



November 3, 2008

Centers for Medicare & Medicaid Services
 Department of Health and Human Services
 7500 Security Blvd.
 Baltimore, MD 21244
 Attention: GPCI: Locality Discussion

Dear Sirs:

On behalf of the Texas Medical Association and the 59,000 practicing physicians in the state of Texas, we thank you for the opportunity to comment on the proposed Medicare locality revision methodologies outlined in "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2009;...; Proposed Rule" published in the *Federal Register* on Monday, July 7, 2008. We are pleased at your effort to implement new payment locality definitions, which is long overdue. We also appreciate the report prepared by Acumen, LLC, which has greatly simplified our analysis and enhanced our understanding of the available options.

Current Conditions

Since the establishment of the current payment locality boundaries in 1997, various urban and suburban areas in Texas have experienced dramatic growth, significantly altering the local economic conditions in some areas of Texas. The failure to update the locality definitions in the past decade has caused the GPICs to become less and less accurate in reflecting differences in local cost. A revision to the locality boundaries and definitions is long overdue. Consequently, the changes that are now necessary are very large. Since any change to the geographic adjustments creates both winners and losers within the physician community, changes are divisive and controversial. Large changes at any one time should be avoided and steps should be made to ameliorate the impact. To avoid the need for future large changes, the locality boundaries should be revised at least every three years, just as is required for the GPCI values.

Criteria

In evaluating the current proposed methodologies, we have considered several factors in addition to the index accuracy. Although we continue to believe that there are flaws in the calculations of the Geographic Practice Cost Indices (GPICs), we have detailed those concerns elsewhere and will not revisit them here.

First, we do not feel that Texas physicians in the "Rest of Texas" payment area can be expected to absorb cuts without a significant adverse impact on access to care for Medicare beneficiaries. These physicians, many of whom practice in rural or small urban communities, are already stretched to the limit in trying to deal with threats to their practice viability. Revenues are decreasing due to inadequate fee updates from payors, particularly Medicare and Medicaid while their practice operating costs have been increasing at twice the rate of inflation. Even without cuts produced by locality revisions, they face the continuing threat of cuts due to the expiration of the temporary work GPCI floor provisions in current law. Any cuts to payment for these physicians will likely result in physician decisions to eliminate or further restrict Medicare caseloads, and possibly practice re-locations or premature physician retirements. All of these would exacerbate patient access problems in areas that already face health care shortages.

Second, although we do not believe that reducing the number of payment areas is necessarily helpful, we do understand that several factors can affect the administrative costs of maintaining and updating the localities and GPCI values.

Option 1: CMS Core-Based Statistical Areas (CBSAs)

Although we see some potential benefits in using Option 1, we are extremely concerned about the potential effects of the resulting significant cuts to payments in the "Rest of Texas" payment area and in other non-urban areas across the nation. There would be an accuracy advantage and an administrative simplicity advantage to this method because it is consistent with the definitions used for the inpatient hospital prospective payment system and other payment systems.

However, because of the adverse effect on the lowest-paid physicians, we urge you not to implement this method unless it can be adopted with a hold-harmless floor on existing payment areas and a material increase in the conversion factor sufficient to ensure real increases in Medicare fees to all physicians in all payment areas.

Option 2: Separate Counties

Option 2, which separates high-cost counties from existing localities, does not create the large cuts to rural physicians that are a feature of Options 1 and 4, but it does have other undesirable features. First, it creates payment differentials within major urban areas that create distorting incentives for "border crossing," moving an office a short distance down or across a street to secure a higher payment. Secondly, it increases administrative complexity by increasing the number of payment areas and by creating unnecessary calculation complexity due to the need to reallocate source data based on metropolitan statistical area into smaller county-level areas.

Option 3: Separate MSAs

Option 3, which separates metropolitan statistical areas from statewide localities, has several advantages. It avoids material cuts to the lowest-paid areas, while it matches payment with the underlying data better than options 2 or 4. It uses fewer payment areas than the county method in Option 2. Expanding the current urban payment areas to include all counties in the metropolitan statistical areas also would create some administrative simplification for CMS. Since the data used to calculate the GPCI values is aggregated and reported by MSA, use of the MSA as the payment area reduces the need for potentially flawed allocations of the data to county areas. Inclusion of the whole MSA in a single payment area will eliminate the incentive for border-crossing distortions within major urban areas. Furthermore, if this method is adopted with updates of the MSA boundaries when they are annually revised by the Office of Management and Budget, the geographic adjusters will maintain better alignment with the local data in the time between major locality updates, automatically adjusting for urban growth. Although the current analysis shows that this method will not result in a separate payment area for one major Texas urban area, future revisions may lead to such a result. If revisions are performed more regularly, such a change can be accomplished without large cuts to other Texas physicians. For these reasons, we have many times in the past suggested an MSA-based approach and we concur with MedPAC's support of this proposed revision method.

Option 4: Statewide Tiers

Option 4 groups counties within states into locality tiers based on costs. It creates payment areas that are poorly aligned with the underlying data and causes unacceptable cuts to physicians in small urban and rural areas. We do not support the use of this method.

Conclusion

We suggest that CMS use the method described in Option 3 to create MSA-based payment areas, and implement the change quickly before larger misalignments result from ongoing urban growth. We further recommend that the MSA boundary definitions be updated annually in accordance with OMB MSA definitions and that locality boundary definitions be revised every three years using a similar MSA-based method.

Sincerely,



Keith A. Bourgeois MD, Chair
Council on Socioeconomics