Statement of the Association of American Medical Colleges (AAMC) on the Institute of Medicine’s Consensus Study on Geographic Adjustment Factors in Medicare Payment

The Association of American Medical Colleges (AAMC) welcomes this opportunity to submit comments on the Institute of Medicine’s (IOM’s) study to look at the geographic adjustment factors used in the Medicare payment system. The AAMC represents all 133 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. Because they deliver approximately one-fifth of all clinical care and serve significant numbers of Medicare patients, accurate Medicare payments are critical to our teaching hospitals and faculty physicians.

This IOM study is the first of two IOM studies regarding geographic adjustments. The second study will focus on the effects of geographic factors on workforce, quality of care, population health and access. While the two studies are related, the AAMC would like to emphasize that the first study focuses on the accuracy of payment methodology, particularly geographic cost adjustments, and encourages the study committee to defer other policy issues related to geographic adjustment to the second study.

Because the Medicare payment systems are national in nature, it is important that adjustment factors recognize differences in input prices that are beyond the control of providers. A key adjustment relates to differences in input prices and resource use due to geographic location. In the hospital inpatient prospective payment system (IPPS), this adjustment is known as the hospital wage index (WI); in the physician fee schedule, the adjustment is reflected by the geographic practice cost indices (GPCIs). These adjustments help ensure that hospitals and physicians receive reasonable payments for services and that the Medicare program does not overpay in certain areas and underpay in others as a result of geography.

We would like to note at the outset, however, that Medicare geographic adjustment policies will not address the problems of the growing physician shortage, nor are they likely to significantly alter the geographic distribution of physicians. As the United States Government Accountability Office (GAO) concluded in its March 2005 report entitled “Medicare Physician Fees: Geographic Adjustment Indices are Valid in Design, but Data and Methods Need Refined,” geographic adjustments to physician payment have a negligible effect on physicians’ decisions to practice in rural areas. This finding is consistent with the findings of the AAMC’s Center for Workforce Studies. Factors such as a spouse’s employment opportunities, the quality of local schools, and the availability of other physicians to consult with all motivate physicians’ decisions regarding where to practice. The physician shortage issue is extremely critical to the health of the nation’s population and must be addressed quickly. Because of the complexity of the issue, however, we believe it should be addressed separately and not as part of these IOM studies.

The AAMC recognizes the importance of the IOM’s impending work on geographic adjustment factors to ensuring accurate Medicare payment adjusters and supports the IOM’s efforts to examine these issues. The federal government has a long history of recognizing the cost differences between geographic regions and

1 The AAMC’s Center for Workforce Studies projects a national shortage of 124,000 – 159,000 physicians by 2025, a shortfall that will only be exacerbated by an increased demand for services as more individuals are insured under the health reform law; many states and physician specialties already are experiencing shortages.
adjusting policies accordingly. The Office of Personnel Management pays civil servants differently based upon where they work and live. Similarly, the Department of Defense pays uniformed services members “Basic Allowance for Housing” (BAH) which varies almost three-fold between locations. The rationale is also used in calculating FHA housing limits which similarly vary across the country. Accurate, data-driven geographic adjustments to Medicare payments must also reflect the differences in input prices faced by health care providers.

MEDICARE’S HOSPITAL WAGE INDEX

The Medicare statute requires that per-discharge payments to hospitals in the IPPS reflect geographic differences in labor costs. A portion of the IPPS standardized payment amount—referred to as the “labor-related share” — is adjusted by the wage index for the geographic area where the hospital is located. The labor-related share is computed by the Centers for Medicare and Medicaid Services (CMS) and may fluctuate from year to year. The labor-related share is currently set at 68.8 percent for hospitals with wage indices greater than 1.0. For hospitals with wage indices less than 1.0, the labor-related share is set at 62 percent. This lower labor share benefits hospitals with lower wage indices because less of the standardized amount is reduced by the wage index.

Issues Regarding the Hospital Wage Index

The hospital wage index is a critical component of the Medicare payment system, especially for major teaching hospitals in large urban and inner-city areas that tend to have high labor costs. The wage index helps ensure that these hospitals receive the appropriate level of payments, so they can continue to deliver high-quality care to Medicare beneficiaries. We believe that several issues regarding the calculation of the hospital wage index merit specific attention by the IOM Committee.

First, the AAMC is concerned about the so-called “cliff”, a problem driven by large differences between the wage indexes of adjoining market areas. This problem has driven many hospitals to seek reclassification from a rural area to an urban area and from one urban area to another urban area, to benefit from a higher wage index. In its June 2007 “Report to the Congress,” the Medicare Payment Advisory Commission (MedPAC) proposed a method of “smoothing” these cliffs in a manner that would reduce differences between adjoining market areas. The AAMC believes that some type of “smoothing” methodology could help to reduce (though not eliminate) the need for geographic reclassifications and could ensure a more equitable wage index system.

Second, the AAMC believes that the best data CMS can use to calculate the wage index are those reported by hospitals on the Medicare hospital cost report. MedPAC suggests an approach that would use wage data from the Bureau of Labor Statistics (BLS) and from the Census instead of self-reported Medicare cost report data. (Under the MedPAC approach, only benefits data would continue to be derived from hospital cost reports.) The AAMC is concerned that the BLS data is incomplete — for example, Part A physician time unrelated to medical education, overtime pay, shift differentials, and jury duty pay is excluded from the BLS data, yet included in the current CMS data. The timeliness of Census data also renders it problematic. Because the most recent Census data available is from the 2000 Census, estimates of wage differences between counties, based on data that are ten years old, may not accurately reflect current wage differences. Although 2010 Census data will be available in the near future, calculating the wage index using this data would only improve accuracy temporarily, and the data will continuously “grow out” over the course of each decade.

http://www.opm.gov/oca/10tables/indexGS.asp

http://www.defensetravel.dod.mil/perdiem/bah.html Example: an 0-5 with dependents in San Francisco, CA receives $3729 per month; the same officer would receive $1440 a month in La Crosse, WI.
PHYSICIAN FEE SCHEDULE GEOGRAPHIC ADJUSTMENTS

When the Medicare physician fee schedule was implemented in 1992, Medicare was required to develop three independent GPCIs to adjust payments to physicians for their services. Practice expense (PE) and professional liability insurance (PLI) GPCIs reflect the full variance between payment areas; but only a quarter of physician work is adjusted. As the committee convenes to review how these adjustments are calculated, they should consider several key questions:

- What are the true cost inputs for each GPCI?
- Which cost inputs vary regionally, and therefore should be adjusted, and which do not?
- What data sources should be used to estimate those costs and how accurate are those sources?
- Do payment localities accurately reflect costs for a region?

Because GPCIs are budget neutral, the slightest change in any of these factors can have a large impact on specific regions.

In addition to the GAO and Medicare, several well respected organizations have reviewed the physician geographic adjustment logic, including MedPAC, and several contractors including Acumen (under contract to CMS) and the Urban Institute (under contract to MedPAC). The AAMC encourages the committee to review this large body of work to help inform their discussion. In particular, the committee should consider these findings:

- GAO found that GPCIs “are valid in their fundamental design as tools to account for geographic cost differences” — although the report acknowledged that the data sources can be improved.
- GAO also noted that the evolution of GPCIs “have further limited the extent of geographic adjustment and have tended to raise fees in rural areas above what they would have been without the changes.” In particular, the quarter work adjustment and establishment of a work floor have limited the negative adjustment to rural areas.
- MedPAC and Acumen studies suggest that current localities have a mix of urban and rural areas. Separating these regions would increase the number of localities and increase payments to urban areas while decreasing payments to rural areas.

Determining Physician Costs

CMS uses the Medicare Economic Index (MEI) to determine what constitutes physician costs and the percentage attributable to physician work, practice expense or PLI. The MEI is an integral part of physician payments and provides the framework for the geographic adjustment. In the 2011 Medicare physician fee schedule proposed rule, CMS proposed to revise and rebase the MEI, which affects the geographic adjustment calculation. The AAMC strongly supports a process to ensure that the MEI accurately reflects the costs of providing physician

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5 *Ibid.* p. 10

6 “Medicare Program; Payment Policies under the Physician Fee Schedule”, 75 Federal Register, p.40087

services. In our August 24, 2010 comment letter, the Association supported a proposal by CMS to convene a technical advisory panel to review all aspects of the MEI. The AAMC suggested that the MEI should not be modified until such a panel completes its review, and recommendations should be considered in a future rulemaking. Similarly, as the IOM committee reviews the accuracy of the geographic adjustment, we ask you to consider the influence of the MEI structure and the recommendations of the CMS MEI technical advisory panel.

**Payment localities**

The GPCIs are applied to geographic localities. In 1992, there were 240 localities. This number dropped to 210 by 1995. In 1997, CMS further reduced the localities to 89. In general, as the localities have been consolidated, rural payments have increased and urban payments have decreased. MedPAC and Acumen studies have analyzed new methods to determine payment localities. All of the proposed methods would increase the number of localities and separate urban areas from rural areas resulting in more accurate payments. The AAMC supports revising localities and believes, that as with hospital wage index, the payment localities should reflect the costs of the area.

**Work GPCI**

When GPCIs were developed, there was discussion as to whether the full cost of wage differences for professional work should be adjusted. After much consideration, the final law stipulated that only a quarter of the physician work be adjusted. By limiting the impact of the work RVU adjustment, more expensive (generally urban) areas receive payments that do not fully reflect their higher costs of living.

In addition, Congress has set “floors” for the physician work GPCI instead of relying on data that demonstrates professional wages in some areas of the country are less than the national average. Specifically, the Medicare Modernization Act of 2003 established a GPCI work floor of 1.0, and Congress has since extended it through the end of 2010. The Medicare Improvements for Patients and Providers Act of 2008 also established a permanent 1.5 work floor for Alaska.

The AAMC has supported these floors because they have not been budget neutral; i.e., the geographic adjustments for higher cost of living (e.g., urban) areas were not reduced to offset the cost of raising the lower work GPCIs to the “floor” amount. The AAMC is concerned, however, that many academic medical centers are located in urban areas and not receiving a full adjustment for the cost of living in such communities. Such a result does not seem equitable. We believe that the full differences in costs should be reflected in the GPCIs. In addition, any payments to preserve payments in low-cost areas should not come at the expense of urban areas.

**Practice Expense GPCI**

Practice expenses are composed of employee labor, office expenses, and medical and other supplies; however, only the labor and rent portions of the practice expense are geographically adjusted. Using the assumption that the other expenses are paid on a national market, CMS does not apply a geographic adjustment to those expenses.

The Affordable Care Act (ACA) required CMS, for 2010 and 2011, to blend local and national rates for practice expense labor and rent. This will raise rates for low-cost rent localities. A hold harmless provision was included to ensure that high cost areas would not see rates decrease due to this blending. The ACA also established a 1.0 GPCI practice expense floor for frontier states. Finally, the ACA required CMS to review the practice expense GPCI methodology and incorporate any changes to the GPCI methodology by 2012.

CMS proposed GPCI methodology adjustments in the 2011 physician fee schedule proposed rule. Many of the changes stemmed from the update to the MEI, which decreased the rent adjustment. The decrease in the percent of
practice expense adjusted means that high cost localities, such as Boston, San Francisco, Manhattan and New Orleans, would have lower practice expense GPCIs, despite being located in areas with extraordinarily expensive commercial rents. This outcome seems counter to the ACA “hold harmless” provision.

The AAMC believes that a thorough review of the MEI is required in order to determine true practice expense costs. The AAMC also believes that the committee should evaluate which of these costs do, in fact, vary across localities and which are standard across the nation. For example, non-physician employee labor and rent are adjusted, but other professional services such as billing clerks, accountants or lawyers are not. The Census data on professional incomes, used in determining the work GPCI, demonstrates that the costs of such professional services vary widely by geographic location; this inconsistency should be addressed by the committee.

Both MedPAC and GAO have reported on the PE methodology. The GAO stated the basic design of the GPCIs is valid, but that CMS should consider improving its data sources for wages and rents. MedPAC commented that the current design does not consider variations in the proportion of equipment and supplies related to type of service. MedPAC proposed an alternative methodology that excludes equipment and supplies. The AAMC encourages the committee to consider these proposals.

Finally, the AAMC appreciates concerns related to HUD rental data as a proxy for commercial rents. The AAMC agrees that commercial rent data is preferred, if such data is available and reliable. Until such time, CMS should use the best data source available to determine rent.

**CONCLUSION**

As multiple studies have demonstrated, the basic approach to geographic cost adjustment used by the Medicare system is valid but the data sources could be improved. As the committee examines this issue, we believe that alternate data sources or improvements to data collection should be proposed. However, imperfections in current data sources should not be used as a rationale to stop cost adjusting or to create artificial proxies not supported by empiric data.

Thank you for this opportunity to present our views. Again the AAMC believes geographic adjustments should use the most accurate and complete data available. We would also appreciate the opportunity to make a statement on the wage index and GPCI issues at one of the IOM’s public meetings and answer any questions the committee may have.

If you have questions concerning these comments, please feel free to contact Atul Grover, M.D., Ph.D, Chief Advocacy Officer, at agrover@aamc.org or Karen Fisher, JD, Senior Policy Counsel, at kfisher@aamc.org, at 202-862-6140