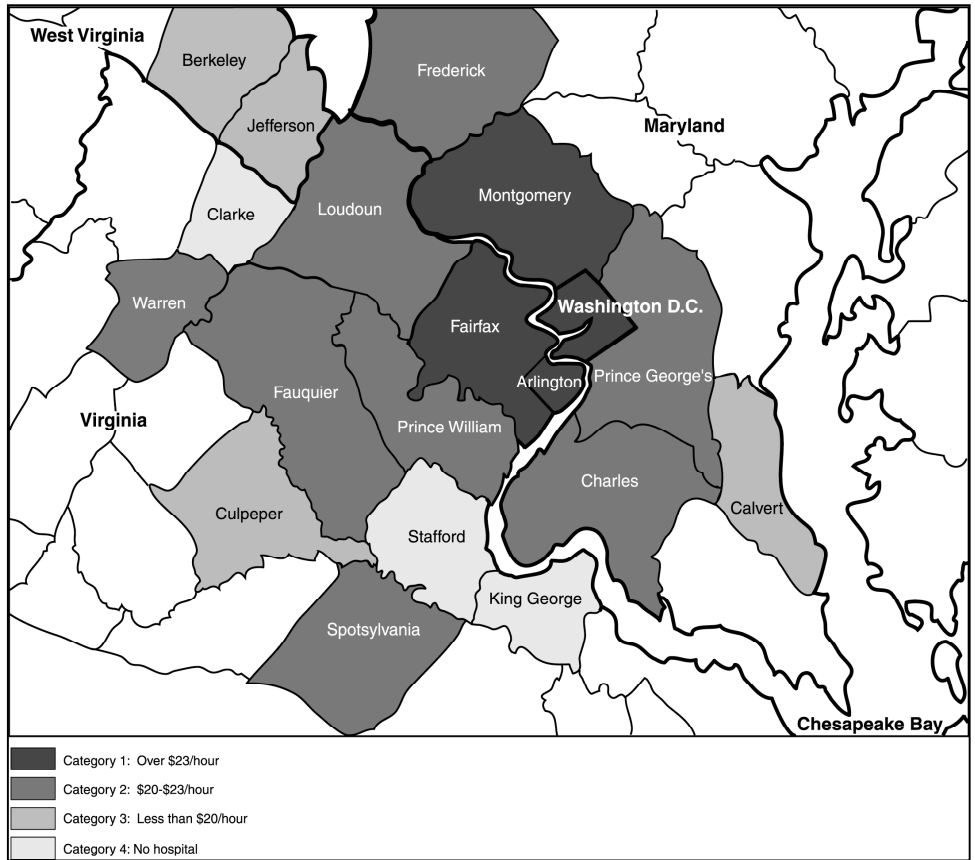
Labor Cost Adjustment Does Not Adequately Account for Wage Differences Within Certain Areas

The variation in hospital wages within some Medicare geographic areas – MSAs or the non-metropolitan areas in a state—is systematic across different parts of these areas. While wages paid by hospitals are expected to vary within a labor market, such systematic variation suggests that some Medicare geographic areas include multiple labor markets within which hospitals pay different average wages. For example, average hospital wages in outlying counties of MSAs tend to be lower than average hospital wages in central counties. Average wages in non-metropolitan large towns tend to be higher than in other non-metropolitan areas within a state. Because the labor cost adjustment does not take this kind of systematic variation into account, the adjustment sometimes does not appropriately reflect the average wages that hospitals pay.

**Medicare Metropolitan
Geographic Areas May
Encompass Multiple Labor
Markets With Varying
Average Wages**

Because an MSA may extend over several thousand square miles, the hospitals within an MSA may not be competing with each other for the same pool of employees. Therefore, these hospitals may need to pay varying wages to attract workers. The Washington, D.C. MSA illustrates how hospital wages in a large MSA can vary across different counties (see fig. 2). It includes hospitals located in the central city of the District of Columbia and in 18 counties in Maryland, Virginia, and West Virginia. Hospital wages averaged \$23.70 per hour in fiscal year 1997 in the District of Columbia and in most adjacent suburban Maryland and Virginia counties, but averaged \$20.14 per hour in the outlying counties. Yet, the labor cost adjustment for hospitals within this MSA is based on an average wage of \$23.41 per hour and is the same for hospitals within all its counties.

Figure 2: Hospital Wages, by County, Washington, D.C. MSA, Fiscal Year 1997



Source: GAO analysis of fiscal year 1997 hospital wages used in calculating the fiscal year 2001 wage index, as reported in Medicare cost reports.

Hospitals in central counties of an MSA typically pay higher wages than hospitals in outlying counties. Central county hospital wages ranged from 7 percent higher than outlying county hospital wages in Houston to 38 percent higher in New York City in fiscal year 1997. In most of the MSAs with the highest population, the difference was from 11 to 18 percent in fiscal year 1997.

Some Medicare Non-metropolitan Geographic Areas Encompass Multiple Community Types with Varying Wages

Medicare uses the same labor cost adjustment for all hospitals in the non-metropolitan areas of a state. The adjustment would be adequate for all hospitals in these sometimes vast areas if the hospitals paid similar average wages. However, we found wage variation across non-metropolitan areas that appears to be systematically related to type of community. In three-quarters of all states, the average wages paid by hospitals in large towns are higher than those paid by hospitals in small towns or rural areas. About 38 percent of hospitals in large towns paid wages that were at least 5 percent higher than the average wage in their area, and 16 percent paid wages that were at least 10 percent higher than the area average.

As a result, the Medicare labor cost adjustment for non-metropolitan areas may be based on average wages that are lower than wages paid by large town hospitals and based on average wages that are higher than wages paid by hospitals in small towns and rural areas. For example, the fiscal year 2001 labor cost adjustment for non-metropolitan Nebraska was based on an average hourly wage of \$17.65. Yet, Nebraska hospitals in large towns had an average wage that year that was 11 percent higher; small town Nebraska hospitals had an average wage that was 5 percent lower; and hospitals in rural areas of the state had an average wage that was 16 percent lower.

Through Reclassification, Some Hospitals Receive a More Appropriate Labor Cost Adjustment

The administrative process for geographic reclassification allows hospitals meeting certain criteria to be paid for Medicare inpatient hospital services as if they were located in another geographic area with a higher labor cost adjustment.⁶ The first criterion concerns the hospital's proximity to the higher-wage "target" area. The proximity requirement is satisfied if the hospital is within a specified number of miles of the target area (15 miles for a metropolitan hospital and 35 miles for a non-metropolitan hospital) or if at least half of the hospital's employees reside in the target area. The second criterion pertains to the hospital's wages relative to the average wages in its assigned area and in the target area. This criterion is satisfied if the hospital's wages are a specified amount higher than the average in its

⁶This discussion pertains only to the reclassification option to be paid based on a higher wage index. Other, less common reclassification options, such as county-wide reclassifications, are available.

assigned area and if its wages are comparable to the average wages in the target area.⁷

Rural referral centers (RRC) and sole community hospitals (SCH) can be reclassified by meeting less stringent criteria. These hospitals receive special treatment from Medicare because of their role in preserving access to care for beneficiaries in certain areas. RRCs are relatively large rural hospitals providing an array of services and treating patients from a wide geographic area. SCHs are small hospitals isolated from other hospitals by location, weather, or travel conditions.⁸ RRCs and SCHs do not have to meet the proximity requirement to reclassify. RRCs are also exempt from the requirement that their wages be higher than those of the average wages in their original market.

Not All Higher-Wage Hospitals Can Be Reclassified

Of the 756 hospitals that paid wages high enough to qualify for reclassification, only 310, or 41 percent, were reclassified in fiscal year 2001. More than one-quarter of these higher-wage hospitals were in large towns, and 73 percent of them were reclassified. Higher-wage hospitals in large towns are likelier to be reclassified than other higher-wage hospitals because many are RRCs, which are exempt from the reclassification proximity criterion.

In contrast to the nearly three-quarters of large town higher-wage hospitals that reclassified in fiscal year 2001, about half of higher-wage hospitals in small towns and rural areas were reclassified. Almost 39 percent of the reclassified higher-wage small town and rural hospitals were exempt from the proximity criterion because they were RRCs or SCHs. Some non-reclassified, higher-wage small town or rural hospitals that were SCHs may have opted out of PPS to receive cost-based payments from Medicare, making reclassification irrelevant.

⁷A metropolitan hospital's average wage must be at least 8 percent higher than the average in its assigned area and at least 84 percent of its target area's average wage. A non-metropolitan hospital's average wage must be at least 6 percent higher than the average in its assigned area and at least 82 percent of its target area's average wage.

⁸In general, SCHs may elect to be paid based on their own hospital-specific costs or the applicable PPS payment amount. SCHs electing payments under PPS may qualify to be reclassified. Payments to SCHs that do not elect the PPS option are not subject to a labor cost adjustment. See U.S. General Accounting Office, *Medicare's Rural Hospital Payment Policies* GAO/HEHS-00-174R, Washington, D.C.: Sept. 15, 2000), for more detail on rural hospital designations.

Moreover, even though metropolitan area higher-wage hospitals made up 42 percent of the higher-wage hospitals, only 12 percent of them were reclassified in fiscal year 2001—a percentage far lower than that for higher-wage hospitals in other areas. Reclassified metropolitan hospitals paid wages that were about 10 percent above the average wage in their former area; those average wages are equal to the average wage in the new areas to which these hospitals were reclassified in fiscal year 2001.

The likely reason that so few metropolitan higher-wage hospitals were reclassified is that few are close enough to a higher-wage MSA to meet the proximity criterion. More than two-thirds of the metropolitan hospital reclassifications in fiscal year 2001 were concentrated in two areas—California and a region that includes parts of New York, Connecticut, New Jersey and Pennsylvania—where metropolitan areas are close enough to each other that more higher-wage hospitals in these areas may be able to meet the reclassification proximity requirement.

Certain Hospitals Can Be Reclassified Without Meeting Wage Criterion

While reclassification is designed to increase payments to hospitals paying wages significantly above the average for their area, certain provisions allow some hospitals that pay lower wages to reclassify. For example, an additional 116 hospitals were reclassified for a higher wage index in fiscal year 2001, even though they paid wages that were too low to meet the wage criterion. Prior to reclassification, these non-metropolitan hospitals had average wages that were close to the area average. With reclassification, these hospitals were assigned to areas with a labor cost adjustment based on wages that averaged 8 percent higher than their own.

Of the 116 hospitals that reclassified for a higher wage index in fiscal year 2001, but failed to meet the wage criterion, 89 were RRCs (see table 1). About 42 percent of these had wage costs below their statewide non-metropolitan average. The other hospitals that reclassified, but did not pay wages that met the wage criterion, include those that were part of county-wide reclassifications and those reclassified through legislation.

Table 1: Reclassified Hospitals That Did Not Satisfy the Wage Criterion, by Reclassification Category, Fiscal Year 2001

Reclassification Category	Hospitals with average wages too low to satisfy the wage criterion	Hospitals with average wages below the average in their original area
RRCs	89	37
Legislative	20	15
County-wide	7	3

Source. GAO analysis of fiscal year 1997 hospitals wages used in construction of fiscal year 2001 wage index, as reported in Medicare cost reports.

Physician Fees Are Adjusted for Cost-of-Living, Practice Expense and Malpractice Premium Differences

Medicare’s physician fee schedule, which specifies the amount that Medicare will pay for each physician service, includes an adjustment to help ensure that the fees paid in a geographic area appropriately reflect the cost of living in that area and the costs associated with the operation of a practice. This geographic adjustment is a critical component of the physician payment system. An adjustment that is too low can impair beneficiary access to physician services, while one that is too high adds unnecessary financial burdens to Medicare. Although much attention in recent months has focused on the method used to annually update the physician fee schedule, concerns have also been voiced about the appropriateness of the geographic adjustments.⁹ H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002, would require us to evaluate the methodology and data that Medicare uses to geographically adjust physician payments.¹⁰ We are beginning an analysis of the methodology and the available data to determine whether Medicare’s geographic adjustment appropriately reflects underlying costs and whether beneficiary access to physician services has changed in certain areas.

In adjusting 2002 fees for physician services, Medicare has delineated 92 separate geographic areas. In some instances, these areas consist of an entire state. For example, physician fees are uniform across Connecticut. In other cases, a large city or group of cities within a state is classified into

⁹U.S. General Accounting Office, *Medicare Physician Payments: Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees*, [GAO-02-441T](#) (Washington, D.C. Feb. 14, 2002).

¹⁰H.R. 4954 was passed by the House of Representatives on June 28, 2002.

one geographic area and the rest of the state is classified into another. Maryland illustrates this case: Baltimore and surrounding counties are classified into one geographic area, and the rest of Maryland is classified as another. Finally, some large metropolitan areas, such as New York City and its suburban counties, are split into multiple geographic areas.

Medicare's geographic adjustments for physician fees are based on indexes that are designed to reflect cost differences among the 92 areas. There are three separate indexes, known as geographic practice cost indexes (GPCI), that correspond to the three components that comprise Medicare's payment for a specific service: (1) the work component, reflecting the amount of physician time, skill, and intensity; (2) the practice expense component, reflecting expenses, such as office rents and employee wages; and (3) the malpractice insurance component, reflecting the cost of personal liability insurance premiums. The overall geographic adjustment for each service is a weighted average of the three GPCIs where the weights represent the relative importance of the components for that service. Across all physician services in 1999, the average weights were approximately 55 percent for the work component, 42 percent for the practice expense component, and 3 percent for the malpractice insurance component.

The GPCIs are calculated from a variety of data sources. The work GPCI is based on a sample of median hourly earnings of workers in six professional categories. Physician earnings are not used because some physicians derive much of their income from Medicare payments, and an index based on physician earnings would be affected by Medicare's existing geographic adjustments. The work GPCI is a weighted average of the median earnings of these professions in the area and their median earnings nationwide.¹¹ If the work GPCI was based solely on the median earnings in each area, physician payments would likely increase in large metropolitan areas and decrease in rural areas. The practice expense GPCI is based on wage data for various classes of workers, office rent estimates, and other information. The malpractice insurance GPCI is based on average premiums for personal liability insurance.

Concerns have been raised that the current geographic adjustments for physician fees do not appropriately reflect the underlying geographic variation in physicians' costs and that, as a result, beneficiary access to

¹¹An area's median earnings are weighted by 0.25, and the national average by 0.75.

services may be impaired in certain areas. Unfortunately, information on physicians' willingness to see Medicare patients is dated—although it does not indicate access problems. Data from the 1990s show that virtually all physicians were treating Medicare beneficiaries and, if they were accepting new patients, accepted those covered by Medicare. A 1999 survey conducted by the Medicare Payment Advisory Commission (MedPAC) from that year found that 93 percent of physicians who had been accepting new patients were continuing to do so. It is unclear whether the situation has deteriorated since 1999. MedPAC is updating its survey, and the new results may shed light on this issue. However, MedPAC's survey results may not be able to identify access problems if they occur only in certain areas. As I said in my testimony before this Subcommittee in February, it is important to identify beneficiary access problems quickly and take appropriate action when warranted. As part of the work we are beginning on access to physician care, we will examine Medicare claims data to get the most up-to-date picture possible of access by area, by specialty, and for new versus established patients.

Concluding Observations

Medicare's PPS for inpatient services provides incentives to hospitals to deliver care efficiently by allowing them to keep Medicare payment amounts that exceed their costs, while making hospitals responsible for costs that exceed their Medicare payments. To ensure that PPS rewards hospitals because they are efficient, rather than because they operate in favorable circumstances, payment adjustments are made to account for cost differences across hospitals that are beyond any individual hospital's control. If these payment adjustments do not adequately account for cost differences, hospitals are inappropriately rewarded or face undue fiscal pressure. The adjustment used to account for wage differences—the labor cost adjustment—does not do so adequately because many of the geographic areas that Medicare uses to define labor markets are too large.

Geographic reclassification provides relief to some hospitals that pay wages that are higher than the average in their area. Yet, other hospitals paying higher wages cannot be reclassified. Still other hospitals get a higher labor cost adjustment than is warranted by the wages they pay, and many are in rural areas and may be facing financial problems. Their labor cost adjustment, however, is not necessarily the cause of these problems. Therefore, reclassification may not be the most effective mechanism to address the financial pressure faced by these rural hospitals.

Madam Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other Members of the Subcommittee may have.

Contacts and Acknowledgments

For more information regarding this testimony, please contact me at (202) 512-7114 or Laura Dummit at (202) 512-7119. Jean Chung, James Cosgrove, James Mathews, Michael Rose and Kara Sokol also made key contributions to this statement.