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Geographic Adjustment in Medicare Payment

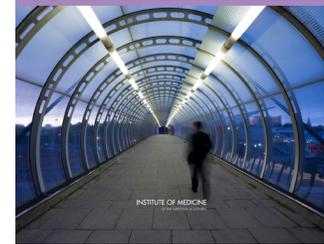
Phase II: Implications for Access, Quality, and Efficiency

Medicare, the world's single largest health insurance program, covers more than 47 million Americans, including 39 million people age 65 and older and 8 million people with disabilities. Although Medicare is a national program, it adjusts payments to hospitals and health care practitioners according to the geographic location in which they provide service, acknowledging that the cost of doing business varies around the country. Under the adjustment systems, payments in high-cost areas are increased relative to the national average, and payments in low-cost areas are reduced.

In July 2010, the Department of Health and Human Services (HHS), which oversees Medicare, commissioned the Institute of Medicine (IOM) to conduct a two-part study to recommend corrections of inaccuracies and inequities in geographic adjustments to Medicare payments. The IOM study committee issued *Geographic Adjustment in Medicare Payment, Phase I: Improving Accuracy* in May 2011 (with a second edition released in September 2011). The report examined the data sources and methods used to adjust payments, and it recommended a number of changes, including using the same geographic boundaries and payment areas for hospitals and health care practitioners; using different data sets for computing the compensation of clinical and administrative hospital staff and those at office-based sites; and expanding the types of occupations used to make the geographic adjustments. This latter change was recommended so that, for example, the full range of occupations employed in physicians' offices would be included in calculating the geographic adjustment, rather than a few select occupations.

The committee's latest report, *Geographic Adjustment in Medicare Payment, Phase II: Implications for Access, Quality, and Efficiency*, applies the first

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GEOGRAPHIC ADJUSTMENT
IN MEDICARE PAYMENT

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report's recommendations in order to determine their potential effect on Medicare payments to hospitals and clinical practitioners. The report also offers recommendations to improve access to efficient and appropriate levels of care. In addition, the committee notes the importance of ensuring the availability of a sufficient health care workforce to serve all beneficiaries, regardless of where they live.

Geographic Adjustments Important, But Not Enough

Through a series of statistical simulations, the committee found that if its Phase I recommendations were adopted, 88 percent of Medicare discharges from hospitals and 96 percent of physician billings would change by less than 5 percent on average. From a broader perspective, however, geographic adjustments now are—and in the future will remain—a relatively small part of the Medicare payment system and only should be used to improve payment accuracy, the committee writes. Further, the committee concludes that geographic adjustment of Medicare payments is not an appropriate approach for achieving such national policy goals as changing the composition and distribution of health care providers. Instead, geographic variations in the distribution of physicians, nurses, and physician assistants should be addressed through other means, as should local shortages of providers that create access problems for beneficiaries.

Improving Access to Health Care

The committee finds that Medicare beneficiaries generally have good access to care—defined as services that are readily available and that yield the most favorable outcomes possible. However, geographic pockets remain in which access to care is more limited and where beneficiaries may have difficulty finding physicians who accept Medicare

patients. Many of these pockets are in medically underserved rural and metropolitan areas and include disproportionate numbers of racially and ethnically diverse beneficiaries.

Because primary care is the foundation of an effective health care system, it is critical to focus on improving patients' access to this care. The committee identifies a number of ways, other than adjusting payments, to improve the distribution of health care providers. Current Medicare payment policies—in particular, the fee-for-service payment system—may influence the availability of primary care services, particularly in underserved areas. There is evidence that fee-for-service payments have encouraged growth in the volume and complexity of services delivered and have contributed to widening income differences between primary care and specialty practitioners. Such payment policies may encourage physicians in training to choose specialization over primary care. The Medicare program should develop and apply policies that promote access to primary care services in locations that present persistent problems to beneficiaries. The committee notes the importance of reconsidering the structure of fee-for-service payments in light of their likely effect on geographic variations in both the supply and type of practitioners.

Reaching Patients in New Ways

Although improving the supply and distribution of primary care providers can play a role—and support for training the health care workforce should continue—this is not the only way to improve beneficiaries' access to care. One promising strategy is to help current practitioners reach more patients through “telehealth” services, which use information and communication technologies to exchange information and provide health care when patients live a considerable distance from providers. For example, more than half of all Medicare beneficiaries have chronic medical conditions, such as diabetes, arthritis, and kidney

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disease, for which regular monitoring is becoming part of the standard of care. An increasing body of evidence shows that telehealth management of such beneficiaries can reduce preventable rehospitalizations and minimize access barriers due to geographic distance, patient disability, lack of transportation, or shortages of practitioners in rural and medically underserved urban areas.

Payment limitations are the most significant barrier to broader use of telehealth services. Currently, Medicare pays for these services when provided by qualified providers to beneficiaries in rural areas, but individuals and facilities in medically underserved metropolitan areas are not eligible. The committee recommends that the Centers for Medicare & Medicaid Services' payment

policy be changed to support telehealth services in all underserved areas.

Health Providers' Scope of Practice

As discussions of new care models have evolved, the roles of members of care teams are changing. This has resulted in legislative action regarding "scope of practice" standards, which spell out the services that health professionals are allowed to provide. As of March 2012, 16 states and the District of Columbia had passed laws giving full primary authority to nurse practitioners (NPs), meaning that NPs in these locations are responsible for the care they deliver, and are able to practice

BOX: Committee Recommendations

- **The Medicare program** should develop and apply policies that promote access to primary care services in geographic areas where Medicare beneficiaries experience persistent access problems.
- **The Medicare program** should pay for services that improve access to primary and specialty care for beneficiaries in medically underserved urban areas and rural areas, particularly telehealth technologies.
- **In order to promote access** to appropriate and efficient primary care services, the Medicare program should support policies that would allow all qualified practitioners to practice to the full extent of their educational preparation.
- **The Medicare program** should re-examine its policies that provide location-based adjustments for specific groups of hospitals, and modify or discontinue them based on their effectiveness in ensuring adequate access to appropriate care.
- **Congress should fund** an independent ongoing entity, such as the National Health Care Workforce Commission, to support data collection, research, evaluations, strategy development, and make actionable recommendations about workforce distribution, supply, and scope of practice.
- **Federal support should facilitate** independent external evaluations of ongoing workforce programs intended to provide access to adequate health services for underserved populations and Medicare beneficiaries. These programs include the National Health Service Corps, Title VII and VIII programs under the Public Health Service Act, and related programs intended to achieve those goals.



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The Centers for Medicare & Medicaid Services

to the full extent of their education, within their scope of preparation, and under their own license.

The Medicare program should support policies that would allow all qualified health care practitioners to practice to the full extent of their educational preparation, the committee states, noting that NPs, who often face scope of practice restrictions, are more likely than their physician counterparts to choose to practice in underserved areas.

Conclusion

The intent of Medicare's geographic adjustments in fee-for-service payments is to equitably compensate providers for differences in the cost of doing business. However, over the years, changes to the adjustments have introduced new inconsistencies.

The changes recommended by the committee in its Phase I report improve the accuracy of payments by providing a technically accurate model on which federal officials can base future policy decisions. The committee recommendations would result in less than a 5 percent change—increase or decrease—in Medicare payments to most hospital and practitioner services. Of course, percentages that may seem small yield real differences to those providers working diligently to provide high-value health care. 

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