Geographic Adjustment Policy in Medicare Part B: The Basics
For the same billing code, same service, a physician is paid a different amount based on geographical location.

**Geographic Variation in Reimbursement**

**Payment for Preventive Screening**

<table>
<thead>
<tr>
<th>State</th>
<th>Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>68</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>72</td>
</tr>
<tr>
<td>Minnesota</td>
<td>78</td>
</tr>
<tr>
<td>Metro PA</td>
<td>82</td>
</tr>
<tr>
<td>New Jersey</td>
<td>84</td>
</tr>
</tbody>
</table>

Payment for Preventive Screening
Geographic Adjustment is Significant in HQC Member States

Annual Impact to HQC States for Medicare Part B Reimbursement

$37.5 million
$79.3 million
$77.6 million
$112.9 million
$30-63.5 million
$124.6 million

Reflected as full GPCI impact below the national average\(^2\)
implemented in 1992 as part of the newly created resource-based physician fee schedule, geographic adjustment was intended to adjust for input prices faced by physicians beyond their control\textsuperscript{5}

intended to promote fairness by acknowledging cost differences across geographic areas\textsuperscript{6}

- Acknowledge, for example, that there are geographic differences in wages for earnings, administrative staff, office rents, and malpractice premiums
## Three Components of Adjustment

<table>
<thead>
<tr>
<th>Geographic Adjustment Type</th>
<th>Accounts for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician work (48% weight of overall GPCI adjustment)</td>
<td>Physician earnings</td>
</tr>
</tbody>
</table>
| Practice expense (47% weight of overall GPCI adjustment) | Staff wages  
Purchased services (e.g. contracting, accounting, legal)  
Office rent  
Equipment and supplies |
| Malpractice (4.5% weight of overall GPCI adjustment) | Professional liability insurance |

The types of geographic adjustment come together to create the “Geographic Adjustment Factor” (GAF)
Problems with Physician Work GPCI

- Rather than a direct measure of physician earnings, the work GPCI is developed from Bureau of Labor Statistics (BLS) data on seven professions with similar years of education (e.g., architects, engineers, artists)
- Spurred intense debate from principal investigators on whether to adjust physician work at all.
- MedPAC has acknowledged the inaccuracies:
  
  “Inherently there are going to be differences in the amenities that are meaningful to physicians versus architects, and so an area that could be reasonably attractive to architects on their amenities might be unattractive to physicians because they’re interested in different amenities.” – MedPAC Chairman Glenn Hackbarth
- Medscape 2012 compensation survey: “the highest-earning physicians practice in the North Central region, comprising Iowa, Missouri, Kansas, Nebraska, and South and North Dakota”
  
  - These payment localities tend to have physician work adjustment well below the national average
- MedPAC: Challenges with validating GPCI work input data
Market Reality – National Market for Physician Services
Physician Wages are Higher in Rural Areas

Source: MedPAC Oct. Slides 4
Since 2003, the Physician Work Adjustment has been subject to a “floor provision.” No payment locality may have a physician work adjuster below the national average (1.0).

This provision provides an increase in reimbursement to many low-cost states.

Expiration set for 12/31/12 will result in payment reductions for many HQC members.
Practice expense data proxies

- BLS data:
  - Employee compensation (non-physician wages)
  - Contracted services expected to be purchased
- Housing and Urban Development (HUD) American Community Survey 2-bedroom rental data for office rent
- Equipment, supplies: standardized nationally

Discrepancies

- No significant difference in non-physician wages between small, moderate urban areas relative to rural\textsuperscript{11}
- Studies show no difference in total practice expenses between metro, non-metro, or census regions\textsuperscript{12,13}
- \textit{Medical Economics}: conflicting findings regarding practice expense finds Midwest highest practice expense among regions; GPCI’s tend to be in the lower tier\textsuperscript{14}
Payers, including Medicare, should reimburse providers for value. Value considers both cost and quality metrics.

As a critical component of the value equation, cost-based inputs need to be accurate and reflective of market dynamics.

- GPCI is fundamentally baked into physician fee-for-service payments, a core cost-based input

The current GPCI adjustments are inaccurate and create a basic flaw in accurately paying for the value physicians provide.

GPCI should be reformed to correctly calculate costs and pay for value.
1) Healthcare Common Procedure Coding System 9904= preventive screening reimbursement for selected geographic localities

2) Calculation derived from Medicare Part B spending at the state level by the difference of the national average and state’s GAF (as of 2012). States with multiple payment localities were averaged equally weighted to provide a range of spending. Medicare Part B spending data retrieved from State Health Facts at the The Henry J. Kaiser Family Foundation: http://www.statehealthfacts.org/


References


