



**STATEMENT**

**of the**

**American Medical Association**

**before the**

**House Ways and Means Committee  
Subcommittee on Health**

**RE: Expiring Medicare Provider Payment  
Policies**

**Presented by Robert M. Wah, MD**

**September 21, 2011**

**Division of Legislative Counsel  
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The American Medical Association (AMA) is pleased to have the opportunity to provide the House Ways and Means Subcommittee on Health with our views on expiring Medicare payment policies concerning: (i) the work geographic practice cost index (GPCI); (ii) the five percent mental health add-on; (iii) direct billing by independent laboratories for the technical component of certain pathology services; and (iv) certain dual-energy x-ray absorptiometry services (DXA scans).

The AMA recognizes that there are a number of Medicare provider payment policies that expire on or before December 31, 2011, and that many of these policies have been extended multiple times over a number of years. We applaud Chairman Herger for his leadership in examining whether these policies are still needed and appropriate. It is critical to continually examine Medicare payment policies and ensure that Medicare payments reflect increases in the cost of practicing medicine and maintain access for Medicare beneficiaries to critical medical services.

Some of the expiring provisions the Subcommittee will be examining include:

- **Physician Work GPCI**

Under current law, the Centers for Medicare and Medicaid Services (CMS) is required to establish Geographic Practice Cost Indices (GPCIs) to adjust the Medicare payment rate for physicians' services. The GPCIs are intended to adjust payments for geographic differences in the cost of providing services, including for physician work (or cost-of-living adjustments), practice expenses, and medical liability insurance. GPCIs are calculated for each of 89 localities across the United States. Adjustments to the GPCIs are required by law to be made on a budget neutral basis, which means that increasing the GPCI for one set of localities would lead to cuts in all other localities. This budget neutrality provision has created friction among and within states and regions, as well as between rural and urban areas. **The AMA has long advocated that any adjustments to the work GPCI should not be budget-neutral.**

On this basis, the AMA has supported numerous Congressional interventions to extend the work GPCI floor of 1.0, which applies to any locality for which the index is less than 1.0. For example, the Patient Protection and Affordable Care Act (ACA) extended the floor of 1.00 on the work GPCI through 2010, and the Medicare and Medicaid Extenders Act of 2010 (MMEA) extended this work GPCI floor through 2011. The work GPCI provision has been funded with new money and has not been implemented on a budget-neutral basis.

At the request of the Secretary of the Department of Health and Human Services, the Institute of Medicine (IOM) is in the process of studying and issuing three reports on how to improve the accuracy of the data sources and methods used for making the geographic adjustments in payments to providers. The AMA has met with the IOM and provided extensive information for the IOM to examine in developing its reports. In June of this year, the IOM issued a report, which recommends an integrated approach that includes:

- moving to a single source of wage and benefits data;
- changing to one set of payment areas and labor markets; and
- expanding the range of occupations included in the index calculations.

The IOM also recommends developing a new source of data on the cost of office rent and applying the hospital wage index for facilities other than acute-care hospitals.

The June report was the first of three to be issued by the IOM. A supplemental report that discusses physician payment issues further will be issued, along with a final report that is expected to be released in 2012.

The AMA believes that once these reports are complete, they should be a starting point for Congress in examining geographic payment adjustments for physician work and practice expenses. The Subcommittee should also examine the impact of the IOM recommendations on physicians and other Medicare providers. For example, the IOM recommends changing to one set of payment areas and labor markets. Specifically, the IOM recommends that Medicare should employ the metropolitan statistical areas (MSAs) developed by the Office of Management and Budget for hospitals and health professionals, including physicians. Currently, there are 441 markets to determine hospital payments and a different set of 89 markets for physicians and health practitioner adjustments. Moving to a single set of markets would create significant changes for many localities, with varying impacts, which must be closely examined.

Upon completion of the IOM reports, the AMA looks forward to working with the Subcommittee and Congress to develop accurate and equitable geographic payment adjustment policies. It is critical, in developing new GPCI payment policies, that the most current, valid, and reliable data are collected and applied in calculating accurate GPICs and in determining geographic payment areas for use in the Medicare

physician payment system, with data collected from rural practice sites for this purpose.

- **Mental Health Add-On Payment**

Congress has intervened on numerous occasions to extend a five percent increase in payments for certain Medicare mental health services through December 31, 2011, most recently under the Medicare and Medicaid Extenders Act of 2010. These add-on payments have been important for ensuring access to mental health services. The AMA CPT Editorial Panel is reviewing the descriptions of all psychological services, and upon completion of this review the AMA/Specialty Society RVS Update Committee (RUC) will review the valuation of these services and make related recommendations to CMS.

- **Direct Billing for Technical Component of Pathology Services**

Congress, with bipartisan support, has also intervened to extend the ability of independent laboratories, under certain conditions, to bill Medicare directly for the technical component (TC) of anatomic pathology services provided to hospital patients through December 31, 2011. The TC of anatomic pathology services are physician services under Part B and include the preparation of tissue samples for pathologist examination and diagnosis. Congress has consistently provided relief in the form of a “grandfather” provision to limit implementation of a regulation that would otherwise eliminate Medicare payments to independent laboratories for these TC services. The “grandfather” applies to hospitals that were using an independent laboratory for these services as of July 22, 1999. A covered hospital can utilize any independent laboratory for these services, which allows for competition among laboratories for delivery of services, and allows hospitals to choose the laboratory that best meets their needs. Without this grandfather provision, there would be significant hardship for independent laboratories and hospitals, along with substantial disruption for patients. Hospitals would have to absorb new costs without a payment increase. New complex billing systems and administrative operations would be required for both the hospital and laboratory. For Medicare beneficiaries, this could result in limited access to surgical services in their hometowns. Smaller hospitals and rural communities would be especially hard hit. Bipartisan legislation to make the grandfather provision permanent is currently pending before Congress.

- **Dual-Energy X-Ray Absorptiometry Services**

Medicare payment for bone density screenings for osteoporosis were reduced by CMS after the agency discovered a clerical error in direct practice costs for DXA scans that resulted in increased payments for these services. The ACA increased payments for certain DXA Scan services to 70 percent of the 2006 Medicare payment level for 2010-2011. After 2011, the payment rate for DXA scans will be reduced by 50 percent. Currently, legislation pending before Congress would extend payment for DXA scans at the current payment rate through 2013. CMS has asked the AMA RUC

to review the valuation of DXA scans, and the RUC likely will undertake this review at its January 2012 meeting.

The AMA understands the Subcommittee's concern about the costs associated with continually extending modified payment policies for these and other expiring provisions. The AMA believes, however, that the additional funding that has been allocated for many of these services has been necessary in the absence of a complete overhaul of the Medicare physician payment system. Due to the flawed sustainable growth rate (SGR), there has been a massive shortfall in Medicare funding for physicians' services. Over the last decade, temporary patches have not kept up with the growth in physician practice costs and real inflation-adjusted Medicare payment rates have been cut 16 percent. Physicians also face a 29.5 percent across-the-board payment cut scheduled for January 1, 2012. Until Congress repeals the current SGR and replaces it with a new Medicare payment system that fairly pays for physicians' services and keeps up with increases in medical practice costs, "extender payments" for these expiring provisions are needed to maintain critical access to these services for Medicare beneficiaries.

Medicare physician payment updates since 2001 have not kept up with the cost of running a medical practice, leaving a 20 percent gap between payment rates and practice expenses. Further drastic cuts pose a very real risk to physicians' ability to retain staff, care for Medicare patients and make the investments needed to modernize their practices and participate in care delivery models intended to improve quality while reducing costs in the Medicare system.

New policies for these expiring provisions should be developed as part of a new Medicare physician payment system. The AMA has recommended a three-pronged approach to reforming the Medicare physician payment system:

- (1) Repeal the SGR;
- (2) Implement a five-year period of stable, positive Medicare physician payments;  
and
- (3) Transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs.

During this period of stable, positive Medicare physician payments, new models would be tested to lay the pathway for a new payment system. These new models should also test new proposals and payment policies that would result in accurate and equitable Medicare payment for the services of these expiring provisions. The AMA is eager to continue to work with members of the Subcommittee and Congress to lay the ground work for Medicare physician payment reform, and we are grateful to Chairman Herger and the Subcommittee for calling this important hearing today.