Testimony on Geographic Adjustment Factors in Medicare Payment

before

The Institute of Medicine

By
Douglas J. Reding, MD, MPH, FACP
Vice President & Chairperson
of Government Relations
Marshfield Clinic
Marshfield, Wisconsin

On behalf of the
Healthcare Quality Coalition

On behalf of the physicians and staff of the Marshfield Clinic and also on behalf of the Healthcare Quality Coalition I am honored to make the following statement. I would like to raise questions regarding the accuracy of the geographic adjustment factors utilized for allocating Medicare payment across the states. Currently Medicare allocates billions of dollars to health care through distribution formulas that were engineered and tempered by the health care challenges of the 60’s 70’s and 80’s. As a representative of the Healthcare Quality Coalition, we want to question the current empirical validity of the adjustment factors, and the measures used for the adjustment factors, their timeliness and the degree to which such data are representative of present day costs, and the present day operational costs of providers who participate in Medicare.

It is important to note that the developers of the mechanisms of geographic adjustment, some of whom are on this Committee, should be commended for the excellence of their work 30 years ago. What we question is whether we would do it the same way again, at this point in time, knowing what we know now about the evolving state of the practice of medicine. We know that costs in the Medicare program are primarily related to preventable chronic diseases and are concentrated in a very small percentage of the population. We recognize the importance of primary care and care coordinated through the use of unitary electronic medical records, but these expectations and values are at odds with the current reimbursement system and the distribution of payments throughout the country. The skill sets that are now necessary to provide efficient, clinically appropriate care are different from those needed 30 years ago.

If you are happy with the status quo then by all means do not change anything. But if the status quo is no longer an option, then it is time to determine what policy objectives Medicare reimbursement serves.

Initially Medicare payment was very effective in assuring the availability of Medicare services and procedures for a segment of the population that initially lacked access to services. Currently services and procedures are provided in abundance regardless of the risk characteristics of the population in some localities while other areas of the country, particularly the rural areas, still have persistent access problems.

It is important to have a very keen understanding of the cost of providing services to assure an equitable distribution of services nationwide. Currently AHRQ tells us that 20% of the nation’s population resides in rural areas, but they are serviced by only 9% of the nations’ providers. On the other hand providers crowd into areas where payments are relatively higher.

Policy makers are challenged to understand the variations in service volume and expenditures, and the paradox that for some diseases and conditions more care is not associated with higher quality care.
The Healthcare Quality Coalition

The Healthcare Quality Coalition (HQC) represents healthcare providers throughout the nation who are dedicated to the concept of value-based care. This philosophy focuses on healthcare practices that promote measurable, high quality care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. We are united in our view that healthcare reform should address more than just government payment systems and health insurance. Reform should change the way health care entities are financed. Currently, too much money is wasted on unnecessary procedures because payment is driven by the amount of care provided, not the quality of that care. Providers should be reimbursed for keeping patients healthy and coordinating their overall care. An essential part of healthcare reform, and our ability to leverage value, is to correct current regional disparities in Medicare reimbursement. Current unmerited regional disparities in reimbursement stifle overall quality and hinder incentives to promote more efficient care. We believe competition and transparency are healthy. Hospitals and physician groups that provide higher quality care, underscored by national measurement indices, should be provided financial incentives. The outcome saves patients, employers and communities precious healthcare dollars – making our nation’s healthcare more affordable. http://www.qualitycoalition.net/default.aspx

Marshfield Clinic

Marshfield Clinic is a not-for-profit, physician-governed multispecialty group practice serving residents of rural Wisconsin through a regional ambulatory care system, an affiliated health plan, and related foundations supporting health research and education. Marshfield Clinic has engaged its physicians and staff in a program of clinical performance improvement aimed at enhancing patient access, coordination of care, and efficiency of clinical operations. An internally developed electronic health record acts as a care planning tool for delivering preventive care and managing chronic diseases. A telemedicine network expands access to care for patients living in rural and remote areas. Marshfield Clinic’s experience shows how an organized group of physicians can improve patient outcomes and reduce costs by undertaking a population-based approach to ambulatory care management supported by robust information technology. It also suggests that group-level performance incentives that are aligned with an organization’s strategic goals have the potential to enhance population health management. Marshfield Clinic: Health Information Technology Paves the Way for Population Health Management, Doug McCarthy, M.B.A., Kimberly Mueller, M.S., Sarah Klein, The Commonwealth Fund, 2009. http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Aug/1293_McCarthy Marshfield_case_study.pdf

Medicare Payment Dilemma

Current Medicare payment policy values service delivery without regard to quality or need. The Medicare system rewards physicians for providing care even when it is not needed. Patients, Medicare, and other third party payers are not getting what they want, but they are getting what they pay for. (Large volumes of discretionary services in high payment localities.)

Medicare physician payment policy is based upon questionable and inconsistent assumptions about the relative costs of providing services.


**Medicare Payment Inequities**

The Update formula for physician services is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume influencing behavior. **If the problem of cost is related to the volume of services provided, shouldn’t payment be volume adjusted for specific localities?** Why should conservative practices and States be punished for the excessive volume of other localities?

**Medicare Payment Adequacy**

Without adjustments for payments associated with its participation in the CMS-sponsored Physician Group Practice Demonstration, Marshfield Clinic would have recovered only 51.6% of its 2009 Medicare allowable costs for serving Medicare patients. This recovery level is similar to that reported by others in Wisconsin and the Midwest. **For instance the Dean Health Care System in Madison, Wisconsin reports that it recovers only 56.7% of its Medicare allowable costs from Medicare Part B reimbursement, and the Park Nicollet System in St. Louis Park, Minnesota recovers only 63.8% of its Medicare allowable costs.**

Cost recovery rates as low as these that are evident across a wide range of physician groups are indicative of broader systemic issues that deserve close review. Nonetheless, it seems increasingly clear that there is a problem with perhaps unjustifiably low Medicare physician payments in Wisconsin and the Midwest. To the best of our knowledge, there are no recent studies of physician practice margins and how these margins vary by geographic area and Medicare payments. Results from Medicare beneficiary surveys of physician access are used as indirect indicators of physician payment margin adequacy. Because of their design, these survey results are applicable only to broad geographic areas and are not highly sensitive to rural access problems, and therefore, by extension, to payment adequacy in those same areas.

By contrast, the Medicare Payment Advisory Commission (MEDPAC) routinely makes assessments of Medicare payment adequacy for hospitals using standardized, regularly collected and audited hospital cost data. MEDPAC assesses the adequacy of Medicare payments for the hospital as a whole, and the primary indicator of the relationship between payments and costs is the overall Medicare margin. The reasons underlying the fundamentally different approaches to assessing payment adequacy for hospitals and physicians are unclear. But if they relate in a systematic way to differences in the organizational structures of hospitals and physician practices, and particularly to views of hospitals as businesses and physician practices as mainly sole proprietorships or small group practices, then they are not supportable in today’s environment where an increasing number of physicians are employees. Report to the Congress: Medicare Payment Policy (March 2010) [http://www.medpac.gov/documents/Mar10_EntireReport.pdf](http://www.medpac.gov/documents/Mar10_EntireReport.pdf)

**Geographic Adjustment of Practice Expense**

Medicare’s physician fee schedule, which specifies the amount that Medicare will pay for each physician service, includes adjustments that are ostensibly made to ensure that the fees paid reflect systematic and enduring variation in geographic practice-related costs. Currently, **this geographic practice expense adjustment has weight of 43% in physician payments, making it a critical component of the physician fee schedule.** To place this in perspective, the Congressional Research Service has reported that Medicare paid physicians $59.5 billion in 2007, implying that about $25.6 billion in payments were potentially affected by practice expense adjustments. **The sheer magnitude of these potential affects is strong reason to develop and maintain finely tuned data for use in geographic adjustment of payments.** In addition, there are also important issues of equity and basic fairness to providers and Medicare beneficiaries that must be considered and that reinforce the need for
consistent, high quality data for geographic adjustment purposes. Based on our own experiences, there are strong reasons to believe that the current geographic practice expense adjustments are less reliable and less valid than they should be and could be.

Our experience suggests that the relative shares of practice expense components (i.e., office rent, wages, supplies and equipment, and malpractice expense) are misaligned and that a proper weighting of these shares would greatly reduce inequities in the portion of Medicare payments affected by geographic practice expense adjustments. We note that the MMA Section 605 report also included discussion about the cost component weights and that estimates of the share of costs attributable to rent/occupancy was reported to range from about 11% to about 28%, depending on the data source. In that same report, there was also indication that the current wage component weight was lower than it should be, perhaps reflecting the trend toward higher relative use of staff personnel to support physician efforts in modern medical practices. [http://www.cms.gov/reports/downloads/RTC-Leavitt.pdf](http://www.cms.gov/reports/downloads/RTC-Leavitt.pdf)

It is extremely important to have accurate and reliable cost shares since these are main drivers in geographic adjustments in physician payments. Because office rent costs exhibit the highest variability among practice expense cost categories, an inappropriately high weighting factor for these costs, which is currently about 28% in the practice expense GCPI, by itself would distort any geographic-based cost adjustment even without consideration of whether the rent proxy itself is a valid and reliable indicator of these costs. But there are many reasons to conclude that the rent proxy used in the current payment adjustment is neither valid nor reliable. At least partly because the current proxy lacks face validity, it has been a long standing point of contention among groups seeking Medicare payment equity.

If Medicare was developing a physician payment system today, it would likely not look like the one that was implemented on January 1, 1992. That system was based more on a solo practitioner model of medicine, and less on an integrated model of care. It was service-based and not outcome-based. It was not quality oriented or quality adjusted. It reflected old medical service production processes and not new processes, which rely on more and different complements to physician inputs, including non-physician labor inputs and supplies, equipment and technical service inputs. Technical service inputs include electronic medical record systems, decision support software, related hardware, and some measure of technical personnel support for these systems and processes.

The PE GPCI is composed of non-physician wages, office space costs, equipment and supplies cost, and malpractice insurance costs. The largest component of the PE GPCI is non-physician employee wages, which accounts for slightly more than 40 percent of the practice expense GCPI. CMS uses US Census wage data on the median hourly earnings of only four occupational classes to compute local wage effects on payments: clerical workers, registered nurses, licensed practical nurses, and medical technicians. These proxies do not include high wage technical support positions such as programmers, compliance and privacy attorneys and insurance benefit specialists that account for nearly 50% of our employee wage input costs. We ask: What recent empirical studies have been done to determine if these proxies are valid indicators of relative geographic costs of practice?

Studies conducted by multi-specialty group practices in Iowa, Montana and Wisconsin and confirmed by the membership of the HealthCare Quality Coalition have questioned the validity of data used in the non-physician wage component of the PE GPCI.

One analysis conducted at Marshfield Clinic found that median current occupational wages for health care employees in Wisconsin were consistently higher than national median wages for the same occupational category. These findings gain potential importance when they are considered in the context of the PE GPCI for Wisconsin, which has a value of 0.921 for 2009.

While differences would be expected in wage estimates from private and government sources, differences as large as those suggested by these data raise questions about the validity of the data used currently to estimate PE GPCIs and the potential distributional effects associated with using alternative wage data sources in the PE GPCI.
CMS uses the median hourly earnings of four occupational classes -- Clerical Workers, Registered Nurses, Licensed Practical Nurses, and Medical Technicians -- found in physician offices as proxy non-physician wage input cost measures. Because these proxy occupational classes are only a subset of non-physician employees at Marshfield Clinic, we mapped the Bureau of Labor Statistics occupational codes for the proxy occupational classes to the subset of our non-physician employment classifications that align closely with the principles used to determine Medicare allowable costs. Our purpose was to determine the proportion of these otherwise allowable labor costs that were not reflected by the proxy occupational classes and trends in these proportions over time within our practice. The results of our evaluations for fiscal years 2004 and 2009 are summarized in the following table. Our data indicate clearly that the proportion of non-physicians employees in the proxy classes has declined both in absolute numbers and as a proportion of total non-physician employment, with the latter decreasing by 19% (from 65.2% to 52.8%). The share of the non-physician wage bill represented by proxy employee classes also decreased from 51.5% to 43.5%, despite a higher growth rate in average wages among proxy class employees compared to other employees. The changes in employment and wage bill shares among proxy and non-proxy employment classes reflect two realities. The first is the changing medical practice environment at Marshfield Clinic during this period. The second is the continuing decline in the apparent relevance of the proxy occupational classes as a reasonable basis for making non-physician labor-related practice expense adjustments to payments.

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<th>Labor Group</th>
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<th>2009</th>
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<td># Employees</td>
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**The Physician Work GPCI**

The physician work GPCI was designed to capture the relative cost of physician labor by Medicare fee locality: it currently reflects 1/4 of expected relative costs. In order to avoid having Medicare payments directly affect physician work adjustment, the physician work GPCI uses proxy earnings of professionals in: architecture and engineering; computer, mathematical and natural sciences; social scientists, social workers and lawyers; education, training and library; registered nurses and pharmacists; and writers, editors and artists. These earnings are drawn from the BLS Occupational Employment Statistics program (OES). The comparison occupational groups are selected to represent highly educated, professional employee categories, whose wages would be expected to reflect the overall geographic differences in living costs and amenities for other professional workers.

We believe that the physician work GPCI is less relevant today because more physicians are employed and there are high quality salary survey data available to directly measure physician labor costs. The reality is that increasingly larger numbers of physicians and other health care providers are functioning as employees rather than as owners or sole proprietors in their practices. As a result, increasingly their compensation is determined by the local supply and demand for their services and their employers’ assessment of their value to the overall practice rather than by the local cost of living.

CMS defines physician work as the amount of time, skill, and intensity a physician puts into a patient visit. There is no difference in the work of physicians in different locations regardless of where the work occurs. We believe that physician work should not be adjusted for geographic location.
However, if work adjustments are deemed appropriate then they should reflect the value that third parties (i.e., physician employers) place on the physicians they hire. The market for physician services is the most appropriate arbiter of physician work value, not proxies associated with other professionals who may either be in excess supply or demand relative to physicians. There is certainly less justification for using proxy measures to adjust physician work for geographic cost when there is increasing anecdotal evidence that these adjustments are often in the wrong direction when compared to market wage data from third party sources such as MGMA, McGladrey and others. What is the rational for paying physicians more in many geographic areas when those same areas have apparently ample numbers of physicians and their wages are trending below physician wages in other areas? We believe there are adequate data available from independent third parties to adjust physician work for payment area supply and demand conditions and that such adjustments are highly preferred to those currently in use.

Forward Looking Payment System

“Our fragmented health care delivery system delivers poor-quality, high-cost care. We cannot achieve a higher-performing health system without reorganization at the practice, community, state, and national levels. ..We can no longer afford, nor should we tolerate, the outcomes of our fragmented health care system. We need to move away from a cottage industry in which providers have no relationship with, or accountability to, one another.”


http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx

The current Medicare payment system is not a forward looking system. It reflects our past medical practices more that it reflects our future medical practices. However, since it is likely that the current system will be in place for the foreseeable future, there are strong reasons to correct its many deficiencies. We fully support those efforts.

In the longer term we believe that it will be important to develop alternative payment systems that properly reflect the emerging realities of delivering health care in the US. Some of the emerging ideas in this regard, including the concepts for Accountable Care Organizations and Medical Home as examples, would seem to require fundamentally different payment arrangements and therefore fundamentally different data collection systems to ensure equity in payments for Medicare services and yet maintain some control over global Medicare expenditures. In our view, it is not too early to begin the process of identifying payment options and the data systems that are available and/or needed to support such options.