

## Regional variations in Medicare payments

If there is one thing that physicians of all specialties and in all parts of the country might agree upon, it is that Medicare payments for physician services are inadequate and are becoming more so each year, – even without the periodic threat of catastrophic cuts like the 21.2% drop that is looming on March 1, 2010.

In particular, physicians in Rhode Island and in certain other parts of the country, especially in rural areas, often voice the impression that Medicare's Resource-Based Relative Value Scale (RBRVS) short changes them to an even greater extent than it does other physicians who are fortunate enough to practice elsewhere. Rhode Island physicians often assume that the discrepancies in commercial insurers' treatment of physicians within New England are reflected equally greatly in Medicare, though this is quite certainly not the case. Some physicians seem to conflate Medicare rates with a comparative survey of Medicaid fee-for-service rates that was published by RIPEC in 1994 – before RIteCare – and showed Rhode Island next to the bottom nationally.

The RBRVS, developed at Harvard in the 1980s and implemented by Medicare in the early 1990s, is far from perfect. It has probably not served the country well (some say its overemphasis on effort and its undervaluation of effect have helped to undermine primary care) and is likely to be substantially modified or supplanted in coming years.

For all its shortcomings, RBRVS is not static and is designed to be self-correcting, to an extent. For example, the RBRVS is systematically updated and modulated to reflect geographic changes and differences in living costs and in the prevailing value of professional work in different parts of the nation. As a result of these modulations, Rhode Island physicians today are paid about 12% more than Arkansas physicians, about 6.6% less than Connecticut physicians and about 11% less than physicians in metropolitan Boston. The differences arise mainly from the federal government's measures, which are updated every three years, of living costs in the various markets as an index to differing overhead expenses for medical practices.

Below is a more detailed explanation of how these calculations come about.

Medicare payment to doctors everywhere in the U.S. is a product of the following three factors: 1) a nationally uniform RBRVS; 2) a set of Geographic Practice Cost Indices (GPCIs) that modulate the RVUs (Relative Value Units) to reflect local economic conditions; and 3) a nationally uniform Conversion Factor (CF), which is currently \$36.08.

Let us take a closer look at the first two factors. The nationally uniform RBRVS assigns a relative value to each of the thousands of discrete services identified by the CPT coding system. The relative value of each service

is expressed as a number, which is the sum of the RVUs that Medicare assigns for each of three components of every service: the value of the work involved (time, intensity, skill, training, experience, etc.), the general practice overhead expense (office rent, personnel, utilities, equipment, supplies etc.); and the medical professional liability insurance expense that can be allocated to the service.

The weight given to work, overhead and liability varies slightly from code to code, but overall in the RBRVS system the "work" component accounts for 52% of RVUs, general overhead accounts for 44% of RVUs and liability expense for only about 4% of RVUs.

The RVUs assigned to each of the three components (work, overhead, liability) of each CPT service are multiplied by a geographic adjustment factor that is specific to that component and to that geographic area or "locality." Medicare divides the nation into 89 "localities." Rhode Island and Connecticut are each a single locality; Massachusetts is two localities, namely "Metro Boston" and "the rest of MA." Every three years, Medicare measures the going rates for professional work, for living costs/practice overhead, and for medical professional liability insurance in each locality and updates the geographic adjustment factors accordingly.

The three geographic adjustment factors compare each locality with the rest of the country. That is to say, an adjustment factor of "1.0" corresponds to what Medicare



Ten Past Presidents of RIMS were hosted by President Vera A. DePalo, MD, for a holiday get-together at RIMS in December. [L-R] Herbert Rakatansky, MD; Arthur A. Frazzano, MD; Richard Wong, MD; Barbara Schepps, MD; Tilak K. Verma, MD; Diane R. Siedlecki, MD; Dr. DePalo; James P. Crowley, MD; Fredric V. Christian, MD; J. Jefferys Bandola, MD; Yul D. Ejnes, MD

considers to be the national average and results in no adjustment in payment. A factor >1.0 means the value is above the national average, and this higher factor results in a higher payment. A factor <1.0 means the value is below the national average, and this lower factor results in a lower payment.

These three adjustment factors are called Geographic Practice Cost Indices or GPCIs. Medicare assigns each locality its own three GPCIs (one for work, one for practice overhead and one for liability cost), in order to account for regional differences and thus make the RBRVS payment system equally fair to doctors everywhere.

Thus, the formula for payment for each service would look like this:

$$\begin{aligned} &[(\text{Work RVUs} \times \text{work GPCI}) + \\ &(\text{overhead RVUs} \times \text{overhead GPCI}) + \\ &(\text{liability RVUs} \times \text{liability GPCI})] \times \\ &\text{CF} = \text{payment} \end{aligned}$$

### How Rhode Island stacks up

Rhode Island's current GPCI for the "work" component is 1.029; thus, it is above the national average and is identical, in fact, to the work GPCI for Metropolitan Boston. The rest of MA, at 1.007, is lower than Rhode Island; CT, at 1.038 for work, is higher than both Rhode Island and Metro Boston.

Rhode Island's "overhead"/living expense GPCI is 1.04; Metro Boston's is 1.311, and the rest of MA is 1.106. CT's is 1.179. Apparently, then, Medicare finds RI's overhead costs (office rent, etc.) are generally lower than those in MA and CT but still higher than the national average.

Rhode Island's liability GPCI is 0.946. Thus, Medicare finds RI's liability expense to be below the national average but higher than that of Metro Boston and the rest of MA, which are both pegged at 0.787, and also higher than CT at 0.934.

To compare Medicare's overall physician payment levels in RI, MA and CT, we have to take into account the different weighting of the three

factors (52% work, 44% overhead, 4% liability expense). Doing so, we can arrive at a rough composite geographic adjustment factor for RI of 1.03052, for CT of 1.09588, and for Metro Boston of 1.14340. (Note: these "composite" factors were generated by RIMS and are not known to be calculated or used by Medicare in any way.) It follows that Medicare pays doctors in all three states at rates that are above Medicare's national average.

Because the actual weighting varies slightly from code to code, these calculated composites are not precise, but they suggest that Medicare pays Metro Boston physicians at rates about 11% higher than what RI physicians receive, and that Medicare pays CT physicians at a rate about 6.6% higher than what it pays RI physicians.

These differences in payment rate are not insignificant, but they are narrower than many Rhode Island physicians may believe them to be. (Rhode Island physicians may tend to generalize from the commercial side,

where the discrepancies have been much greater, as the Massachusetts Medical Society's study released in 2003 demonstrated.)

### For comparison's sake, add Arkansas to the mix

A state where the three components of RBRVS are lower provides some additional perspective on the range of payment differences that exists within the Medicare system. Arkansas, like CT and RI, is a single "locality" in Medicare's payment system. AR's GPCIs are 1.0 for professional work (thus, neither higher nor lower than the national average), 0.846 for practice overhead (below the national average), and 0.446 for liability insurance expense (well below the national average), which would yield a composite geographic adjustment of about 0.91008. From this calculation, one can infer that Medicare pays AR doctors at rates that are about 12% less than what RI doctors receive from Medicare and 23% less than what Metro Boston doctors receive. ❖

## Will you be ready for PECOS by April 5?

An understated communications effort by CMS has left some medical practices in the dark about a looming deadline that could confront some doctors with a string of Medicare claims rejections starting April 5, 2010.

In a nutshell: all ordering and referring physicians must be enrolled in the Medicare Provider Enrollment Chain and Ownership System (PECOS) by April 5 of this year, or their claims will no longer be paid. (This requirement was originally slated to go into effect on January 4, 2010, but AMA prevailed upon CMS to delay the effective date in order to give physicians more time to comply.)

All physicians and non-physicians who order services or items for Medicare patients or refer Medicare

patients to other Medicare professionals or suppliers are included under the new requirement.

Doctors who signed up with Medicare after November 2003 are probably in the clear. However, doctors who enrolled in Medicare earlier and have not updated their Medicare enrollment since November 2003 must do so before April 5, 2010, or their Medicare claims will be automatically rejected starting on that date. During the current phase-in period, physicians who do not have a current enrollment record in PECOS are supposed to be receiving warnings when they submit claims, but for now their claims are still being paid – until April 5.

Medicare-enrolled physicians can enroll in PECOS or verify that their