

August 11, 2009

The Honorable X
Office Building
Washington, DC 20515

Dear Congressman X,

On behalf of the Geographic Equity in Medicare (GEM) Coalition, representing more than two dozen state and specialty medical societies, we write to express our gratitude for your diligent, committed efforts to reform our health care system. We are concerned that all Americans will experience incremental reductions in access and coordination of care without urgent, bold action. The GEM coalition believes that if America aspires to sustainable, accessible, affordable health care, Congress must address three key features of health care reform proposals currently in the Congress.

Public Plan Based on Medicare Payments

We are concerned that any financing option **using Medicare payment rates** will have a severe negative impact on access to physician practices in our states and lead to further cost shifting. Medicare reimbursements in our states do not fully cover the many expenses involved with diagnosing and treating patients. We believe that so long as cost shifting is a financing strategy, entitlement beneficiaries – which include ultimately all of us – will not truly have secure access to care. More citizens covered by Medicare reimbursement rates could paradoxically dismantle some of our nation's most successful but vulnerable delivery systems which have produced higher-value, more efficient, cost-effective care. The promise of universal coverage could be dashed in GEM Coalition states by just such a reduction in access.

Geographic Payment Disparities

The health care systems in our GEM states are among the most cost-efficient in the country in caring for Medicare patients, but are assigned some of the lowest Medicare reimbursement rates. Despite the equal contribution by our states' residents to Medicare, they receive a smaller benefit in Medicare redistributions for their care and rewarded with declining access as providers near their homes cannot afford to treat them. If government is to promise people healthcare, it must also account for the expense.

This payment crisis is the predictable consequence of the neglected inequity of Medicare geographic payment disparity. As we form Medicare formulas for payment, these fundamentally flawed methods known as Geographic Practice Cost Index adjustments must be corrected. In Appendix A, we describe the faulty assumptions and their proper corrections. Current proposals rely on the current payment methodology; but overlook providing a basis for retaining the physician payment system that tolerates inequitable geographic disparities. One proposed amendment addresses this concern by calling for an Institute of Medicine study. This is a positive action, but we urge the Congress to assure that payment reforms addressing existing disparities ultimately have the force of law. These Medicare payment fixes, while crucial, are transitional bridges to the wiser platform of paying for value instead of volume.

Value Index Proposal

President Obama has stated that defining, measuring, and paying for value is essential for controlling cost within the U.S. health care system. We couldn't agree more. What is at issue now is whether our political decision-making in health care shall willfully choose **value instead of volume** for all Americans in all states, not just some states. Americans deserve access to "outcomes" not just "care." We believe inserting a value index into Medicare payment for physician fees and hospital rates is the best way to accomplish this goal. We suggest that such an index can be considered thus:

$$\text{Value} = \frac{\text{Quality (e.g., Outcomes, Safety, Service)}}{\text{Cost over a span of care}}$$

Useful components of this equation include work by The Agency for Healthcare Research and Quality (AHRQ), AMA's Physicians Consortium for Performance Improvement (PCPI), Dartmouth Atlas and aggregated claims databases. Bills have been introduced that seek to legislatively define this concept: Kind, H.R. 2844; Klobuchar, S. 1249

We assert that only a value-based approach will secure the path of improvement at an accessible price for our children and grandchildren. Not addressing this fundamental discipline, we believe, will leave us economically compromised.

Thank you for the opportunity to comment on the reform proposals before the Congress. We again honor your significant efforts on this most important topic. Please call on any of us at any time if you have further questions.

Sincerely,

Appendix A: Primer on GPCI

Medicare¹ Defines 89 GPCI Regions - How is physician payment determined for Medicare?

Three factors comprise the physician payment formula for Medicare. Each factor -- physician work, practice expense and malpractice -- is adjusted for geography, then multiplied by a conversion factor:

$$\begin{aligned} & \text{Work RVU} \times \text{Work GPCI} \\ + & \text{Practice Expense (PE) RVU} \times \text{PE GPCI} \\ + & \text{Malpractice (PLI) RVU} \times \text{PLI GPCI} \\ \hline & = \text{Total RVU} \\ & \times \\ & \text{CY 2009 Conversion Factor of } \$36.0666 \\ \hline & = \text{Medicare Payment} \end{aligned}$$

The faulty elements to these geographic adjustments are obscured in the complex formula overall. Further explanation of each factor may help clarify.

I: Geographic Practice Cost Index adjustments – 3 components

A. Physician Work GPCI - Intended to be the “cost of living” adjuster. This component is based on census data describing earnings of college educated workers. Periodic floor of 1.0 has been legislatedⁱⁱ

B. Practice Expense (PE) GPCI – 3 Components - Intended to measure geographic differences, where they may exist, in the price of medical inputs. Composed of three categories:

	Proportion of 100% PE	Geographically adjusted?
• Rent	28%	Yes
• Wages	43%	Yes
• Other Expenses	29%	No

These categories were given weights of 28%, 43% and 29%, respectively, based on AMA Socioeconomic Monitoring System surveyⁱⁱⁱ of practice expenses for specialty PE differences.

i. Rent:

MGMA survey data^{iv} has consistently shown “rent” to be about 10% of the overall practice expenses. The assigned 28% therefore overestimates the CMS “rent” category by 18% and, for GEM states, improperly adjusts downward too large a proportion of Practice Expense.

CMS has used 2000 HUD apartment rental data as a proxy to adjust PE rents geographically.

Recommendation: Reduce Rent component as indicated by MGMA and PPI survey below to 10%

ii. Wages:

Adjusting wage GPCI by use of four occupations' data for wages in regions of the country does not take into account many other health worker occupations (e.g. information technology), and that many have national markets and comparable salaries across geographies. Wage adjustments by Wage GPCIs are not properly represented by proxy of the 4 occupations.

Recommendation: to assure a more accurate measurement of employee wage costs, data on the following occupational categories should be sampled nationwide:

(a) Ancillary Services - personnel involved in laboratory testing and radiology/diagnostic exams and all related staff supporting these services.

(b) Nurses - includes all licensed LPN's and RN's below a clinician who is a licensed advance practice provider/nurse prescriber.

(c) Management and administrative support - all levels of mgt. plus Info. Systems, Medical Records, Med. Transcribing, Building Services(maintenance, housekeeping, security, etc.) purchasing, business office or patient accounting/reimbursement, Human Resources, Legal Services, Accounting & Finance, Marketing/Communications/Public Relations, secretarial staff, Education, etc.

(d) Paramedical support - medical dept. support staff such as medical assistants, appointing & reception staff, health care technicians/professionals (generally non licensed care givers) that assist with direct patient care not included in categories 1-3.

iii. Other Expenses:

"Other Expenses" category at 29% includes medical supplies and medical equipment for office procedures, drugs, billing and office management services, CME, dues, books, journals, and professional expenses.

Additional expenses for practices include furniture, telephone, office equipment and office supplies, and billing, scheduling, e-prescribing HIT as well as electronic medical record (EMR) expenses. Some of these actual expenses were not anticipated by HHS in 1992 GPCI rule making or legislation.

The Ask: explicitly declare above as not subject to geographic adjustment, unless rural adjustment is made to acknowledge higher costs in rural environments.

- C. Professional Liability Insurance GPCI:** reflects actual premium experience in the last 3 years, with adjustment for mandatory patient compensation funds.

Recommendation: No action at this time

II: Geographic Practice Expense Surveys

As a result of a resolution at the November 2008 (Interim-2008) meeting, the AMA will geographically analyze their latest **PPI survey** that was done to determine current physician practice expenses. With over 5000 responses this survey should be able to determine if there are any differences in practice expenses from geographic region to another such as rural vs. urban/inner city.

Though the AMA has had previous surveys (Socioeconomic Monitoring System surveys were done regularly until 2000) used by CMS to determine practice expenses differences for the various different specialties in medicine, since enactment in 1992. CMS has not subsequently surveyed to substantiate geographic practice expense differentials.

CMS has expressed confidence in the recently completed PPI survey. The CMS proposed rule changes for 2010 show that practice expense RVU values for various specialties have changed dramatically due to this PPI survey. If the survey has reliable and valid practice expense data that is used to change physicians' RVU payment, the survey should be able to determine and compare practice expenses for geographic regions, or rural vs. urban differences. Unfortunately the AMA geographic analysis is not anticipated until later in 2009

III. Technical component fees for diagnostic testing

Though GPCI adjusted differences in physician **professional fees** can be as high as 33% or more, **technical fees** to pay for diagnostic and imaging procedures are geographically adjusted to an even great degree. The GPCI adjustment of the technical component fees does not include a physician work component, so the adjustment therefore is made by using only the practice expense (PE) and malpractice (PLI) GPICs.

The Medicare **technical component fees** for imaging and other diagnostic tests (with no professional work component) after GPCI adjustment results in a difference (San Francisco, California vs. rural Missouri) in payment of around **55-60% higher** than Missouri's technical fees. Since diagnostic imaging and testing equipment and supplies in rural areas are the same price as in California, this huge differential in technical component fees threatens the ability to procure diagnostic imaging and other testing in rural areas.

The major basis for the differential in Medicare payment for both professional fees and technical fees is the practice expense GPCI which ranges from **1.441** (California) to **.821** (rural Missouri). This large GPCI differential therefore **claims that physician practice expenses are 76% higher** in some areas of the country than others. Recent practice physician expense surveys however have shown that practice expenses in rural areas are **higher** than in urban or inner city locations (in large part due to higher patient load and longer work hours). (*Medical Economics*, Dec 7, 2007)

Recommendation: as in I (part B), correct the PE GPICs; also in II (use actual practice expense survey data).

ⁱ Brief History:

1966	Medicare 42 U.S.C., "Customary, prevailing, reasonable, (CPR) charges
1989	RBRVS legislated Omnibus Budget Reconciliation Act of 1989
1991	RBRVS implemented Federal Register, November 25, 1991
1992	GPCI Social Security Act, 42 U.S.C. 1395w-4

ⁱⁱ Work GPCI Floor @ 1.0

1/1/04 to 12/31/06:	The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)
1/1/07 to 12/31/07:	The Tax Relief & Health Care Act of 2006
1/1/08 to 6/30/08:	Medicare, Medicaid and SCHIP Extension Act of 2007
7/1/08 to 12/31/09:	Medicare Improvements for Patients and Providers Act (MIPPA) of 2008

ⁱⁱⁱ *Federal Register*, Vol. 73, No. 224, p. 69901, Table 32, Nov. 19, 2008, CY 2009 Medicare Physician Fee Schedule Final Rule

^{iv} MGMA Cost Survey for Multispecialty Practices: 2007 Report Based on 2006 Data

^v *Medical Economics*, Dec 7, 2007