RECONSIDERING GEOGRAPHIC ADJUSTMENTS TO MEDICARE PHYSICIAN FEES

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), signed into law in December 2003, included several provisions that altered provider payments as a way to address concerns about access, especially in rural areas.[1] One of those provisions alters the adjustments made to Medicare physician fees that account for geographic differences in practice costs (known as the geographic practice cost indices or GPCIs). This change will reduce the extent of the variation in allowed payments for the physician work component of each Medicare fee by setting a floor on the practice costs adjuster for that component so that every area is paid at least at the average, regardless of its relative costs.[2] This provision, effective only for calendar years 2004 through 2006, will raise physician fees in areas with below average costs for work without adversely affecting fees elsewhere. An earlier version of the Medicare bill had also imposed a floor on the other practice cost adjusters in the fee schedule, the practice expense and the professional liability insurance (PLI) components. Those provisions were not adopted.

Because the work GPCI floor is temporary, policymakers will have a natural opportunity to review the provision and the issues of geographic differences in physician payments and access to services. Congress will have input on this from its mandated General Accounting Office (GAO) study on geographic differences in payments for physician services, due by September 2004. Among other issues, this GAO study will explore the effect of the work GPCI floor on physician location and retention. To further assist this discussion, it may be useful to

[1] Most of the rural and access-related provisions of MMA are in the 17 sections of Title IV: Rural Health Care Improvements. These represent the largest, most comprehensive set of rural provisions ever enacted by Congress regarding the Medicare program.

[2] The Medicare physician fee schedule is comprised of three elements (a relative value scale, a set of geographic practice cost indices or GPCIs, a conversion factor). First, so that differences in payments across services reflect differences in the amount of time, effort, and practice costs required to provide them, payments are derived from a resource-based relative value scale. The total relative value for a given service is the sum three components, which correspond to the main inputs required to produce the service: physician work, practice expenses, and the cost of professional liability insurance or PLI. Second, so that payments reflect differences in local prices, payments are adjusted by GPCIs. Each component of the relative value scale (work, practice expense, PLI) is adjusted by a separate GPCI. By law, the work GPCI reflects only 25 percent of actual variation in wages. There are 89 physician payment localities, 35 of which are state-wide. Third, a conversion factor is used to translate the adjusted relative values into dollar amounts. Note that in Medicare's prospective payment systems for facility providers (hospitals, nursing facilities, etc), the base rate (or conversion factor) is adjusted for geographic differences in costs (eg, rather than the hospital DRGs or nursing facility RUGs) while in the physician fee schedule, the set of relative values is adjusted for these differences. This difference in the placement of the geographic adjustment in a payment formula does not alter the actual payment amount, although the adjustments may appear more fundamentally tied, conceptually, to physician services than to hospital or nursing facility services, given the placement of the adjustment in the physician payment system.

explore the objectives of the GPCIs when they were being developed and implemented, as well as the goals of now placing floors on a geographic cost adjuster. If the original goal of having fee differences across areas reflect practice cost differences is still the objective, then the question is whether floors are consistent with that goal or broader goals, such as improving access.

We address these issues in this paper. We first provide some background on geographic adjusters in Medicare payment systems as they relate to the floor provision. We then review the conceptual foundation for the geographic practice cost adjusters used in the Medicare physician fee schedule. In particular, we emphasize why researchers and policymakers who developed and implemented the payment system viewed it as appropriate to adjust for geographic differences in the costs of physicians' own time. In addition, we describe how the initial implementation of the adjustment and later changes made to the number and size of physician payment areas reduced the potential impact of the newly adopted floor policy, relative to the geographic indices originally developed. Finally, we discuss the floor provision in the context of the broader aims of its proponents— to increase access to physician services in those areas affected by the floor.

Background

The goal of the Medicare fee schedule was to create a payment system for physician services in which fees varied with resource costs. The resource-based relative value scale (RBRVS) established fee differences across services, while the GPCIs were needed to reflect resource cost differences across geographic areas. The fundamental reason that policymakers vary physician fees across geographic areas is to adjust for differences in input prices faced by physicians that are beyond their control. There was agreement to make this adjustment to the fee schedule when it was implemented in 1992, and this type of adjustment also is applied to Medicare's other fee schedules and prospective payment systems. Adjustments for input price differences can be seen as promoting fairness by acknowledging cost differences across areas. Geographic cost indices that reflect differences in wages for clinical and administrative staff, office rents and PLI premiums were readily adopted as part of the fee schedule in the interest of fairness. However, the largest share of physician practice revenues represents the costs of

compensating the physician for his or her own time, and there has been considerable debate over how geographic differences in these time costs should be taken into account.

Geographic adjusters in the physician fee schedule now appear to be moving beyond reflecting only differences in input prices. An emerging justification for varying the fee schedule rates across areas, raised by rural advocates and some policymakers, is to assure that fees promote adequate *access to care*, presumably without overpaying for services. This has not been a traditional role for the geographic practice cost indices. Instead, Medicare typically addresses access concerns by creating explicit additional payments, rather than by embedding increased payments within the structure of the fee schedule. Payment increases to promote access typically are based on direct indicators of access problems, such as an area's provider supply, an area's care needs, and availability of services in nearby areas. As discussed further below, the MMA included two explicit provisions regarding additional payments to help ensure access to care in areas with physician shortages.

Prior to the MMA, geographic practice cost adjusters used in the physician fee schedule, as in Medicare's other provider payment systems, had allowed for variation in fees both above and below a national average. The work GPCI floor represents a policy precedent that seems to establish the principle that geographic practice cost adjusters may be used to achieve broader objectives. In this instance, policymakers were focused on rural providers and thus altered the fee schedule's basic goal of varying fees according to relative resource costs across areas. Once this precedent is set, it may be more likely that changes to the practice cost adjusters could occur to further other policy goals. That is, if it is considered acceptable to use the work GPCI to alter fees by geography, would it also be possible to apply the work GPCI in ways that could encourage the provision of certain types of services or specialists' care? For example, to encourage the use of services that may be viewed as under-supplied in rural areas (e.g., diagnostic tests), one might establish a floor on all of the GPCIs used in determining Medicare fees for such services. This action clearly would raise fees in rural areas for these services, however would begin to undermine the resource-based relative value scale that underpins the physician fee schedule, and make the fee schedule somewhat arbitrary.

Conceptual Foundations of Geographic Practice Cost Indices

At the time the fee schedule was being developed some felt that physicians' work was the same in all areas of the country and, therefore, should be paid for at the same rate in all areas. As the recent debate over adopting a floor under the physician work GPCI suggests, this view still persists. However, as the research underpinning the GPCIs showed, creating a *fair* compensation system could involve allowing payments for physicians' own time to vary in relation to costs of living and other factors, and a policy consensus developed around this approach when Congress passed the fee schedule legislation. Although the recent legislation focuses on the work GPCI, future changes could also affect the practice expense and PLI indices. Therefore, we review the development of all three GPCIs (work, practice expenses, and professional liability insurance costs), but provide more detail regarding the physician work adjuster.[3]

Physicians' Own Time

The fundamental reason to allow for geographic variation in the costs of physicians' own time is to create fees that compensate physicians at the same *real* rate in all areas of the country. An area's real rate of compensation can be thought of as the ratio of the dollar payment to the area's costs. Although a cost-of-living adjuster may be an intuitively appealing measure of an area's costs, this type of adjuster does not take into account the impact that an area's amenities might have on compensation. Amenities differ across areas due to professional factors such as access to quality colleagues, availability of physicians to share on-call obligations and the presence of modern hospitals and medical technologies, and due to personal factors such as availability of good schools, proximity to cultural events, and clean air. By not accounting for these differences, a cost-of-living adjuster would have the undesirable effect of over-adjusting physician fees.

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[3] See also Zuckerman, S., W.P. Welch and G. Pope, "A Geographic Index of Physician Practice Costs," *Journal of Health Economics* 90(1), June 1990, pages 39-69.

Economics predicts that compensation would not fully reflect an area's high costs of living if the area had desirable amenities. That is, desirable amenities would be a type of compensation of their own and would offset some of the high costs of living. For example, workers are willing to locate in Honolulu despite its high cost of living because of its attractive environment. Similarly, for low-cost areas with poor amenities to attract and retain physicians, compensation would have to exceed costs of living. For example, if physicians value urban amenities, they would need to be paid more relative to the cost of living to locate in rural areas. Over time, compensation differences across areas would adjust so that a physician who is deciding where to locate would not care in which area he or she locates. Properly adjusted for geographic differences in practice costs, Medicare physician payments would tend to promote an adequate supply of physicians in *both* urban and rural areas, without explicitly making other adjustments related to access considerations.

What could be used as a geographic adjuster of physician time costs to equalize real compensation instead of the costs of living? Data on geographic variation in physician earnings were available from the U.S. Census Bureau. However, it would have been inappropriate to use these data to adjust payments under the Medicare fee schedule because these earnings were, in part, determined by historical patterns of Medicare's charge-based reimbursement system (which the fee schedule was designed to replace). Further, these data were hard to work with because they could not be adjusted to control for specialty-mix differences across areas and because they reflect the profitability of physicians' practices as well as earnings.

As an alternative, hourly earnings of workers in professional occupations with five or more years of college education were used to derive a *proxy* for the physician work component of the geographic practice cost adjuster. This group of highly educated workers was viewed as being similar to physicians with respect to the types of goods and services they purchase and with respect to their preferences for area amenities.[4] Therefore, they should have earnings that reflect the appropriate amount of geographic variation that should be captured in the Medicare fee schedule. In addition, this adjuster did not perpetuate distortions that were present in the

[4] It is possible that the geographic differences in professional earnings may not fully reflect physicians' preferences for amenities related to the health care system. However, a policy consensus accepted that the professional earnings proxy could serve as the basis for the work GPCI.

geographic distribution of Medicare payments in the years before the fee schedule was adopted, under the charge-based reimbursement system.

Essentially, the *geographic variation in* payments for physicians' own time under the fee schedule, as it was originally developed, would have reflected the *variation* of earnings for other highly educated professionals. This does not imply that the *absolute level or amount* of physician earnings would be comparable to that of other professionals with five or more years of college education within a geographic area. Instead, it simply means that the *relative* earnings of physicians across areas are likely comparable to the relative earnings of other highly educated professionals across areas. After considerable sensitivity analyses that explored alternatives to using professional earnings, it appeared that this was the most defensible geographic adjuster for physicians' own time costs. Thus, the geographic adjuster that was originally developed was based on professional earnings and ranged from about 28 percent above the national average (in Manhattan, New York) to about 16 percent below the national average (in rural areas of Missouri).

However, as the fee schedule was being debated prior to its implementation, policymakers concluded that this degree of geographic variation in physician work costs appeared to be too large. As such, the geographic adjuster that actually was incorporated into the Medicare fee schedule reflected only one-quarter of the geographic variation in professional earnings. Primarily as a result of this decision, from 1992 until the work floor provision the geographically adjusted physician work payment ranged only from a high of about 9 percent above the national average (in Manhattan, New York) to a low of about 5 percent below average (in rural Missouri). This policy decision produced higher physician payments in low cost areas (many of which are rural) than what would have occurred under the proposed "full" work GPCI. Even use of the "full" work GPCI, however, would have produced higher fees in rural areas than what had been in place under the charge-based method that preceded the fee schedule.[5]

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[5] Pope GC, Welch WP, Zuckerman S, and Henderson MG. "Cost of Practice and Geographic Variation in Medicare Fees," *Health Affairs* 8(3), Fall 1989: 117-128.

As required by law, the GPCIs have been updated three times since the fee schedule was implemented. Throughout these updates, this "quarter work" GPCI policy has remained in place. Although the one-quarter work GPCI is not consistent with the original developmental work on the geographic practice cost adjusters and is not likely to be fully equalizing real compensation across areas, later research suggests that it still may track the geographic variation in one measure of physician time costs. Gillis and colleagues found that geographic variation in employee physician wages— collected before implementation of the fee schedule— was closely related to the variation exhibited in the one-quarter work adjuster.[6] Relatedly, these researchers concluded that the one-quarter work adjuster tracked employee physician wages better than allowing for no geographic adjustment. This suggests that an adjuster with less geographic variation, such as the MMA's physician work GPCI floor, would not have tracked employee physician wages as well as the one-quarter work GPCI.

Practice Expenses

Employee wages is the second largest overall source of a physician's practice costs, and is the primary group of costs comprising the practice expense GPCI. An index based on median hourly earnings of administrative support occupations, registered nurses, licensed practical nurses or LPNs, and health technologists and technicians (excluding LPNs) is used as the employee price adjuster.[7] To reflect the occupation mix in physicians' offices, each category of hourly earnings is weighted to reflect the occupation's share of physician expenditures for employees.

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[6] Gillis K, Willke R and Reynolds R, "Assessing the Validity of the Geographic Practice Cost Indices," *Inquiry* 30(3), Fall 1993: 265-280.

[7] Because the prior, charge-based reimbursement system distorted geographic differences in physician earnings, the work GPCI did not rely on historical physician earnings data. However, the pattern of earnings of nonphysician clinical staff were less directly affected by the charge-based reimbursement system because physicians must compete for these workers with other health care providers and other industries, and must pay wages that reflect market rates. While it is possible that geographic differences in these market wage rates could be influenced by Medicare payment rates across a range of providers (e.g, hospitals and skilled nursing facilities), physicians' practices should still be viewed as price takers for these types of employees.

The next largest expense category is office rents. There are no nationwide data on rental rates for physician office space, however the U. S. Department of Housing and Urban Development annually derives a "fair market rent" for all areas with a Section 8 Housing Assistance Program. These data represent the 45th percentile rent for various sized units in each geographic market and are used as a proxy for a geographic adjuster of physician office rents. A key advantage of this price information is that it is available for all metropolitan areas and rural counties. A weakness of this proxy is that physician offices are in commercial as well as in residential buildings. However, residential and commercial rents are likely to be highly correlated because the same factors— such as population density, construction costs, and area income— are likely to affect both. The limited evidence shows that residential and commercial rents do tend to track each other across areas.

Another component of practice expense costs is medical supplies, equipment, and miscellaneous expenses. Roughly 14 percent of total physician practice revenues are accounted for by these costs. During the GPCI development efforts, a review of available data uncovered no information on geographic differences in the prices of these inputs. Anecdotal evidence also suggested that price variation in these inputs is minimal, and that the market for them essentially is a national market. Therefore, in computing the practice expense GPCI, these input prices were assumed to be the same across all areas.

Professional Liability Insurance

Costs for professional liability insurance (PLI) is a relatively small input in physicians' total practice costs (roughly 3 percent, on average), however the cost variation by specialty and by area is several times greater for PLI than for other cost components. Geographic differences in PLI costs are measured by comparing premiums charged for a mature claims-made insurance policy with $1 million/$3 million limits of coverage in each area to a national average. The data are derived from periodic surveys of professional liability insurers in all states and, where necessary, reflect intrastate variation. Specialty-specific premiums are combined into an area average based on the most common 20 physician specialties, weighted by their national shares of Medicare physician payments, so as to represent the full range of professional liability risk

classifications.[8] The national average premium is computed as a weighted average of the area average premiums, where the weight for each area is the total number of RVUs provided to Medicare beneficiaries in each area.

The goal of the PLI adjuster is to fully reflect variation in PLI premiums for the specialties that most frequently serve Medicare beneficiaries. Although the time required to collect the underlying data does not allow the PLI GPCI to be based on premiums in the current year (or even in the immediately preceding year), Medicare is required to update all of the GPCIs every three years, using the best available data. Although the components of the GPCIs that are based on decennial Census data on wages are necessarily updated less frequently, the PLI GPCI is updated on a three-year cycle (as is the office rents component).

Application of GPCIs to Geographic Payment Areas

Prior to implementation of the fee schedule, Medicare carriers administered physician payments within state boundaries and had a great deal of discretion as to how payments for services would vary across geographic areas within their jurisdictions. Although there were statewide payment areas, some states had highly disaggregated payment areas. For example, Texas was divided into 33 payment areas for some specialties. In contrast, the conceptual basis of the GPCI development efforts included a more consistent set of criteria to define payment areas in and across states. The goal was to develop and apply GPCIs to areas that: 1) had reasonably consistent prices for practice inputs within their borders; 2) were large enough to be a fairly self-contained market for practice inputs; and 3) were compatible with Medicare's administrative practices. The areas selected for the GPCIs were metropolitan areas and state rural areas, because they were (and are) being used in the Medicare inpatient prospective payment system, and because these areas struck an acceptable balance across the three conceptual criteria.

[8] It is possible that geographic variation in premiums is not uniform across all specialties. However, the Medicare fee schedule does not allow for specialty-specific differences in payments (nor for specialty-specific geographic

Thus, when the fee schedule was implemented, GPCIs were adapted for use across 210 metropolitan and rural areas, or "payment localities". Subsequently, in 1997 Medicare adopted statewide payment areas for use in physician payments, with exceptions that allow for sub-state payment localities in those states with substantial within-state practice cost variation. This reduced the number of payment localities to 89, however the magnitude of the change in terms of payment distribution within states was small. In the 28 states that did not have statewide payment areas before 1997, the geographic area revision affected GPCIs in 154 out of 188 of the original payment localities; the average change in these 154 areas was less than 3 percent in the overall geographic adjustment.[9] Although the changes were small, this revision served to raise fees in lower cost areas (many of them rural) and reduce them in higher cost areas of states.

Recent Discussions about Physician Payment Adjusters

As we have described above, three developments in physician payment policy have served to narrow the range in the geographic variation in fees, and effectively have raised fees in low-cost (mainly rural) areas. First, the shift from charge-based reimbursements to a resource-based fee schedule reduced this variation. Second, the adoption of the quarter-work GPCI raised fees in areas with below-average costs. Third, the reduction in the number of payment localities has the effect of raising payments to physicians in low-cost areas as well.

However, proponents of the MMA work floor provision essentially argue that these developments do not go far enough in this regard. Four main points were raised, at various times, during the MMA floor provision debates. First, the data used in developing and updating the work GPCIs do not capture some higher costs that are associated with low-cost, predominantly rural practices (e.g., higher costs are cited for recruitment and retention, equipment maintenance, and standby capacity in rural areas).[10] Second, some reject the work

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adjusters). The weighting of the premium data by the top 20 specialties' shares of Medicare payments, however, captures the majority of such variation.

[9] Health Care Financing Administration, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1997; Proposed Rule," *Federal Register* 61(128):34614-35662, July 2, 1996.

[10] For example, see American Academy of Family Physicians. Letter to CMS Administrator, October 6, 2003 regarding August 15, 2003 CMS Notice of Proposed Rulemaking.

GPCI altogether, and the conceptual foundation of the work GPCI as a way of equalizing *real* fees, or the purchasing power of the fees across areas. Third, even if fees accurately reflect input prices in those areas, advocates for the floor policy note that the elderly account for a relatively high share of physician practices in rural areas. The combination of lower fees and a high share of Medicare patients may result in a total income that is unattractive to physicians.[11] Finally, some assert that higher fees than are currently paid in these areas are necessary to attract and retain physicians and consequently to maintain access to care for Medicare beneficiaries.[12]

The original GPCI research explicitly considered concerns about the level of fees that could exist in rural areas under the fee schedule.[13] Indeed, although the research suggested that the GPCIs did a reasonably good job of tracking practice costs across rural and urban physicians, the developers recognized that policymakers may want to consider changes to the GPCIs related to factors other than input price differences in order to meet other objectives, such as maintaining physician availability and assuring access to care. In fact, setting GPCI floors was one policy lever suggested at the time as a means to increase fees in rural areas.[14]

Similarly, the MMA floor provision has a broader stated aim of helping ensure physician availability and access to care. One critical policy question is: "will the higher resulting fees in fact increase provider availability and beneficiary access?" In low-cost areas, the floors will raise fees by as much as 5 percent.[15] The effect on access is an empirical issue that should be studied

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[11] For example, see MacKinney, A.C., M.D. Shambaugh-Miller and K.J. Mueller, "Medicare Physician Payment," RUPRI Center for Rural Health Policy Analysis Rural Policy Brief, 8(2), January 2003.

[12] For example, see Charles Grassley (R-IA) Press Release "Senator Unveils Legislation to Improve Health Care Access for Iowans" Thursday, May 9, 2002. Available at http://grassley.senate.gov/releases/2002/p02r5-9b.htm

[13] Welch, W., S. Zuckerman and G. Pope, "The Geographic Medicare Economic Index: Alternative Approaches," Urban Institute Working Paper 3839-01-01, June 1989.

[14] Absent additional funding allowed by Congress, a GPCI floor policy leads to lower fees in high-cost areas in order to offset the cost of the floors. Because of this tradeoff, GPCI floors have been a contentious proposition in the past. In the recent Medicare legislation, Congress granted additional funding to offset the cost of the floor provision and thus fees in higher areas will not be reduced to fund the provision.

[15] The lowest work GPCI is about 0.9, or 9 percent below the national average, however the work component accounts for roughly one-half of the total value of fees on average.

after implementation of the higher fees, and will be addressed in part by the GAO mandated study on the floor provision.

A second critical policy question is: "are altering GPCIs the best policy lever for meeting access goals?" One feature of using GPCI floors as a means to improve access is simply the administrative ease of implementing the provision. Another feature of the floors is their universality—that is, every physician treating Medicare patients in every payment locality that has a quarter-work GPCI value less than 1.0 will have their fees automatically increased. Some rural advocates may find this desirable, but such a policy does not target the additional spending toward the particular rural areas that have the greatest problems in physician retention and beneficiary access. A third feature of the floor provision is that it entangles the broader goals of physician retention and beneficiary access with the traditionally narrow and technical input price adjustment mechanism. Every prospective payment system and fee schedule used by Medicare includes input price adjusters to account for geographic variation in these costs. Then, separate payment adjustments typically are applied to help preserve beneficiaries' access to care and providers' financial viability. These additional payment policies are clearly identified and can be monitored and assessed. The floor provision makes it more difficult to debate the explicit goals, monitor the policy effects and develop future refinements.

MMA Provisions Explicitly Addressing Access

While the use of GPCI floors provides additional payments to areas through the input price adjuster, an alternative aimed at raising fees, improving physician retention, and increasing beneficiary access is to target additional monies based on physician availability. This type of explicit policy was discussed during the MMA debates, and two provisions were included in the final legislation.

First, under prior law physicians qualified for a 10 percent add-on to their fee schedule payments when they furnished services in Health Professions Shortage Areas (HPSAs).[16] To receive the payments, physicians had to indicate their eligibility on their Medicare billing or claims forms. Due in part to research indicating that physicians were not fully claiming HPSA payments,[17] the MMA included a provision that, effective in 2005, makes CMS rather than physicians responsible for identifying claims that qualify for HPSA payments.

In addition, the MMA established new "Physician Scarcity Areas" and created a new, temporary 5 percent add-on to physician payments for services furnished in the areas, effective for three years (2005 through 2007). The Secretary will identify Physician Scarcity Areas according to the number of practicing primary care physicians (PCPs), practicing specialists, and Medicare beneficiaries in every county. Counties/tracts with the lowest PCP-to-beneficiary ratios (up to an aggregate of 20 percent of all Medicare beneficiaries) are Primary Care Scarcity Counties, and those with the lowest specialist-to-beneficiary ratios (up to an aggregate of 20 percent of all Medicare beneficiaries) are Specialist Care Scarcity Counties. Thus, a county/area can be designated as either a PCP scarcity area, a specialist scarcity area, or both. The use of specialists in the scarcity area designation is different from the HPSA designation process, which is based largely on an area's PCP availability. As with the changes to the HPSA payments process, CMS will identify claims qualifying for scarcity area payments. Services provided in counties that are both a Physician Scarcity Area and a HPSA will receive both incentive payments, for a total add-on of 15 percent.

Unlike the GPCI work floor, the physician scarcity area and HPSA payment provisions each combine the features of administrative simplicity, flexibility in achieving targeted payment

[16] HPSA designations are based on the ratio of primary care physicians (PCPs*)* to an area's total population as well as evidence that PCPs in the surrounding areas are overutilized, excessively distant, or otherwise inaccessible. The PCP to population ratio must be at least 1 to 3,500. If the area has unusually high need for services or insufficient capacity of existing PCPs, the minimum ratio is lower (1 to 3,000). High needs are identified by factors such as a high infant mortality rate or a high poverty rate. About 20 percent of the U.S. population resides in primary care physician HPSAs. The MMA provision for automatic HPSA payments applies to services furnished in full-county HPSA areas; the Secretary may include services furnished in partial county HPSAs if it is feasible to do so.

[17] Shugarman LR and Farley DO, "Shortcomings in Medicare Bonus Payments for Physicians in Underserved Areas", Health Affairs 22(4): 173-178.

increases, and a straightforward orientation and transparency with regard to the goal of improving access in areas hampered by problems in physician attraction and retention. If addressing these concerns is a fundamental objective of the GPCI floor provision as well, then policymakers could choose to apply funds associated with the floor to these bonus payments.

Conclusion

As the debate over geographic adjustments to the Medicare physician fee schedule continues, the adjuster for physicians' own time costs remains a contentious issue. Some argue that the physician labor market is a national market and, as such, physicians should be paid the same in all areas. Even if physicians are recruited from all areas of the country, it does not follow that their *nominal* level of compensation should be the same everywhere in order to achieve payment equity. However, as originally implemented, 75 percent of the payment for the physician work component of a Medicare fee was the same in all areas. The remaining 25 percent was adjusted to reflect differences in earnings that capture differences in costs of living and area amenities. Although this partial adjustment may not have achieved the objective of the geographic adjuster as originally proposed by its developers—an equalization of *real* compensation across areas—the one-quarter work adjustment nonetheless moved fees in that direction in all areas. However, the adoption of the work GPCI floor has taken the debate over geographic adjusters in the Medicare fee schedule well beyond the more technical issues that were considered when the GPCIs were developed. Policymakers have shown an interest in moving in the direction of geographic payment parity as it relates to physician work, while ignoring potentially substantial differences in the costs of physicians' work.

If access is the driving force behind provisions to increase Medicare fees in low-cost areas, it is not clear that a payment floor affecting all low-cost areas is the best way to target this extra spending. Addressing these issues— and understanding which issues are driving the debate— will help to clarify why the work GPCI floor was adopted and provide guidance about whether and how geographic adjustments in the fee schedule may be changed in the future.