A Rural Perspective

Regional differences in Medicare payment and costs

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- Multispecialty clinic, 154 physicians
- 300,000 patients, 880,000 visits/yr.
- Clinic patients 32% Medicare
- Hospital patients 50-75% Medicare
From 2000 to 2003

- 192 physicians to 154 now
- Offices in 34 sites, now 23 sites
- Recruitment is extremely difficult, some searches open for over 5 years
- Waiting time to see key specialists is lengthy
- Patients have to leave the community for care
Recruitment and retention problems

- No Neurosurgeon
- No Spine surgeon
- No Infectious Disease specialist
- No Interventional Cardiology
- One pulmonologist/critical care specialist
- For 300,000 patient population, a critical shortage
Rural shortage: Physicians per 100,000 residents
Geographic adjustments

99213 office recheck fee example

- $63.10 in New York City, $64.09 San Francisco, $59.10 Chicago
- Rural Missouri $45.13, Iowa $46.53
- This difference is 40% for this fee, and is higher for other fees (e.g. surgery)
GPCI adjustments (penalties)

- Medicare fees (RVUs) have three components (and GPCI adjusters)
- 55% Work effort: time, training, skill, mental and physical effort
- 42% Practice costs (overhead)
- 3% Liability insurance
- 89 different regions for fees and GPCIs
RVU Work component GPCI

- Same training
- Same skills
- Same time
- Same mental and physical effort
- Additional effort in rural areas for on-call
- Additional effort and cost for outreach
GPCI penalties affect recruitment

- Think about our recruitment:
- Otolaryngologist will receive 22-23% less in fees than Chicago, and instead of (e.g.) every 7-8th night and weekend on call, every third weekend and night
- Pulmonologist on call every other night and weekend— and 20-21% lower Medicare fees than Detroit
- Medicare can’t solve all rural problems, but shouldn’t make them worse!
Hospital wage indexes must also reflect realistic differences

- Hospital wage expenses average about 50% of total costs, but Medicare uses 71% in computing regional (decreased) adjustments to hospital payments, penalizing much more than actual cost differences

- Supplies, equipment, and often personnel costs are not less in rural areas

- Medicare hospital margins are often negative in rural areas (Iowa hospitals lost $100 million despite the lowest cost per discharge nationally)
Double penalty for rural areas: GPCIIs and SGR update

- SGR (update) formula most agree is flawed, but the original reason for the update was to limit utilization
- If physicians increase intensity, volume, or utilization to increase their income, the SGR would limit payments
- SGR is a NATIONWIDE penalty, hurting even the lowest utilizing physicians
SGR update penalty

- Because of excess utilization in some areas, access to care in rural areas is impeded
- Should SGR update be a regional adjustment?
Large differences in Medicare payments from region to region

- 30-40% of the difference is in “input prices” or geographic penalties that are not reflective of actual cost of practice, and reduce the ability to recruit and retain high quality health providers.

- 60-70% of the difference is in volume, intensity and utilization that may be due to unnecessary, wasteful care.
What we reward, we receive

- **Urban physicians > rural physicians = rural shortages**
- **Urban hospitals > rural hospitals = loss of services in rural areas**
- **Volume of procedures > efficient practices = higher payments to inefficient providers**
- **Quantity > quality = our mess today**
Medicare Reform

- Eliminate geographic penalties that do not reflect actual cost differences
- Reward high quality, cost-effective evidence-based practice