The Impact of the Medicare Inequity on Iowa Health Care

Introduction
Senator Grassley, thank you for allowing me the opportunity to bring the perspective of Iowa physicians on a critically important area of public policy to the nearly 500,000 Medicare beneficiaries in Iowa. With my comments today, I am representing over 4,000 members of the Iowa Medical Society, as well as the patients who we provide care for 24 hours every day, seven days each week, all year.

Iowa citizens are victims of inequities in the Medicare fee schedule. Despite historically receiving the lowest reimbursement per enrollee per year, Iowa health care providers have been able to keep our quality of care very high (currently sixth in the latest CMS ratings). Our increasing practice expense and professional liability costs make it necessary for us to have increased funding to avoid cuts that could jeopardize care to our patients. It is imperative that federal legislators move quickly to eliminate these disparities.

Overview
A recent national survey found that 42% of physicians said they would consider dropping out of Medicare participation if further cuts were made in physician fees. The reasons for physician discontent are many. Increasing paperwork, regulations and compliance issues which add time and cost, such as HIPAA, have not been reimbursed. The costs of technology and equipment have risen without adequate reimbursement. The nationwide shortage of nurses, techs, and other health care workers has added to the difficulty in practicing today. Professional liability insurance has skyrocketed all across the country, with more threat of litigation that makes a complex task even more challenging. The threat of bioterror and other disaster preparedness have added many costs to the system as well.

The nationwide cut of Medicare physician fees by 5.4% in 2002 added to physicians' concerns. According to the AMA, Medicare physician payments have been cut four times since 1991, and the payments have only increased 1.7% per year since then. As of 2001, Medicare physician payments had dropped 13% behind inflation. The 2003 Medicare fee schedule was going to be cut again by 4.4%. By Congressional action recently, the fees were instead increased by 1.6%, but physician fees are not keeping up with inflation in our costs.

The reason for the nationwide cuts in 2002 and 2003 is the conversion factor adjustment, a nationwide adjustment that is computed yearly and is based on the sustainable growth rate (SGR). The SGR was designed to limit the growth of physician payments, to avoid over-utilization or "excess productivity." There has been controversy about errors in the calculation of the SGR, and it has been called a "flawed formula." There have been a number of methodological problems such as using the gross domestic product (GDP) growth, changes in fee-for-service enrollment, and use of increasing chemotherapy drug charges as "physician fee" charges. Because of the perception of increased utilization, the SGR computation has triggered the decreases in the conversion factor and these nationwide cuts in Medicare fees. This flawed formula, unless it is changed, will cut fees even more in the future, until it is forecast that Medicare fees will be lower than they were in 1991!

It is a sad irony that, because of utilization patterns in more highly-reimbursed states, beneficiaries in the lower-reimbursed states will have their access to care impeded.

Practice pressures, increased costs, and these across-the-board payment cuts affect all physicians. But those of us in Iowa and other rural areas feel as though we have a double Medicare penalty – from the SGR and secondly from geographical adjustments because of where we live.

The Iowa Experience
Physicians in Iowa and other rural areas have for many years suffered from low Medicare reimbursement, and we have become increasingly frustrated because of cuts in physician Medicare fees which make it even

more difficult to deliver good care to our patients. It has affected McFarland Clinic, a multi-specialty group of physicians, where I work as a neurologist. Our clinic serves about 300,000 current patients, with 880,000 patient visits last year. Thirty-two percent of our patients are enrolled in Medicare. Over the last two years we have downsized, from 192 physicians to 154. We also had offices in 34 different sites in central Iowa, but we are now covering just 23 offices. Recruitment in Iowa is very difficult because of the low Medicare reimbursement. We are currently recruiting 16 different physician positions, including some specialty searches we have not filled in the last 4-5 years. Though we could have a lengthy discussion about the reasons for the downsizing, suffice it to say that the Medicare disparity played a significant role.

Obviously, with such difficulty recruiting and retaining physicians, the ability to serve our patients' needs becomes quite difficult. Timely access is a major problem. Patients either have to endure long waits or they have to leave their communities to find the primary or specialty physician they need.

Our physicians also feel the burden of an increased workload because of the pressure to see more and more Medicare patients. Iowa currently ranks 49th in the nation in practicing physicians per 100,000 population (Oklahoma is 50th). With our very high percentage of Medicare population in Iowa, this must mean we have the most Medicare patients per physician in the country. In fact, statistically, each practicing Iowa physician is caring for the needs of 622 patients. In contrast, each practicing Massachusetts physician cares for the needs of 280 patients. Believe me, the added burden matters when a community needs a gastroenterologist, an orthopedist, a neurologist, or a family physician.

Iowa has the lowest Medicare reimbursement per enrollee per year at $3,414, with the total state Medicare payment of about $1.6 billion. Though it is true that much of that imbalance is a function of consumption, it appears that Iowans simply do not go to the doctor as much as patients in some other states. But, on a per service basis, Iowa physicians are reimbursed considerably less than if that service had been provided in many other areas of the country. Patients in Iowa suffer from unfair geographic adjustments called geographic practice cost indices (GPCIs).

In 1989, a national Medicare fee schedule for physicians was derived by the Physician Payment Review Commission to slow growth of spending and remove some wide discrepancies in payments to primary care physicians and specialists and to providers who practiced in different geographical areas (ref 1). The payments for physicians since 1989 have been based on resources needed to provide services, known as a resource-based, relative value scale (RBRVS). The fee schedule was derived by using what is called relative value units (RVUs) and for each procedure, whether it is surgery, an office visit, consult, etc., there is a value in RVUs that is adjusted by the nationwide conversion factor and geographical factors (GPCIs). There are now 89 payment localities nationwide, each with different GPCIs affecting the physician fee, and Iowa physicians rank near the lowest fees in the country (80th out of 89).

The relative value units (RVUs) have three components. The first is work effort – the time, mental effort, physical effort, and training required to provide the service. The second is the practice expense, including rent, utilities, equipment, supplies, and staff salaries. The third is cost of professional liability insurance. On the average, these RVU components account for 55%, 42%, and 3%, respectively, of the average physician fee. These three components are each adjusted by the GPCIs to come up with the fee for a particular service code.

I will use an example to illustrate the inequity. The most commonly used procedure code is 99213, a recheck office visit fee; reimbursement varies from $64.09 in San Francisco, $63.10 in New York City, and rural Missouri at $45.13 (Iowa's is $46.53). The overall difference is 30%, though other codes have even greater differences. The reason for the variation is each of the three RVU components is adjusted by a geographic factor, a GPCI. This adjustment of the components varies by locality. For example, the work component adjustment is increased by a factor of 1.094 for New York and decreased by .959 in Iowa – a difference of about 14%. So what is the difference in a physician's work effort in New York vs. Iowa? In Iowa, we physicians have the same training, time, and effort applied for our patient care. Do we adjust our military salaries for the region where they live, or the salaries for our members of Congress?

Apparently the justification for the difference in the payment for the work RVU component is to reflect a portion of cost-of-living differences. The work GPCI is based on the 1990 census results of variation in earnings between college-educated workers. The reasoning behind this adjustment in the work effort for cost-of-living is not clear to me. The impact, however, is very clear: we cannot recruit physicians because they are going to more highly-reimbursed locations. Data supports that conclusion, and that impacts the care that Medicare patients in Iowa receive.

Another unique problem in Iowa is call coverage for both primary and specialty care. We currently have two otolaryngologists and are recruiting a third. The candidate has a choice of joining our clinic where the call would be every third night and every third weekend. If the candidate chose an area with a greater population of physicians, the call might be every eighth or tenth night. We are currently recruiting a second pulmonologist, and will we find someone who wants to take every other night and weekend call? This is a significant barrier for recruiting to Iowa, as the increased work and personal cost is greater because of the greater call burden to serve our patients.

The GPCI adjustments for practice expense and professional liability are also suspect, as the data used for practice expense does not always represent the true costs. For example, in rural areas many physicians have to travel many miles on outreach to serve their patients. McFarland Clinic providers (44 physicians, nurse practitioners, and physician assistants) made 3,581 trips to other communities to do outreach in 2002, and the total miles driven were 265,912. The cost for rent of these outreach facilities was $73,000 and the mileage at $.345 per mile was $91,000 last year. The real cost, however, is the time it takes to travel: about 60 minutes for each 50 miles, or 5,318 hours, or about 120 hours per provider that is not reimbursed.

A true practice expense adjuster would accommodate that very real cost. So while I must agree that office space in Brooklyn, New York is more expensive than office space in Brooklyn, Iowa, there are factors that make it more expensive to provide care in a state that is populated with small towns and rural areas. The formula ignores those factors.

Our costs for equipment, supplies, and staff are not necessarily lower in rural areas as these are affected by national markets. The GPCI determination for practice expense also includes a survey of apartment rental costs. Apartment rental costs are not the same as medical building rental costs, which have more detailed specifications and, therefore, higher relative costs in rural areas.

Of the three GPCIs, the one that can be calculated with the most validity is the professional liability GPCI. But even this GPCI is flawed in its implementation. The liability GPCI calculation being used today is based on data from 1996 through 1998. As you well know, the liability situation in our society is exceedingly fluid. Our McFarland Clinic liability insurance went up over 60% last year and over 30% this year, and ours is not an uncommon experience.

Though GPCIs might be a good idea in theory, and they might be an interesting intellectual exercise, they are severely flawed in their implementation, and the disparities they instill are harmful to millions of Medicare beneficiaries throughout the nation.

Utilization

Decisions on utilization are primarily made by physicians. Choices of which or how many tests, surgery vs. conservative care, admission vs. outpatient treatment, expensive vs. cheaper drugs, intensive care unit admission, specialty consultation, and length of stay all affect the total costs for health care. It has been estimated that 80% of health care costs are controlled by physician decisions. Many physicians feel pressured by patients who demand more tests, drugs, or procedures, and there is threat of litigation to do more.

Fisher et al (ref 2), after extensive research of regional variations in Medicare spending, concluded that there is no evidence that Medicare enrollees in high-spending regions had higher quality of care. The methods used in this study eliminated the question of "regional differences in illness levels (enrollees in Louisiana are

sicker than those in Colorado) and price (Medicare pays more for the same service in New York than in Iowa).” This research used the “End-of-life Expenditure Index,” which showed that the Medicare spending is “due to physician practice rather than regional differences in illness or price.” In this study they found there were 60% higher costs in some regions of the country without any differences in quality compared to areas where lower costs were noted. One could conclude that this 60% is wasted on ineffective care.

Another study (ref 3) concluded also that Medicare “expenditures are strongly related to the volume of services provided,” not the per unit reimbursements. If every state had the same fee schedule, practice efficiency, and utilization per enrollee as Iowa, at 57% of the average state reimbursement, the $235 billion total costs of the nationwide Medicare program could theoretically be cut by about $100 billion.

In Iowa we were rated (ref 4) as sixth best in health care quality by the latest CMS (Centers for Medicare and Medicaid Services) study. The state with the highest per enrollee reimbursement (at $8,099) is Louisiana, which ranked last in quality. Obviously, the residents of Iowa receive tremendous value for their tax dollars, but our infrastructure is on the brink of disaster if we continue to lose health professionals.

Mr. Chairman, I will bring my comments to a close by mentioning the formation of the Geographic Equity in Medicare (GEM) Coalition. The Iowa Medical Society played a leadership role in forming the GEM Coalition last June. Today, the coalition consists of 23 state medical societies and the American Academy of Family Physicians. Nearly nine million Medicare beneficiaries are being cared for in GEM Coalition states. I will close by reading from the GEM Coalition position statement:

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.

GEM is formed to remedy this alarming inequity. The member organizations believe that federal policy-makers must assign a high priority to eliminating Geographic Practice Cost Indices and other components of the Medicare Part B program that result in this inappropriate and inequitable reimbursement to the tens of thousands of physicians across this country providing medical care to millions of Medicare beneficiaries. The critical nature of this problem compels immediate attention and action.

Thank you.

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