

Congress of the United States
Washington, DC 20515

May 13, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Mail Stop 314G
Washington, D.C. 20201

RE: 7th GPCI Review

Dear Administrator Tavenner:

This year the Centers for Medicare & Medicaid Services (CMS) will conduct its 7th review of the Geographic Practice Cost Indices (GPCIs) prior to releasing the proposed CY 2014 Medicare physician payment rule this summer. On behalf of our physician and patient constituents, we are contacting you to ascertain the Agency's approach in conducting the 7th GPCI review and request that CMS demonstrate that the process will be transparent and prove that GPCI calculations are supported by timely and accurate data.

Certain experts state that GPCIs were intended to equalize the relative cost of delivering a medical service to all areas of the country. The real differences in regional input prices, i.e., employee wages, occupancy costs, purchased services, and physician labor costs, should all be measured accurately before any adjustments are made. In the absence of credible data and lacking accuracy in GPCI methodology, we feel the best rule would be to **do no harm**. Many payment localities, particularly rural regions, have been punished by arbitrary and inaccurate GPCIs. Congressional floors on the Work and, for two years, the Practice Expense (PE) GPCIs have helped mitigate that harm.

Studies conducted on Medicare's geographic adjusters acknowledge that GPCI measurements are based on data sources *other than* actual physician practice or work costs. Efforts to improve upon those data sources still rely upon proxies, just new ones. Proxies, data imprecision, and lack of transparency continue to plague the GPCIs. The Work GPCI not only is derived from proxy data, it fails to account for physician work factors, such as longer clinic hours, unreimbursed travel time to satellite sites, and frequent call responsibilities.

We would like to emphasize that there are two main areas of faulty methodology that have led to inaccurate measurement of input prices and, therefore, inaccurate adjustments of Medicare payment to physicians. These are: 1) the Work GPCI, which uses an irrelevant proxy, and 2) inaccurate cost share weighting for the PE GPCI, which relates to lack of data on physician office expenses and, primarily, occupancy costs (rent and utilities).

Work GPCI Measurement Inaccuracy

In 2010-2012, the Institute of Medicine's (IOM) Committee on Geographic Adjustment of Medicare Payment studied the GPCIs but did not come up with a final recommendation on methodology for adjusting the physician work component (Work GPCI). The IOM Committee stated that they "emphasized improving accuracy by reflecting market forces faced by all healthcare employers in local markets."

The IOM Committee and MedPAC have both determined that the value of physician work is not the same around the country and that the Work GPCI should continue to adjust for the value of physician labor. Therefore, there should be accurate measurement of the regional input price of physician labor, just as employee market labor costs are measured.

The IOM Committee reviewed the current Work GPCI method of using a proxy of other professional wages in regions and considered this proxy a relativity index of "amenities vs. cost-of-living" in various regions. Committee members explained that physicians would value local amenities and cost of living factors just like other professionals would. But the proxy of other professionals' wages does not take into consideration one of the major factors for input price of physician labor – local market supply and demand for physician labor that has little or no relation to other professionals.

MedPAC, in its October 2012 meeting, reviewed data that showed physician wages were higher for primary care physicians in rural areas, an inverse relationship to Medicare fees that are set higher for urban areas. Data from recruiting companies also reinforces the finding that where there are shortages of physicians, the price of physician labor is higher. One could quickly confirm this supply-demand concept by surveying the cost for an employer, e.g., hospital or medical group, to hire a primary care physician in the suburbs of Chicago vs. rural Iowa. Rural areas generally have an equal or higher input price of physician labor.

The Work GPCI proxy of other professionals has never reflected the reality of the local market prices for physician labor. The PE GPCI uses real market data for employee wage costs, so we would ask that CMS use real market data for input prices for physician labor rather than the proxy of unrelated professions.

Cost Share Weighting Inaccuracy

We believe the basis for the PE GPCI in proportioning the amount of expenses, i.e., cost share weights from the Medicare Economic Index (MEI), has not been accurately determined. The IOM Committee did not address cost share weighting methodology in their Phase One report but, in response to questioning whether the IOM Committee did perform cost share weighting validation, said they "concluded that the evidence supporting regional, as opposed to national, weights was inadequate."

The latest MEI, which is the basis for GPCI adjustments, used a 2007 Physician Practice Information Survey (PPIS) by the American Medical Association (AMA) to determine the proportion of physician expenses for six major categories: physician work, employee wages,

occupancy costs, purchased services, equipment and supplies, and liability costs. However, the major problem with the PPIS is that the survey, like previous practice expense surveys, did not break out the many different office expenses into specific categories.

CMS did disaggregate the many different office expenses in 2010, but a non-transparent process, which included 2002 BEA data, was used to derive new cost share weights of numerous expense categories. We doubt the accuracy of this non-transparent derivation from BEA data. No evidence has ever been presented that office rent and utilities are 10.2% of the cost share weighting, as the MEI and GPCIs claim. In the IOM Phase One report, there was a recommendation to “develop a new source of data on the cost of office rent” since they concluded there is no good data on physician office rents.

Transparency

The IOM Committee recommended “transparency” as a major principle, stating that “the geographic adjustment process should allow empirical review of the data and methods used to make the adjustments.” The IOM did not make their cost share weighting evaluation a transparent process, however, so we have no confidence that the MEI cost share weighting is accurate. The reasons why accurate cost share weighting is so important is that over the last 5-10 years: 1) the total amount of physician expenses has risen dramatically, 2) the proportion of some expenses (rent, for example) has dropped, and 3) other expenses, such as IT, EHR, and medical supplies and equipment that do not vary geographically, have also dramatically risen. We remain interested in the recommendations of the MEI Technical Advisory Panel and continue to await publication of its report.

Timely, Accurate Data

What survey data will be used to determine physician practice expenses in the 2013 7th GPCI update? If GPCI adjustments are based on data from 2007 or earlier, there is great doubt about accuracy – especially when the data is incomplete and lacking many details.

The AMA survey in 1999 showed that total practice expenses were \$77.04/hour, and in the PPIS in 2007, total expenses rose to \$116.96/hour. This 8-year increase is an increase of over 50%, so if we estimate a similar increase of over 6% per year by 2013 (in some categories more than others), cost share weighting is susceptible to major inaccuracies. A survey from six years ago will not be accurate, and BEA data (from 2002 or when?) lacks relevancy in measurement of modern physician practices. A PPIS analysis indicated there was no difference in overall physician practice expenses between regions of the country, or rural vs. urban locations. *Medical Economics* surveys in the past have also shown rural physician practice expenses were actually higher than those in metropolitan areas.

Alternative Sources of Practice Expense Data

So what other data could be used in the 7th GPCI update? We believe the most timely and best survey data would be Medical Group Management Association (MGMA) data, which has historically measured over 50,000 physician practices even though it has been criticized for not

representing all states proportionally. The cost share weighting in the MGMA is, however, very detailed and has little variation with whatever state or urban vs. rural area is measured. Even if the MGMA survey cannot be used in its entirety, it is the only survey with detailed breakdown of the cost share weighting, including rent and utilities, which are around 6-7%, not 10.2% as the MEI claims.

Another source of physician practice expense data with 6,000 different practice locations nationally is the Federally Qualified Community Health Centers. The data may be quite different from an average physician practice, e.g., the practice expenses per physician were \$1.5 million per year, but at least the relative cost share weighting and variations – or lack of variation – in geographic regions could be compared.

Number of GPCI Regions

Since there is a lack of accurate data for regional input prices, we also would ask that fewer regions be adjusted and limited to a maximum amount. Among many reasons the majority of states had voted to become a single region for GPICs has been the concern that regional payment adjustments are arbitrary and subjective and can affect access. Having 441 regions for adjustments would make it even more difficult to make the payments accurately reflect differences.

In conclusion, our constituents and we would like to see CMS:

1. Use actual market data on physician labor prices for the Work GPCI (not a proxy of other professionals' wages);
2. Reduce the PE GPCI impact by one-half if no transparent, accurate cost share weighting methodology is demonstrated;
3. Reduce the number of payment localities to 50-70 while keeping the current 34-statewide localities; and
4. Have the increases and decreases in payment overall be less; reduce the highest-to-lowest ratio payments to 10% less spread each year for the next 4 years until the spread from highest to lowest is only 60% of the current percentage spread.

Thank you for your attention to this matter and feel free to contact us with any questions.

Sincerely,



Bruce Braley



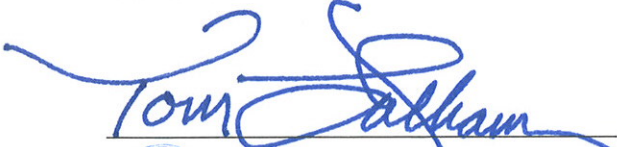
Ron Kind



Tom Petri



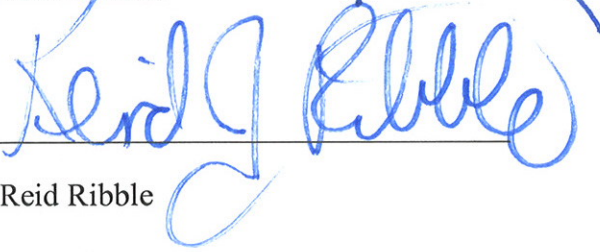
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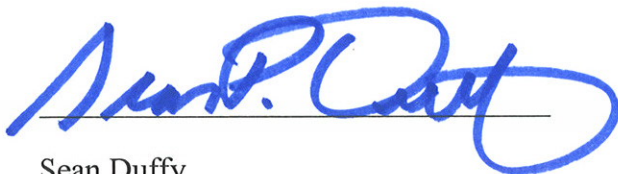
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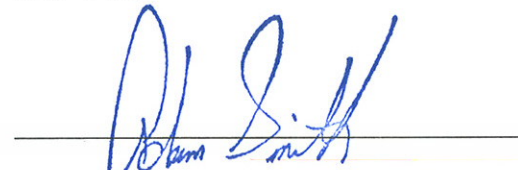
Mike Michaud



Tim Walz



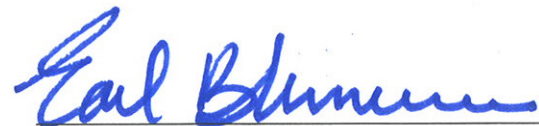
Sean Duffy



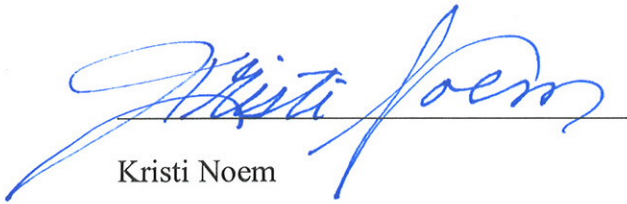
Adam Smith

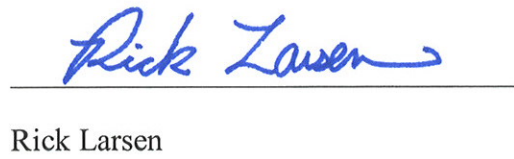


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