Rutgers
Journal of Law & Public Policy

VOLUME 5 | SPRING 2008 | ISSUE 2

Editor-in-Chief
KRISTYN BYRNES

Executive Editor
NEENA VERMA

Symposium Editor
CARRIE FORD

Business Editor
MICHAEL BARNES

Managing Editor of Articles
TIFFANY D. JOHNSON

Managing Technology Editor
LOUIS E. MOYA

Managing Editor of Notes
JULIE HOROWITZ

Senior Articles Editor
CHANTAL ARTUR

Managing Research Editor
AMY N. KESEDAY

Senior Notes Editor
BRIAN E. HILDEBRANDT

Submissions Editors
LAUREL B. BUDMAN
ADAM MARC KAPLAN

Senior Technology Editors
SUPURNA BHAR
BRENDAN P. FERNALD
DARRELL MARTINELLI

Marketing Editor
RUCHIKA SACHDEVA

Articles Editors
KEVIN BIRKHEAD
ANDY HUGHES
ANTHONY VECCHIO
MARIE OLIVER
SUSAN SHAW
TARA CANNADAY
LALENA J. TURCHI
CHRISTINA J. KUBIAK
ALEXANDRIA JEAN-PIERRE

Technology Editors
RENEE DELLA FAVE
JONATHAN GROPPER
BRYCE GUINGRICH
JULIE PAULL

Notes Editors
A. MASON ROHRER
JESSE MELENDREZ
ASHLEY G. D'AMATO
RACHAEL MINARDI
A. ERIC LEVINE
BRIAN PREW

Members

Melissa Abatemarco
Richard Batelman
Jessica Bisignano
Krishna Sanat Bhavsar
Sarah Boyer
Kevin Davenport
Christopher Emrich
Elizabeth Foradori
Michael Ford
Kevin Golden
Brandon Hawkins
Charles Holmgren
John C. Hyon
Matthew Kohut
Mark F. Kowal
Jaclyn Levash
Denise M. Maher
Douglas C. Maute
Kathleen M. McClure
Jessica Miller
Hedwig Murphy
Elizabeth Myers
Adam V. Orlacchio
Robert Richardson
Matthew Robinson
David F. Roeber
Noah Schwartz
Boris Shapiro
Joseph A. Wacker
Richard David Walker
John Wyand

Faculty Advisors

Philip L. Harvey
Sarah E. Ricks
Damon Y. Smith

About the Rutgers Journal of Law & Public Policy

The *Rutgers Journal of Law and Public Policy* (ISSN 1934-3736) is published three times per year by students of the Rutgers School of Law – Camden, located at 17 North Fifth Street, Camden, NJ 08102. The views expressed in the *Rutgers Journal of Law & Public Policy* are those of the authors and not necessarily of the *Rutgers Journal of Law & Public Policy* or the Rutgers School of Law – Camden.

Form: Citations conform to *The Bluebook: A Uniform System of Citation* (18th ed. 2005). Please cite the *Rutgers Journal of Law & Public Policy* as 5 RUTGERS J.L. & PUB. POL'Y __ (2007).

Copyright: All articles copyright © 2007 by the *Rutgers Journal of Law & Public Policy*, except where otherwise expressly indicated. For all articles to which it holds copyright, the *Rutgers Journal of Law & Public Policy* permits copies to be made for classroom use, provided that (1) the author and the *Rutgers Journal of Law & Public Policy* are identified, (2) the proper notice of copyright is affixed to each copy, (3) each copy is distributed at or below cost, and (4) the *Rutgers Journal of Law & Public Policy* is notified of the use.

For reprint permission for purposes other than classroom use, please submit request as specified at http://www.rutgerspolicyjournal.org/.

Manuscripts: The *Rutgers Journal of Law & Public Policy* seeks to publish articles making original contributions in the field of public policy. The *Journal* accepts both articles and compelling essays for publication that are related to the expansive topic of public policy. Manuscripts must contain an abstract describing the article or essay which will be edited and used for publication on the website and in CD-ROM format. The *Journal* welcomes submissions from legal scholars, academics, policy makers, practitioners, lawyers, judges and social scientists.

Electronic submissions are encouraged. Submissions by email and attachment should be directed to submissions@rutgerspolicyjournal.org.

Paper or disk submissions should be directed to *Rutgers Journal of Law & Public Policy*, Rutgers University School of Law – Camden, 217 North 5th Street, Camden, New Jersey 08102.

Subscriptions: Subscription requests should be mailed to to *Rutgers Journal of Law & Public Policy*, Rutgers University School of Law – Camden, 217 North 5th Street, Camden, New Jersey 08102, or emailed to info@rutgerspolicyjournal.org.

Internet Address: The *Rutgers Journal of Law & Public Policy* website is located at http://www.rutgerspolicyjournal.org.

OFFICERS OF THE UNIVERSITY

RICHARD L. MCCORMICK, B.A., Ph.D., *President*
MARGARET S. MARSH, B.A., M.A., Ph.D., *Interim Provost and Dean, FASC*

LAW SCHOOL ADMINISTRATION

RAYMAN L. SOLOMON, B.A., M.A., J.D., Ph.D., *Dean and Professor of Law*
JAYDEV CHOLERA, B.A., M.B.A., *Director, Finance and Administration*
JOHN S. BECKERMAN, A.B., M.A., J.D., Ph.D., *Associate Dean—Academic Affairs*
CAMILLE SPINELLO ANDREWS, B.A., J.D., *Associate Dean—Enrollment*
ANNE V. DALESANDRO, A.B., M.L.S., J.D., *Director of Law Library*
BARBARA MAYLATH, A.B., *Director of Development*
EVE BISKIND KLOTHEN, B.G.S., J.D., *Assistant Dean for Pro Bono and Public Interest Programs*
ANGELA V. BAKER, B.A., J.D., *Associate Dean of Students and Career Planning*

FACULTY

AARON ARI AFILALO, A.B., J.D., LL.M., *Associate Professor of Law*
DAVID E. BATISTA, A.B., J.D., M.S., *Librarian*
LINDA S. BOSNIAK, A.B., J.D., M.A., *Professor of Law*
HON. DENNIS BRAITHWAITE, B.S., J.D., LL.M., *Visiting Professor of Law*
A. HAYS BUTLER, B.A., J.D., M.S. (LIS), *Librarian II*
LISA CAPASSO, *Visiting Clinic Asst. Prof. - LRW*
MICHAEL A. CARRIER, B.A., J.D., *Associate Professor of Law*
FRED C. CHANDLER, Jr., B.A., LL.B., LL.M., *Professor of Law Emeritus*
GLORIA F. CHAO, B.A., M.L.S., *Librarian II*
EDWARD E. CHASE, B.A., J.D., *Professor of Law Emeritus*
VICTORIA L. CHASE, B.A., J.D., *Clinical Associate Professor of Law*
ROGER S. CLARK, B.A., LL.B., LL.M., J.S.D., LL.D., *Board of Governors Professor*
JASON K. COHEN, B.A., J.D., *Legal Writing Clinical Asst. Professor*
RUSSELL M. COOMBS, B.A., J.D., *Associate Professor of Law*
LUCY COX, B.A., M.S., Ph.D., M.L.S., *Librarian II*
PERRY DANE, B.A., J.D., *Professor of Law*
JOHN H. DAVIES, B.S., LL.B., LL.M., *Professor of Law Emeritus*
JAY M. FEINMAN, B.A., J.D., *Distinguished Professor of Law*
KIMBERLY D. FERZAN, B.S., J.D., *Professor of Law*
DAVID M. FRANKFORD, B.A., J.D., *Professor of Law*
ANN E. FREEDMAN, B.A., J.D., *Associate Professor of Law*
STEVEN F. FRIEDELL, B.A., J.D., *Professor of Law*
SANDRA GAVIN, B.A., J.D., *Director of Advocacy Programs*
ERIC GILSON, B.A., J.D., M.L.I.S., *Librarian III*
GEORGE GINSBURGS, Bacchalaureat Serie Mathematiques, B.A., M.A., Ph.D.,
HARRIET N. KATZ, B.A., J.D., *Clinical Professor of Law & Director, Lawyering Program*
A. KODZO PAAKU KLUDZE, B.A., LL.B., Ph.D., *Distinguished Professor of Law Emeritus*
DONALD KOROBKIN, B.A., A.M., J.D., *Professor of Law*
ARTHUR B. LABY, B.A., J.D., *Associate Professor of Law*
F. GREGORY LASTOWKA, B.A., J.D., *Associate Professor of Law*
ARNO LIIVAK, B.A., M.L.S., J.D., *Professor of Law Emeritus*
HARRY LITMAN, A.B., J.D.,*Visiting Associate Professor of Law*
MICHAEL A. LIVINGSTON, A.B., J.D., *Professor of Law*
JOHN C. LORE, III,*Visiting Asst. Clinical Professor of Law*
JONATHAN MALLAMUD, A.B., J.D., *Professor of Law Emeritus*
EARL M. MALTZ, B.A., J.D., *Distinguished Professor of Law*
KIMBERLY MUTCHERSON, B.A., J.D., *Associate Professor of Law*
JOHN F. K. OBERDIEK, B.A., M.A., J.D., Ph.D., *Associate Professor of Law*
CRAIG N. OREN, A.B., J.D., *Professor of Law*
TRACI OVERTON, B.A., J.D., *Clinical Staff Attorney*
DENNIS M. PATTERSON, B.A., M.A., J.D., Ph.D., *Distinguished Professor of Law*
IMANI PERRY, B.A., J.D., L.L.M., Ph.D., *Professor of Law*
STANISLAW POMORSKI, LL.B., LL.M., J.S.D., *Distinguished Professor of Law Emeritus*
SARAH RICKS, B.A., J.D., *Clinical Associate Professor, Legal Writing*
RUTH ANNE ROBBINS, B.A., J.D., *Clinical Professor of Law & Chair, LRW Program*
SHEILA RODRIGUEZ, *Clinical Asst. Professor-LRW*
RAND E. ROSENBLATT, B.A., M.Sc., J.D., *Professor of Law*
PATRICK J. RYAN, B.A., M.A., J.D., LL.M., J.S.D., *Associate Professor of Law*

Distinguished Professor of Law Emeritus
SALLY F. GOLDFARB, B.A., J.D., *Associate Professor of Law*
ELLEN P. GOODMAN, A.B., J.D., *Professor of Law*
JOANNE GOTTESMAN, B.A., J.D., *Clinical Associate Professor of Law*
PHILLIP L. HARVEY, B.A., J.D., Ph.D., *Professor of Law*
ELIZABETH L. HILLMAN, B.S.E.E., J.D., Ph.D., *Professorof Law*
N.E.H. HULL, B.A., Ph.D., J.D., *Distinguished Professor of Law*
RICHARD HYLAND, A.B., M.F.A., J.D., D.E.A., *Distinguished Professor of Law*
JOHN P. JOERGENSEN, B.A., M.A., M.S. (LIS), J.D., *Librarian II*
DONALD K. JOSEPH, B.S., LL.B., *Visiting Associate Professor of Law*
MEREDITH L. SHALICK, B.A., M.S., J.D., *Visiting Clinical Asst. Professor of Law*
SANDRA SIMKINS, *Clinical Associate Professor of Law*
RICHARD G. SINGER, B.A., J.D., LL.M., J.S.D., *Distinguished Professor of Law*
DAMON Y. SMITH, B.A., M.U.P., J.D., *Assistant Professor of Law*
WILLIAM M. SPEILLER, B.S., LL.B., LL.M., *Professor of Law Emeritus*
ALLAN R. STEIN, B.A., J.D., *Professor of Law*
BETH STEPHENS, B.A., J.D., *Professor of Law*
GERARDO VILDOSTEGUI, B.A., J.D., *Visiting Professor of Law*
CAROL WALLINGER, B.S., J.D., *Legal Writing, Clinical Associate Professor of Law*
ROBERT M. WASHBURN, A.B., J.D., LL.M., *Professor of Law*
ROBERT F. WILLIAMS, B.A., J.D., LL.M., LL.M., *Distinguished Professor of Law*

Rutgers
Journal of Law & Public Policy

VOLUME 5 | SPRING 2008 | ISSUE 2

Current Issues in Public Policy

© 2007 by Rutgers University School of Law – Camden
ISSN 1934-3736

Rutgers
Journal of Law & Public Policy

VOLUME 5 SPRING 2008 ISSUE 2

CONTENTS

OUTSIDERS LOOKING IN: THE AMERICAN LEGAL DISCOURSE OF EXCLUSION 283
Luis E. Chiesa

LAND USE LAW AND ACTIVE LIVING: OPPORTUNITIES FOR STATES TO ASSUME A LEADERSHIP ROLE IN PROMOTING AND INCENTIVIZING LOCAL OPTIONS..............................317
Patricia E. Salkin and Amy Lavine

GEOGRAPHIC INEQUITY IN MEDICARE REIMBURSEMENT - EFFECT OF GEOGRAPHIC PRACTICE COST INDICES ON PHYSICIAN REIMBURSEMENT AND PATIENT ACCESS 361
Melissa H. Weresh

SEPERATION OF POWERS WITHIN THE IVORY TOWER – AN ORGANIZING PRINCIPLE FORUNIVERSITY GOVERNANCE...372
Bruce Pardy

PROYECTO ACCESO: USING POPULAR CULTURE TO BUILD THE RULE OF LAW IN LATIN AMERICA...........................378
James M. Cooper

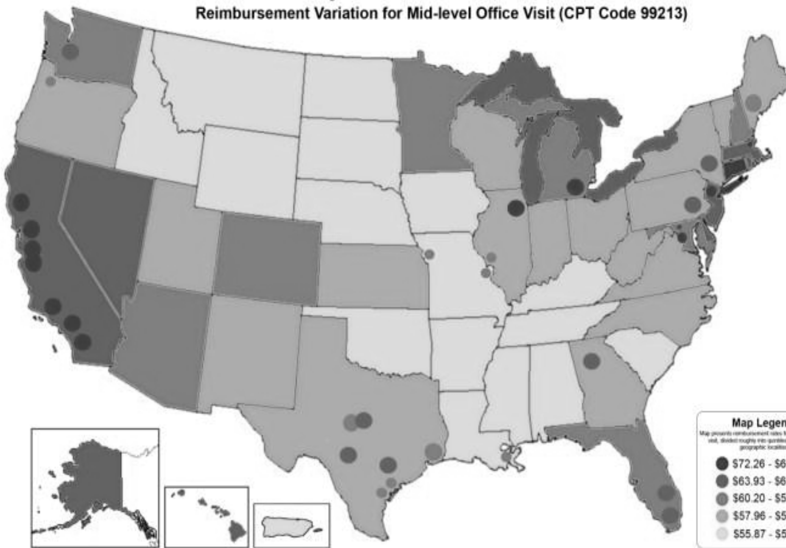
Geographic Inequity in Medicare Reimbursement

Effect of Geographic Practice Cost Indices (GPCIs) on Physician Reimbursement and Patient Access

Melissa H. Weresh, Professor of Law, Drake University Law School

Physician Reimbursement

Reimbursement Variation for Mid-level Office Visit (CPT Code 99213)



Degree of Reimbursement Variation

Identical Service - Reimbursement Amount Modified by GPCIs

	Payment Amount	% of Average Payment	% of Highest Payment
High (CA Santa Clara)	$76.26	1.265	1
Low (Puerto Rico)	$50.56	.839	.663

Effect of Geographic Variation on Patient Access to Physician Care

Comparison of Geographic Adjustment Factor (GAF) with Physician / Population Ratio

2007 GAF, Ratios exclude physicians located in the Possessions*

High Reimbursement Locations

Locality	2007 GAF Rank (out of 89 localities)	GAF	Physician per Population: Rank (by entire state / out of 51)	Physician per Population: Individuals per 1 Private Physician
NY - Manhattan	4	1.184	4	295
MA - Boston	8	1.153	2	260
DC - MD / VA Suburbs	10	1.132	1	152

Low Reimbursement Locations

Locality	2007 GAF Rank (out of 89 localities)	GAF	Physician per Population: Rank (by entire state / out of 51)	Physician per Population: Individuals per 1 Private Physician
Idaho	83	.922	50	616
Mississippi	85	.919	49	607
Oklahoma	86	.913	51	635

Source: U.S. Census Bureau, Population Division, Annual Population Estimates and Estimated Components of Change for the United States and States, April 1, 2000 to July 1, 2005; Physician Characteristics and Distribution in the U.S., *Dept. of Physician Practice and Communications Information, Division of Survey and Data Resources, American Medical Association, 2006 and prior editions.*

GEOGRAPHIC INEQUITY IN MEDICARE REIMBURSEMENT

EFFECT OF GEOGRAPHIC PRACTICE COST INDICES ON PHYSICIAN REIMBURSEMENT AND PATIENT ACCESS

Melissa H. Weresh[1]

Health care reform, particularly Medicare reform, is a central issue in the 2008 presidential election.[2] Candidates and voters are focused on issues related to fees and access to physician care.[3] The Medicare system is divided into three main parts.

---

[1] Melissa H. Weresh is a Professor of Law at Drake University Law School in Des Moines, Iowa. J.D. 1992, with high honors, University of Iowa College of Law; B.A. 1989, *summa cum laude*, Wake Forest University. The author would like to thank the staff at the Iowa Medical Society for their assistance with this project.

[2] "Medicare, one of the central topics for debate in the 2004 presidential election, promises to continue to be controversial for both the 2006 congressional elections and 2008 presidential election." SourceWatch, A Project for the Center of Media and Democracy, Medicare, http://www.sourcewatch.org/index.php?title=Medicare (last visited Mar. 28, 2008).

[3] As noted on one website:

> Voters have identified health care as the leading domestic issue for the government to address and for the presidential candidates to discuss in the 2008 campaign. In particular, voters would like to hear the candidates' positions on reducing the cost of health care and health insurance and expanding coverage to the 47 million uninsured Americans.

The Henry J. Kaiser Family Foundation, Health08.org, 2008 Presidential Candidate Health Care Proposals: Side-By-Side Summary, http://www.health08.org/sidebyside.cfm (last visited Mar. 28, 2008).

Part A is primarily related to hospital insurance.[4] Part B is primarily related to medical insurance.[5] Part C provides alternatives to Medicare's traditional benefits package, including Medicare Advantage, and Part D is related to drug coverage.[6] The accompanying visual scholarship addresses issues specifically under Medicare Part B. It is designed to illustrate inequities associated with physician reimbursement and patient premiums as well as the access concerns that stem from those inequities. A longer article will explore potential legislative solutions.

MEDICARE PHYSICIAN REIMBURSEMENT

Relative Value Units: Under the Medicare program, Part B, physicians are reimbursed for services based upon a physician fee schedule determined by the Centers for Medicare and Medicaid Services (CMS).[7] In setting the reimbursement rates for a service, costs associated with performing the service, based upon relative value units (RVUs), are multiplied by geographic practice cost indices (GPCIs) designed to reflect geographic variations in costs.[8] The resulting geographically adjusted RVU is then multiplied by a conversion factor to transform the RVU into a dollar amount.[9]

To determine RVUs, CMS considers three weights, which relate to three categories of inputs associated with the cost to the physician of providing the service.[10] The first RVU is the physician work RVU (Work RVU), which refers to the

---

[4] 42 U.S.C.A. § 1395i et. seq. (2006).

[5] 42 U.S.C.A. § 1395j et. seq. (2006).

[6] 42 U.S.C.A § 1395w et. seq. (2006).

[7] *See generally* 42 U.S.C.A. § 1395w-4(b) (2007). *See also* 42 C.F.R. § 414.22 (2008) (stating "CMS establishes RVUs for physicians' work, practice expense, and malpractice insurance.").

[8] *See generally* 42 C.F.R. § 414.22(c) (2008).

[9] *See generally* 42 U.S.C.A. § 1395w-4(d) (2007).

[10] *See generally* 42 U.S.C.A. § 1395w-4(c) (2007).

physician's individual effort in providing the service.[11] The work RVU is designed to reflect the level of effort, skill, time, and stress associated with providing the service.[12] The second RVU is the practice expense RVU (PE RVU), associated with the overhead costs physicians incur in providing services, including rental payments, supplies and equipment, and clinical and administrative staff salaries and benefits.[13] The final RVU is the professional liability insurance RVU (PLI RVU) and reflects the physician's costs associated with medical malpractice insurance.[14]

---

11 42 U.S.C.A. § 1395w-4(b)(1)(A) (2007) ("The term 'work component' means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service."). *See also* 42 C.F.R. § 414.22(a) (2008) (providing the general rule with regard to physician work RVUs which states that "[p]hysician work RVUs are established using a relative value scale in which the value of physicians' work for a particular service is rated relative to the value of work for other physician services.").

12 *Id.*

13 42 U.S.C.A. § 1395w-4(b)(1)(B) (2007) (stating "[t]he term 'practice expense component' means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses."). *See also* 42 C.F.R. § 414.22(b) (2008). Section 414.22(b) provides:

> Practice expense RVUs.
> (1) Practice expense RVUs are computed for each service or class of service by applying average historical practice cost percentages to the estimated average allowed charge during the 1991 base period.
> (2) The average practice expense percentage for a service or class of services is computed as follows:
> (i) Multiply the average practice expense percentage for each specialty by the proportion of a particular service or class of service performed by that specialty.
> (ii) Add the products for all specialties.

Id.

14 42 U.S.C.A. § 1395w-4(b)(1)(C) (2007) ("The term 'malpractice component' means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service"). *See also* 42 C.F.R. § 414.22(c) (2008). Section 414.22 provides:

> Malpractice insurance RVUs.
> (1) Malpractice insurance RVUs are computed for each service or class of services by applying average malpractice insurance historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

Geographic Adjustment: The RVUs for services are adjusted to take into account geographic variations.[15] Specifically, each of the RVUs is adjusted by a geographic practice cost index, or GPCI.[16] Three GPCIs – work, practice expense, and professional liability insurance – were developed to reflect geographic variations in costs associated with performing services.[17] So, the formula for computing a physician fee for a service can be generally reflected as:

> [(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (Professional Liability Insurance (PLI) RVU x PLI GPCI)] x Conversion Factor[18]

GPCIs are set for 89 payment localities.[19] A composite geographic adjustment factor (GAF) can be used to reflect

---

> (2) The average historical malpractice insurance percentage for a service or class of services is computed as follows:
> (i) Multiply the average malpractice insurance percentage for each specialty by the proportion of a particular service or class of services performed by that specialty.
> (ii) Add all the products for all the specialties.

Id.

[15] *See generally* 42 U.S.C.A. § 1395w-4(e)(1) (2007). *See also* 42 C.F.R. § 414.26(a) (2008). Section 414.26(a) states:

> Geographic indices. CMS uses the following indices to establish the GAF:
> (1) An index that reflects one-fourth of the difference between the relative value of physicians' work effort in each of the different fee schedule areas as determined under § 414.22(a) and the national average of that work effort.
> (2) An index that reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in each of the different fee schedule areas as determined under § 414.22(b) compared to the national average of those costs.
> (3) An index that reflects the relative costs of malpractice expenses in each of the different fee schedule areas as determined under § 414.22(c) compared to the national average of those costs.

Id.

[16] *Id.*

[17] *Id.*

[18] U.S. Dept. of Health and Human Servs., Ctrs. for Medicare and Medicaid Servs., *Physician Fee Schedule: Overview*, http://www.cms.hhs.gov/PhysicianFeeSched/ (last visited Mar. 28, 2008).

variation across localities.[20] The GAF indicates how Medicare reimbursement rates in a locality differ from the national average.

CRITICISM OF GEOGRAPHIC VARIATION

Concerns relating to Methodology: Geographic adjustments are common in the Medicare system.[21] However, the GPCI adjustments have been widely criticized in theory as well as in application. The current methodology for computing the work and practice expense GPCIs is flawed and creates unwarranted variation in physician reimbursement. For example, the work GPCI measures relative costs by an indirect measure - the relative hourly earnings of workers in professional occupations

---

[19] CMS is required to establish physician fee schedule areas. 42 C.F.R. § 414.4 (2007).

[20] 42 C.F.R. § 414.26(c) (2008). Section 414.26(c) provides:

> Computation of GAF. The GAF for each fee schedule area is the sum of the physicians' work adjustment factor, the practice expense adjustment factor, and the malpractice cost adjustment factor, as defined in this section:
> (1) The geographic physicians' work adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the work component and the geographic physicians' work index value established under paragraph (a)(1) of this section.
> (2) The geographic practice expense adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the practice expense component, multiplied by the geographic practice cost index (GPCI) value established under paragraph (a)(2) of this section.
> (3) The geographic malpractice adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the malpractice component, multiplied by the GPCI value established under paragraph (a)(3) of this section.

Id.

[21] *See, e.g.*, 42 C.F.R. § 412.312(a) (requiring that the payment amount for each Medicare discharge be modified by "[a] geographic adjustment factor is applied that takes into account geographic variation in costs."); 42 C.F.R. § 412.529 (2007) (requiring that hospital inpatient prospective payment be "adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications.").

with five or more years of college education - rather than on relative physician earnings.[22] The data used to construct the work GPCI are not current, and the professional occupation proxies have not been validated. [23] The practice expense GPCI reflects variation in non-physician wages, office space costs, and equipment and supplies.[24] The calculation for non-physician wages is based upon the median hourly earnings of four occupational classes: registered nurses, licensed practical nurses, medical technicians, and administrative support staff.[25] Current physician practices are comprised of additional categories of personnel whose salaries are not evaluated in the practice expense GPCI.[26] Thus, current staffing mixes are not adequately reflected in the non-physician wage index. Moreover, the office space expense is based upon a proxy of a

---

[22] U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICARE PHYSICIAN FEES: GEOGRAPHIC ADJUSTMENT INDICES ARE VALID IN DESIGN, BUT DATA AND METHODS NEED REFINEMENT, GAO-05-119, 7 (2005), *available at* http://www.gao.gov/new.items/d05119.pdf [hereinafter GAO-05-119] (noting that "the work GPCI measures relative costs exclusively by an indirect measure: the relative wages of six categories of nonphysician professional occupations, including lawyers, architects, social workers, and teachers."). The GAO notes that the indirect measure is preferable for two reasons. First, physician earnings in geographic areas are influenced by both the volume and intensity of services as well by physician specialty. *Id.* at 15-16. These variations could inflate the work GPCI in high expenditure areas as well as areas with a high intensity of physician specialists. *Id.* Furthermore, because physician earnings are based, in part, on Medicare earnings, including physician earnings in the work component would result in a circular measure. *Id.*

[23] *Id.* at 13. (acknowledging that "the data used to construct the work GPCI are not current.") *Id.*

[24] *See generally id.* at 16.

[25] *Id.* at 16 n.26

[26] The GAO acknowledges that "data on one type of nonphysician staff—physician assistants—are available from the decennial census and are expected to be available from the ACS. These data could be incorporated into the calculation of the practice expense GPCI." *Id.* at 17. While GAO notes that the inclusion of such data would "enhance [the] credibility" of the practice expense GPCI, it concludes that "the effect of the inclusion of these data is likely to be slight." *Id.*

residential rent index.[27] Physician practices, in contrast, are typically located in commercial buildings. Indeed, the Government Accountability Office has recommended that CMS update its data and methodology to account for these problems.[28] On July 12, 2007, CMS proposed updated GPCIs for 2008.[29] These GPCIs continue to use outdated data, rely on proxies that have not been validated, and fail to account for current physician practice arrangements.[30]

Concerns relating to Validity: In addition to problems associated with GPCI computation methodology, there remain concerns regarding the practical validity of some of the geographic adjustments. Notably, the work GPCI is designed to reflect geographic variation in physician time, skill, and effort. Opponents of the work GPCI argue that work is work, regardless of geography.

Concerns relating to Effect of Variation on Access to Physician Care: Thus, the geographic variations in payments for services may not accurately or fairly reflect differences in costs associated with performing those services. Moreover, lower GAF areas serve a disproportionately high percentage of Medicare patients, which exacerbates reimbursement disparity for physicians in low GAF, predominantly rural, areas. As a result, variations in Medicare reimbursement rates can have an adverse impact on physician recruitment in low GAF areas. A related concern is that of physicians limiting service to Medicare

---

[27] *Id.* at 18.

[28] *See generally id.* at 30.

[29] Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008, 72 Fed. Reg. 38122-01 (July 12, 2007).

[30] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008, 72 Fed. Reg. 66222-01 (Nov. 27, 2007) (rejecting the inclusion of physician earnings in the work component "because Medicare payments are a key determinant of physicians' earnings; therefore, including physician wages in the physician work GPCI would, in effect, make the index dependent upon Medicare payments," and noting with respect to the office rents calculation for the practice expense GPCI, "[w]hile it has been suggested that we explore sources of commercial rental data for use in the GPCI, we do not believe there is a national data source better than the HUD data.") *Id.* at 66244.

patients.[31] Compounding the inequity is the fact that Medicare Part B premiums are not adjusted geographically.[32] In short, Medicare patients are subject to the same premiums across the country but, due to GPCIs, physicians serving Medicare patients in low GAF localities receive significantly lower reimbursement than those in high GAF localities for performing the identical service. A coalition of organizations has formed Geographic Equity in Medicare, whose statement of purpose articulates:

> Americans everywhere pay equal premiums to support Medicare, yet there is substantial geographic disparity in patient services and physician reimbursement levels in the Medicare Part B program. The degree of this disparity is unjustified and inherently unfair – and is having an increasingly negative impact on patient care and access in many parts of the United States.[33]

LEGISLATIVE SOLUTIONS

GPCI floors: In December 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).[34] The MMA included many modifications to provider payments, including one that addressed the extent of variation in physician fees attributable to GPCIs. Specifically, the MMA set a temporary floor of 1.0 on the work GPCI, which

---

[31] Keith J. Mueller, et. al., *Rural Physicians' Acceptance of New Medicare Patients*, 9 RURAL POL'Y BRIEF 1 (2004), *available at* http://www.unmc.edu/ruprihealth/Pubs/PB2004-5.pdf (concluding that the "trend among all physicians is to *not* accept new Medicare patients.").

[32] In 2007, Medicare Part B premiums, which had previously been uniform, were adjusted according to modified adjusted gross income. These amounts do not vary geographically, however, such that individuals in different geographic locations within the same income bracket pay identical amounts but do not receive the same value for physician services because of the geographic adjustments attributable to GPCIs. 42 U.S.C.A. § 1395w-4(e)(1)(E) (2007).

[33] Geographic Equity in Medicare Coalition, Statement of Purpose, *available at* http://www.iowamedical.org/legis/GEM_Statement_2-9-07.pdf.

[34] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

ensured that all payment localities are paid at least the national average for the work component of the physician fee.[35] The floor was effective for the calendar years 2004 through 2006.[36] Congress then extended the floor through 2007.[37] Rejecting legislative initiatives[38] to make the floor permanent, the floor was once again extended in December 2007 to services offered through July 1, 2008.[39] As noted, CMS has proposed revisions to the GPCIs which, if adopted, will begin to be phased in for CY 2008.[40] The proposed GPCIs do not include the floor provision on the work GPCI.

Physician Bonuses: There are additional legislative attempts to address the disparity, including bonuses for health professional shortage areas (HPSA)[41] and physician scarcity

---

[35] *Id.* at Section 412, codified at 42 U.S.C.A. § 1395w-4(e)(1)(E)(2007).

[36] Iowa Medical Society, Facts Re: Medicare Physician Reimbursement, http://www.iowamedical.org/legis/GEM_update/Facts.pdf (last visited Mar. 28, 2008).

[37] Tax Relief and Health Care Act of 2006, Pub. L. 109-432, 120 Stat. 2922 (2006).

[38] *See, e.g.*, Medicare Equity and Accessibility Act of 2007, S. 2007, 110th Cong. (2007); Medicare Equity and Accessibility Act of 2007, H. R. 2827, 110th Cong. (2007).

[39] Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110-173, 121 Stat. 2492 (2007).

[40] 72 Fed. Reg. 38122-01 (July 12, 2007) (noting that the "effects of the 2008 transition year will be only one-half of the total amount of the revisions associated with the updated GPCI values. As required by law, the GPCIs would be phased in over a 2 year period.").

[41] 42 U.S.C.A. § 254e(a)(1) (2002) defines health professional shortage area as:

> (A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage and which is not reasonably accessible to an adequately served area, (B) a population group which the Secretary determines has such a shortage, or (C) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage.

areas (PSA).[42] These methods, while administratively efficient, have unintended and perverse effects on physician recruitment and patient access and care. Specifically, these types of remedies provide disincentives for physicians practicing in scarcity areas to recruit additional physicians at the expense of the bonuses. They also provide incentives to specialists to go into scarcity areas, with less sophisticated staff and equipment, to perform procedures that will be reimbursed at a greater rate. Both of these examples illustrate how the legislative attempts to remedy the apparent inequity may ultimately undermine patient care.

CONCLUSION

As noted, the accompanying visual scholarship is designed to illustrate the inequities of Medicare reimbursement, both in terms of physician reimbursement as compared with Medicare patient Part B premiums, as well as the effect of those inequities on physician recruitment patterns and resulting patient access to care. A longer article, in progress, continues the discussion.

---

[42] 42 U.S.C.A. § 1395l (2007) provides incentive payments to physicians in scarcity areas. As noted in GAO-05-119:

> Physician scarcity areas, defined by MMA, are of two types: primary care scarcity areas, which are determined by the ratio of primary care physicians to Medicare beneficiaries, and specialist care scarcity areas, which are determined by the ratio of specialty care physicians to Medicare beneficiaries. For both types, counties are ranked according to the ratio of physicians to Medicare beneficiaries, and the counties with the lowest ratios that represent 20 percent of Medicare beneficiaries are designated as scarcity areas. A physician who practices in an area that is both a shortage area and a scarcity area will receive a total incremental incentive payment of 15 percent.

GAO-05-119, *supra* note 23 at 13 n.20.