MEDICARE PAYMENT IN 2012 FOR IOWA PHYSICIANS – GPCIs AND THE SGR

By Jeanine Freeman, JD

Medicare payment for physicians in calendar year (CY) 2012 calls forth a wide berth of issues. This article will focus on 1) the geographic practice cost indices (GPCIs) and 2) the sustainable growth rate (SGR) factor. Both of these issues significantly impact payment to all Iowa Medicare participating physicians.

The GPCIs. Because of the GPCIs, Iowa physicians continue to be paid by Medicare at a substantially reduced level for the same service provided to Medicare beneficiaries by their colleagues in other payment localities. The CMS proposed CY 2012 physician payment rule lands Iowa physicians near the bottom in payment (86th among the 89 Medicare fee schedule areas). The GPCI payment differential between physicians in the highest paid Medicare fee schedule area (Alaska) and the lowest paid (Puerto Rico) is 38.969% under the proposed rule, an extremely high difference in pay under a national medical delivery and payment system.

Relief from GPCI payment disparities continues as a top priority for IMS in its national advocacy. We work toward this goal in many forums, including Congress; the Institute of Medicine (IOM) committee charged by HHS Secretary Kathleen Sebelius to study Medicare's geographic adjusters; and CMS in its study of the practice expense (PE) GPCI and its annual Medicare payment rulemaking. Iowa's congressional delegation, particularly Senators Grassley and Harkin and Congressman Braley, have been powerful and impactful allies in calling for GPCI study and relief. Michael Kitchell, MD, Ames, past president of IMS, remains an informed, tireless advocate for IMS member physicians on this issue.

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Much of our GPCI advocacy is technical. Overall, we have focused on CMS' continued reliance upon proxy data and proxy weights in establishing the PE and Work GPCIs and the resultant geographic adjustment factor (GAF) for each Part B payment locality. IMS sees marked and unexplained discrepancies between what CMS' GPCI data and weights indicate and what actual physician practice cost data demonstrate. For instance, in its proposed CY 2012 Medicare physician payment rule, CMS says that rent and utilities account for more than 10% of a physician's overall practice costs and that non-physician employee wage and benefit costs account for 19.2%, but MGMA data suggests that rent/utilities comes in around 6% and nonphysician employee costs are closer to 32.9% of overall practice costs. GPCI data and weighting discrepancies mean lost dollars to payment localities like Iowa.

CMS took small steps to improve GPCI input and weighting accuracy in its CY 2012 proposed rule by: 1) no longer using residential 2-bedroom low income apartment rent data as a proxy for physician office occupancy costs in favor of more current marketplace apartment rent data; 2) utilization of more recent (2006-08) Bureau of Labor Statistics (BLS) wage data instead of 2000 Census data to support the physician Work GPCI; 3) expansion of the base of occupations in determining the non-physician employee wage and benefits input of the PE GPCI; and 4) establishment of a new PE GPCI input category for purchased services. CMS also proposes changes to the Medicare Economic Index (MEI) and to GPCI weights. These positive changes, however, fail to adequately reflect the realities of physician practice costs evidenced in AMA and MGMA survey data or experienced by physicians day to day.

On another front, the IOM committee studying Medicare's geographic adjusters recently issued its final recommendations for changes to the GPCIs

and the hospital wage index and now has moved into its analysis of the impact of those recommendations on the health care delivery environment. The IOM's final report will be issued in late spring of 2012 and that report likely will impact Medicare payment to physicians in CY 2013. IMS closely monitors the work of the IOM, has provided frequent testimony, and will continue to do so in this final year of study.

Finally, and importantly, the 2-year partial PE GPCI floor authorized by the ACA and 1.0 Work GPCI floor continued for CY 2011 by the Medicare and Medicaid Extenders Act will expire effective January 1, 2012. Congressional action is required to extend the floors. CMS cannot do so by rule. Expiration of these floors would mean a 5% or $20 million drop in Medicare payment for Iowa doctors. IMS is working directly with Representative Braley and Senators Harkin and Grassley to restore these GPCI floors at least through 2012 and preferably through 2013.

The SGR fix. IMS coordinates its advocacy on the SGR with the AMA and the federation of state and specialty medical societies. Congress and regulators agree that the SGR is not workable and Congress has intervened on 12 separate occasions since 2002 to avoid the SGR cuts. Dollars to do away with the SGR, however, continue to compound to a current estimated cost of nearly $300 billion over a 10-year period. The AMA, in May 5, 2011 testimony before the House Energy and Commerce Committee's Subcommittee on Health, recommended a three-pronged approach to reforming the physician payment system: 1) repeal the SGR; 2) implement a 5-year period of stable Medicare physician payments; and 3) transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs.

Untouched, the SGR will result in a 29.5% reduction in Medicare physician fees in CY 2012. Only Congress can avert this reduction. As such, CMS' proposed CY 2012 physician payment rule reflects the 29.5% reduction, resulting in an estimated $210 million loss in Medicare revenues to Iowa physicians alone. To illustrate, if the 29.5% SGR reduction goes into effect, Iowa physician payment in CY 2012 for E/M mid-level office visit code 99213 (with expiration of the Work and PE GPCI floors) would be **$44.69** and **$47.06** if the Work and PE GPCI floors are restored (see discussion above). The CY 2011 fee for E/M 99213 (with the Work and PE GPCI floors in place) is **$65.43**.

Based on its work with congressional leadership, the AMA anticipates that the SGR cut again will be averted for CY 2012. A permanent SGR fix is a tough ask due to its costs. An extended (i.e., 2-3 years) short-term fix remains feasible. Underlying the call for relief is the very real concern of what physicians could lose in exchange. MedPAC, for instance, supports SGR repeal but balanced by a 10-year freeze on primary care payment levels and a 5.9% reduction each year for three years for specialists followed by a 7-year freeze. Organized medicine opposes MedPAC's proposal.

The AMA is forthright in advising that once again physicians likely will not know the outcome of SGR correction until the waning days of December. The AMA is working directly through deficit reduction processes currently underway. Congress' "Super Committee," charged with reducing the national debt by $1.5 trillion over the next 10 years, must issue its debt reduction report by November 23. That report then must be sent to the floors of the House and Senate for passage before December 23. Physicians averting a 29.5% cut nonetheless may see a payment reduction in the range of 2% as part of the deficit reduction process but, possibly, not until CY 2013.