RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2014-8 **July 2014** **www.public-health.uiowa.edu/rupri**

The Effect of Medicare Payment Policy Changes on Rural Primary Care Practice Revenue

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In this policy brief we analyze the effect of Medicare payment adjustments on Medicare-derived revenues to rural primary care providers. Building on prior work in this area,[1] we look at the effect of changes in the Geographic Practice Cost Indices (GPCIs) from 2013 to 2014 as implemented in the Pathway for SGR Reform Act of 2013[2] and the Protecting Access to Medicare Act.[3]

Key Findings

- Changes to the GPCIs made between January 1, 2013, and March 31, 2014, resulted in an average 0.12% (median 0.18%) Medicare-derived revenue increase in rural primary care practices.

- Without the GPCI work floor reinstatement, primary care practices in rural areas would have been disproportionately impacted through lower Medicare-related revenues.

Background

Medicare payments to health care providers for covered services are established by payment policies and rates under the Medicare Physician Fee Schedule (MPFS). Each service is assigned relative value units that reflect the amount of provider work, practice expense, and malpractice cost involved in providing that service. The three relative value units for each service are adjusted by three GPCIs that adjust payments for local variation in the cost of furnishing services.[4] There are 89 unique geographic payment localities in the United States that include metropolitan-defined areas (e.g., Los Angeles, California), entire states (e.g., Alaska), or entire states absent metropolitan areas (e.g., Louisiana, excluding New Orleans). The Centers for Medicare and Medicaid Services (CMS) is required to update the GPCIs every three years to reflect changes in the local cost of operating a medical practice relative to the national average.[5] The Pathway for SGR Reform Act of 2013 and the Protecting Access to Medicare Act of 2014 updated the 2013 GPCIs. They reinstated the GPCI work floor of 1.0, limiting the downward geographic adjustment of physician work in payment localities with work GPCIs less than the national average. For example, a payment locality whose input costs associated with physician work are less than the national average might have a work GPCI of 0.958, which would be revised up to a floor of 1.0. This policy brief describes the impact of recent Medicare payment updates to the GPCI portion of the MPFS on rural primary care providers' practice revenue from Medicare.

RHRC Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

Funded by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (Grant # U1C RH20419)

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Methodology

We developed a revenue model using Medicare provider claims from 2009 to evaluate the impact of Medicare payment policy adjustments on Medicare-derived primary care provider revenue for practices located in rural areas of the United States. A random selection of rural providers and their associated 2009 Medicare claims were obtained from CMS based upon self-reported primary care provider designation, including internal medicine, family medicine, pediatric medicine, geriatric medicine, nurse practitioner, clinical nurse specialist, and physician assistant.[6] We classified these providers as either primary care physicians or primary care non-physician providers, and further subclassified the providers by the degree of rurality of their practice location using Rural-Urban Commuting Area (RUCA) codes. Three types of rurality were created using the RUCA Categorization A scheme from the WWAMI Rural Health Research Center[7]: large rural, small rural, and isolated rural. We created six provider type/rural combinations to evaluate differences in practice patterns by type of provider (physician or non-physician provider) and rural practice locale (isolated, small, and large). We aggregated these combinations to each of four census regions to ensure that the number of providers used to calculate the estimated average practice revenues for a particular geographic locality was large enough to provide statistical reliability. We then applied the 2013 MPFS relative value units to each Medicare claim using the Healthcare Common Procedure Coding System codes, the 2013 GPCIs for 50 "Entire State" and "Entire State absent Metropolitan" localities,[8,9] and the GPCI updates from the Pathway for SGR Reform Act of 2013 to derive estimates of average revenue in 2013 and change-in-average-revenue percentage due to the GPCI updates for the 50 non-metropolitan localities. The Medicare conversion factor, which converts geographically adjusted relative value units into a dollar payment amount, was held fixed across years so that the impact from GPCI changes alone could be evaluated. Comparisons are always of rural-to-rural providers, including when comparing providers in "Entire State" payment localities to those in "Entire State absent Metropolitan" payment localities.

Average Rural Primary Care Practice Revenues from Medicare

Average Medicare-derived revenue estimates in 2013 (excluding bonuses) to rural primary care practices in the United States ranged from a low of $14,291 in Idaho for non-physician primary care providers in isolated rural areas to a high of $180,141 in non-metropolitan Florida for primary care physicians in small rural areas. Average revenue estimates by locality type ("Entire State" vs. "Entire State absent Metropolitan") did not vary significantly at the aggregate level, but at the provider type and rural combination level, primary care providers practicing in large rural areas in "Entire State" localities had relatively higher average revenue estimates than those practicing in isolated and small rural areas in "Entire State" localities (Table 1).

Table 1. Average Estimated Medicare-derived Revenue by Locality Type

	Primary Care Physicians in Rural			Non-Physician Primary Care Providers in Rural		
Locality Type	**Isolated**	**Small**	**Large**	**Isolated**	**Small**	**Large**
Entire State, $	94,073	109,979	138,910	34,413	48,518	52,709
Entire State absent Metropolitan, $	96,665	111,926	134,415	35,180	49,505	48,495
Average $	94,902	110,602	137,472	34,568	48,834	51,360

Impact of Changes in GPCIs on Revenue

Percentage changes in the estimated average revenue for each of the 50 non-metropolitan localities due only to changes in GPCIs between calendar year 2013 and the updated 2014 GPCIs were calculated (the Medicare conversion factor and relative value units were held fixed between years). The range of all changes was -0.76% to +1.20%, and the mean change was +0.12%. The median change across the six provider type/rural combinations was +0.18%. The three localities with the most positive change in estimated average practice revenue were Louisiana

(excluding New Orleans), +1.15%; Alaska, +0.86%; and Oklahoma, +0.63%. The three localities with the most negative change in estimated average practice revenue were Ohio, -0.66%; Florida (excluding metropolitan areas), -0.60%; and Washington (excluding Seattle), -0.60%.

Rural providers in the "Entire State" category had higher average positive change percentages than those in the "Entire State absent Metropolitan" category (Table 2). Change percentages were influenced by the relative contribution of the work GPCI adjustment, practice expense GPCI adjustment, and malpractice GPCI adjustment.

Table 2. Average Percentage Change in Estimated Medicare Revenue due to Changes in GPCIs, 2013 to 2014

	Primary Care Physicians in Rural			Non-Physician Primary Care Providers in Rural		
Locality Type	**Isolated**	**Small**	**Large**	**Isolated**	**Small**	**Large**
Entire State	0.12%	0.12%	0.13%	0.13%	0.13%	0.13%
Entire State absent Metropolitan	0.09%	0.09%	0.10%	0.10%	0.09%	0.09%

An analysis of the GPCI changes that were proposed prior to enactment of the Pathway for SGR Reform Act of 2013 and the Protecting Access to Medicare Act shows that "Entire State" localities would have been disproportionately negatively impacted had the work floor of 1.0 not been reinstated. Table 3 shows a breakdown by type of locality (including metropolitan) that would have experienced a decline, an increase, or zero change in their work GPCI.

Table 3. Work GPCI Change Direction prior to 2014 Updates, by Locality Type

Work GPCI Change Direction	**Entire State (%)**	**Entire State absent Metropolitan (%)**	**Metropolitan (%)**
Negative Adjustment	30	12	20
Positive Adjustment	3	4	14
Zero Adjustment	3	0	3
Total	36	16	37

Table 4 shows the impact of the work floor reinstatement on the three types of localities. All practices in "Entire State" and "Entire State absent Metropolitan" localities would have experienced a decline in the portion of their Medicare revenue from the work component due to negative changes in the GPCI work indices. Other localities might have experienced a negative change, but their proposed 2014 work GPCI did not fall below 1.0 so they were not impacted by the 1.0 work floor adjustment.

Table 4. Impact of GPCI Work Floor Extension, by Locality Type

Impact	**Entire State**	**Entire State absent Metropolitan**	**Metropolitan**
Total number of localities with negative change	30	12	20
Change from < 1.0 to 1.0 (floor)	30	12	9
Percent of all negative changes affected by work floor	100%	100%	45%

Changes in the estimated average practice revenue for each combination of provider type and rural attribute and for each of the 50 non-metropolitan localities are available on the RUPRI Center website at www.ruprihealth.org.

Discussion

We show that GPCI changes between calendar year 2013 and 2014 have variable effects on estimated average rural primary care provider revenue, and that these effects depend on the size of the change, the direction of the change, and the GPCI component being changed. Of the three GPCI components, the work component has the largest impact on revenue (50.9%) followed by the PE component (44.8%) and the malpractice component (4.3%).[10] Absent the reinstatement of the 1.0 work floor in 2014, practices in non-metropolitan localities ("Entire State" and "Entire State absent Metropolitan") would have been the most negatively impacted, as the majority of localities in these categories were scheduled to see their work GPCIs fall below 1.0 in 2014. Since "Entire State" and "Entire State absent Metropolitan" localities include all rural providers (versus "Metropolitan" localities, which by definition are urban), this downward payment adjustment in the work floor would have had a disproportionately negative effect on the average revenue of rural primary care providers. Policies that reduce rural provider revenue compared to urban provider revenue may make rural provider recruitment and retention more difficult.

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[1] MacKinney C. *Increases in Primary Care Physician Income due to the Patient Protection and Affordable Care Act of 2010 – Continued Tweaking of Physician Payment* (Rural Policy Brief No. 2010-2). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; July 2010.

[2] Pathway for SGR Reform Act of 2013, Pub. L. No. 113-67, http://docs.house.gov/Billsthisweek/2013-1209/AMNT-113-HJRes59sa-2.

[3] Protecting Access to Medicare Act of 2014, Pub. L. No.113-93, http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf.

[4] Fact sheet: Final Policy and Payment Changes to the Medicare Physician Fee Schedule for Calendar Year 2014. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-11-27-2.html

[5] Medicare physician fee schedule payment system fact sheet series. April, 2013. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medcrephysfeeschedfctsht.pdf.

[6] Shane D, MacKinney C, Ullrich F, Mueller K, Weigel P. *Assessing the Impact of Rural Providers Service Mix on the Primary Care Incentive Program* (Rural Policy Brief No. 2013-16). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; December 2013.

[7] WWAMI RUCA Rural Health Research Center. http://depts.washington.edu/uwruc/ruca-uses.php.

[8] We excluded the following metropolitan localities: Anaheim/Santa Ana, Los Angeles, Marin/Napa/Solano, Oakland/Berkley, San Francisco, San Mateo, Santa Clara, and Ventura, CA; DC + MD/VA suburbs; Fort Lauderdale and Miami, FL; Atlanta, GA; Chicago, East St. Louis, and suburban Chicago, IL; New Orleans, LA; Southern Maine; Baltimore/surrounding counties, MD; Boston, MA; Detroit, MI; Kansas City, KS; St. Louis, MO; Northern NJ; Manhattan, NYC suburbs/Long Island, Poughkeepsie/N NYC suburbs, and Queens, NY; Portland, OR; Philadelphia, PA; Austin, Beaumont, Brazoria, Dallas, Ft. Worth, Galveston, and Houston, TX; Seattle (King County), WA. We also excluded two "Entire State" localities because we did not have claims from these areas: Puerto Rico and Virgin Islands.

[9] "Entire State absent Metropolitan" localities include Florida, California, Texas, Massachusetts, Illinois, Georgia, Washington, Oregon, Louisiana, Maine, Michigan, Missouri, New York, Pennsylvania, New Jersey, Maryland.

[10] Office of the Federal Register. 78 FR 74382, page 74382. https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#h-245.