REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-11)
Practice Expense Data and the Medicare Economic Index
(Resolutions 207-I-10, 211-I-10 and 106-A-11)
(Reference Committee J)

EXECUTIVE SUMMARY

At the American Medical Association's (AMA) 2010 Interim Meeting, the House of Delegates referred Resolutions 207-I-10 and 211-I-10, both introduced by the Iowa Delegation. Resolution 207-I-10 asks that our AMA: (1) "request the Centers for Medicare & Medicaid Services (CMS) to keep the current relative value of work and the proportion of the Medicare fees in the physician work component of the Medicare Economic Index (MEI) at the current level (i.e., 52.47 percent and not decrease it to 48.27 percent);" (2) "demand CMS make Medicare payment methodology and explanations transparent and simple enough for all to understand, including physicians and politicians;" (3) "through the use of more surveys, advise CMS in determining the correct inputs into the MEI and continue to educate Congress that Medicare payments are not keeping up with practice costs in every region of the country;" and (4) "emphasize to CMS that physicians need to be paid more for their increasing practice costs as well as inflationary increases in the payment for their work." Resolution 211-I-10 asks that our AMA seek to partner with other organizations "to encourage fuller participation in a nationwide physician practice expense survey that could be funded from all these entities," or by CMS.

At the 2011 Annual Meeting, the House referred Resolution 106, also from the Iowa Delegation. Resolution 106-A-11 asks our AMA to: (1) "insist that CMS immediately correct the error of including total office expenses instead of only rent/occupancy costs in weighting the Practice Expense component of the Geographic Practice Cost Indices, and that CMS properly weight all components of the..(MEI)…using surveys of physician practice expenses… including rent and percentage of rent with regard to total practice expenses;" and (2) "lobby for legislation to require CMS to use actual practice expense survey data for determination of any practice expense weighting and for any expense differences or indices that could potentially be used for any geographic adjustment of Medicare payments."

The Board of Trustees assigned these items to the Council on Medical Service for a report back to the House of Delegates at the 2011 Interim Meeting. The Council gave thoughtful consideration to these resolutions. This report provides background on the MEI, details geographic adjustments, discusses the AMA Physician Practice Information survey, summarizes AMA advocacy and policy, and presents policy recommendations.

There are significant challenges in developing consensus within the physician community regarding improvements to the MEI and to geographic adjustment of Medicare pay. Therefore, the Council believes that the best alternative to address many of the concerns related to the resolutions is to rely on long-standing AMA policy. AMA insistence on the use of consistent and reliable data provides the best strategy to ensure accurate geographic payment differentials. There is general agreement among experts that the use of apartment rental data as a proxy for physician office rent is a significant shortcoming of the current Medicare geographic adjustment formula. In 2011, a panel convened by the Institute of Medicine recommended that CMS identify a new source of data on commercial office rent. Consistent with the intent of Resolution 106-A-11, the Council recommends that the AMA support such an effort if it is based on voluntary surveys, rather than mandatory cost reports.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-11

Subject: Practice Expense Data and the Medicare Economic Index (Resolutions 207-I-10, 211-I-10 and 106-A-11)

Presented by: Thomas E. Sullivan, MD, Chair

Referred to: Reference Committee J (Barbara J. Arnold, MD, Chair)

At the American Medical Association's (AMA) 2010 Interim Meeting, the House of Delegates referred Resolutions 207 and 211. Resolution 207-I-10, introduced by the Iowa Delegation, asks that our AMA: (1) "request the Centers for Medicare & Medicaid Services (CMS) to keep the current relative value of work and the proportion of the Medicare fees in the physician work component of the Medicare Economic Index (MEI) at the current level (i.e., 52.47 percent and not decrease it to 48.27 percent);" (2) "demand CMS make Medicare payment methodology and explanations transparent and simple enough for all to understand, including physicians and politicians;" (3) "through the use of more surveys, advise CMS in determining the correct inputs into the MEI and continue to educate Congress that Medicare payments are not keeping up with practice costs in every region of the country;" and (4) "emphasize to CMS that physicians need to be paid more for their increasing practice costs as well as inflationary increases in the payment for their work." Resolution 211-I-10, also introduced by the Iowa Delegation, asks that our AMA "seek to partner with the Medical Group Management Association (MGMA), American Medical Group Association, and state and specialty societies to encourage fuller participation in a nationwide physician practice expense survey that could be funded from all these entities, or by CMS."

At the 2011 Annual Meeting, the House of Delegates referred Resolution 106, also from the Iowa Delegation. Resolution 106-A-11 asks our AMA to: (1) "insist that CMS immediately correct the error of including total office expenses instead of only rent/occupancy costs in weighting the Practice Expense component of the Geographic Practice Cost Indices (GPCIs), and that CMS properly weight all components of the Medicare Economic Index using surveys of physician practice expenses such as the AMA's own Physician Practice Information Survey, Medical Economics surveys, and/or MGMA yearly surveys of detailed physician practice expenses including rent and percentage of rent with regard to total practice expenses;" and (2) "lobby for legislation to require CMS to use actual practice expense survey data for determination of any practice expense weighting and for any expense differences or indices that could potentially be used for any geographic adjustment of Medicare payments."

Reference committee testimony on these items noted that the Institute of Medicine (IOM) was conducting a study of GPCIs and identifying data sources for physician practice costs. As the resolutions called for the pursuit of costly surveys, the reference committee recommended referral to allow an opportunity to review and assess the IOM study.

The Board of Trustees assigned these items to the Council on Medical Service for a report back to the House of Delegates at the 2011 Interim Meeting.

THE MEDICARE ECONOMIC INDEX (MEI)

The MEI has been used since 1975 as a measure of inflation specific to medical practices and is used in determining updates to Medicare physician payment. It also factors into the annual change in the budget for Medicare physician services under the Sustainable Growth Rate (SGR) system. Generally speaking, an increase in the MEI translates into more funding for Medicare physician services and an increase in pay (relative to what pay would have been). However, since 2004 Medicare physician pay updates have been set statutorily as progressively larger SGR cuts have been postponed by Congress. Over the last decade, the average annual increase in the MEI was 2.3 percent. In comparison, the average annual increase in the US consumer price index (CPI) over this period was 2.4 percent.

The MEI is constructed by dividing medical practice resources such as office space, medical equipment and supplies into categories and measuring the year-to-year change in price for resources within each category. The price changes are then weighted according to their share of total practice resources to obtain the overall change in the MEI. As shown in Table 1 below, the weighted average of the price changes for the 2011 MEI was 1.6 percent. A productivity allowance of 1.2 percent was then subtracted to arrive at the 2011 MEI value of 0.4 percent.

Table 1
The 2011 MEI

Component	*Weight (percent of total)*	*Wage/Price Change*
Physicians' own time	48.3%	2.4%
Nonphysician payroll	19.2%	1.5%
Office expense	20.0%	0.6%
Medical supplies	1.8%	0.4%
Professional liability insurance	4.3%	–2.9%
Medical equipment	2.0%	0.5%
Other expenses	4.5%	1.4%
Total (weighted average)		1.6%
Less productivity adjustment		–1.2%
2011 MEI		0.4%

CMS has revised the MEI weights three times over the last 18 years, with the most recent revision applying to the 2011 MEI. The revisions have been largely based on physician practice expense and income data collected in AMA surveys.

Table 2 compares the 2011 MEI weights to those for 2010. The 2011 weights for the major categories shown were based on physician practice expense and income data from the AMA's 2007/2008 PPI survey. A significant change with the 2011 MEI is that the office expense category was broken into 10 subcategories based on data from the US Bureau of Economic Analysis. AMA practice expense surveys such as the PPI survey have included rent, utilities, telephone and other

expenses all in one office expense question. CMS split these other expenses out with the 2011 MEI using this new data source. The "fixed capital" category now represents pure office rent.

Table 2
Changes in the MEI Weights

Component	*2010 Weight*	*2011 Weight*
Physicians' own time	52.5%	48.3%
Nonphysician payroll	18.7%	19.2%
Office expense	12.2%	20.0%
Utilities	-	1.3%
Chemicals	-	0.7%
Paper	-	0.7%
Rubber & Plastics	-	0.6%
Telephone	-	1.5%
Postage	-	0.9%
All Other Services	-	3.6%
All Other Products	-	0.5%
Fixed Capital	-	9.0%
Movable Capital	-	1.4%
Medical supplies	4.3%	1.8%
Professional liability insurance	3.9%	4.3%
Medical equipment	2.1%	2.0%
Other expenses	6.4%	4.5%
Total	100.0%	100.0%

THE MEI WEIGHTS AND GEOGRAPHIC ADJUSTMENT

The MEI weights are a chief focus of the resolutions associated with this report. These weights are important not only because they affect the calculation of the MEI, but also because they affect other elements of the Medicare Physician Payment Schedule. The MEI weights are used in the calculation of the practice expense GPCIs.

The GPCIs measure geographic differences in the prices of medical practice resources. There are three GPCIs corresponding to the three components of the Medicare physician payment schedule – physician work, practice expense, and PLI. The practice expense GPCI accounts for geographic differences in the wages of non-physician staff and in office expense (rent). The prices for medical supplies, medical equipment, and other resources are assumed to be the same across the country – they are not geographically adjusted. Prices for these various inputs are combined to produce the practice expense GPCI, using the weights from the MEI. As a result, a change in the MEI weights can affect the share of the practice expense GPCI that is geographically adjusted, which in turn can redistribute Medicare pay between rural and urban areas.

Table 3 illustrates that based on the 2010 MEI weights, 71 percent of the 2010 practice expense GPCI was accounted for by nonphysician payroll and office rent, and was subject to geographic adjustment. In the 2011 Proposed Rule, CMS used the 2011 MEI weights to calculate the practice

expense GPCI, and geographically adjusted only the "fixed capital" portion of office expense. These changes reduced the portion of the practice expense GPCI subject to geographic adjustment to 58 percent, which increased Medicare pay in rural areas, and reduced pay in high cost areas. Based on the comments they received, CMS decided not to implement the proposed changes to the 2011 practice expense GPCI weights. For 2012, CMS has again proposed to use the new MEI weights in the practice expense GPCI, but has also proposed to geographically adjust more of "office expense" and part of "other expenses," with the result that 72 percent of the proposed 2012 practice expense GPCI is subject to geographic adjustment

Table 3
Practice Expense Subject to Geographic Adjustment

Practice Expense Component	*2010 Actual*	*2011 Proposed Rule*	*2012 Proposed Rule*
Nonphysician payroll	all	all	All
Office expense	all	some	Some
Medical supplies	none	none	None
Medical equipment	none	none	None
Other expenses	none	none	Some
Percent of practice expense GPCI with geographic adjustment	71%	58%	72%

THE PPI SURVEY

The Physician Practice Information (PPI) survey was a coordinated effort by the AMA and more than 70 national medical specialty societies and health care professional organizations to collect practice cost data to be used in the Medicare Physician Payment Schedule. The AMA utilized the services of the Gallup Organization and dmrkyentec to field the survey. The Lewin Group participated in the survey design and analysis as a contractor to CMS. The PPI survey was fielded in 2007 and 2008 and collected practice expense information for 2006. CMS agreed to purchase data from the survey effort to offset a portion of the $2.4 million in cost. A total of 5,825 physicians and 1,578 other health care professionals completed the PPI survey, which included questions not only on practice cost, but also other practice-related items (e.g., physician utilization of electronic medical records). Of these respondents, 3,659 provided complete practice costs information and were eligible to be included in the practice cost computations provided to CMS in March 2009.

The PPI survey was designed to ensure that a minimum number of responses were available for 50 specialties. Data by CMS geographic payment locations are not available for the PPI survey. In order to collect data at this level of detail, more than 10,000 complete practice cost responses would be necessary. The fiscal notes presented on Resolutions 207-I-10 and 211-I-10 of $6 million were likely conservative in comparison to the cost of collecting the 2006 data for 3,659 PPI survey respondents.

In the Final Rule for the 2011 Medicare Physician Payment Schedule, CMS revised the MEI revenue shares using data from the PPI survey. The previous shares were based largely on data

from the AMA's Socioeconomic Monitoring System surveys and Patient Care Physician surveys, the last of which was fielded in 2001. The updated shares (or "components") are shown in Table 1 above. With Resolutions 207-I-10 and 211-I-10, the Iowa Delegation asks that CMS revert to the 2010 revenue shares, and also asks for a new practice expense survey. However, the new 2011 shares of work, practice expense and professional liability were formulated from the AMA's PPI survey. The survey indicated that practice costs have increased and now consume a greater proportion of total revenue. Variation in practice costs now applies to a greater proportion of overall payment and the authors of the resolution prefer that a larger proportion of payment relate to physician work. It is unlikely that a new survey would produce a significantly different result.

AMA ADVOCACY

Request for MEI Review: The AMA continues to aggressively advocate for a systematic review of the methodology used to compute the MEI that includes a review of the appropriate categories of costs. The MEI does not reflect contemporary medical practice, with significant costs required to comply with regulatory standards implemented subsequent to the initial creation of the MEI in 1973. In response to AMA advocacy, CMS announced the agency's intent to create a new technical panel to review all aspects of the MEI, including the inputs, input weights, price measurement proxies, and the productivity adjustment. In July 2011, CMS indicated that it is working through the requirements to formally organize the MEI technical advisory panel.

Institute of Medicine (IOM) Review: The Secretary of HHS called for the IOM to review the methodology and data used to compute the hospital wage index and the physician GPCIs. The IOM released an initial report in June 2011. The AMA participated in the IOM meetings, sharing AMA policy on GPCIs and explaining the PPI survey process and data. The AMA shared the Policy Research Perspective *Physician Practice Expenses by Location* (developed in accordance with AMA Policy D-400.985, AMA Policy Database) and explained that the PPI survey did not measure input prices. Similarities in total practice costs by geographic location reflect not only prices, but also hours worked and number of employees. The AMA also expressed support of a review of American Community Survey (ACS) data when available and improved data collection related to both the proportion and geographic differences in rent costs.

In its first report, the IOM committee concluded that the current basis of determining rent/office expense, median rent for a two-bedroom apartment from the US Department of Housing and Urban Development (HUD) data, is imperfect but preferable to other potential data sources (General Services Administration, United States Postal Services, or MGMA). The IOM concludes that a new data set should be established, using either new surveys, new questions on existing surveys, or physician cost reports. In addition, the IOM recommends that the 89 physician geographic locations be modified to be consistent with the hospital wage index geographic locations, currently 441 markets based on Metropolitan Statistical Areas (MSAs). This recommendation would create redistribution amongst physicians and would eliminate the 34 single statewide GPCI localities.

In late September 2011, the IOM released a second edition of its June 2011 report. The second report recommends that CMS continue to use the expense category weights from the MEI to set the expense category weights for the GPCIs, and that GPCIs continue for all three components of the RBRVS (work, practice expense, and liability insurance). The IOM also recommended that CMS continue to study the proxies used for physician income geographic variation as well as the assumption that only 25% of the income differential be incorporated into the work GPCI computations. A third IOM report is due in spring 2012 that will address the impact of the GPCIs on workforce, quality of care, population health, and the ability to provide efficient, high value care.

Medicare Proposals: CMS proposed a number of changes to the practice expense GPCIs in the Proposed Rule for the 2012 Physician Payment Schedule, published in the July 19, 2011 *Federal Register.* These proposals include the following:

- Employee compensation will be geographically adjusted using 2006 – 2008 Bureau of Labor Statistics (BLS) office of physician data.

- Rent will be adjusted using 2006-2008 data from the ACS residential rental data for two bedroom units. This proxy replaces the data from HUD that is unlikely to be available going forward. CMS includes a discussion that physician office data is unavailable, requiring them to use apartment data as a proxy. CMS has responded to Iowa's criticism regarding the proportion of the expense attributed to rent, by removing telephone expense from this category. Rent now includes the fixed capital and utilities portion of the MEI, representing approximately 10 percent of revenue.

- Responding to comments from physician organizations, CMS will create a purchased services category (legal, janitorial, information technology costs) to adjust these costs geographically using BLS data.

- The MEI weights implemented in 2011 will also be used for the GPCI cost share weights.

Consistent with current Policies H-400.984 and H-400.966, the AMA issued an August 2011 letter to CMS, with the following comments regarding its proposal:

- The CMS proposal to switch from the HUD apartment rental data to the ACS rental data seems appropriate since the ACS data is updated more frequently. Still, it is basically a substitution of one proxy for office rent for another proxy based on apartment data. A far better solution would be for the government to develop actual data on the cost of renting medical office space.

- The CMS process for splitting office expenses into 10 categories is questionable. CMS is somehow melding data on these categories that they obtained from the Commerce Department with office expense data from the AMA PPI survey. It is not clear how this matching was accomplished or why. It would have been better to use actual data on physician office expenses. A key question is whether there is any way to validate the CMS numbers for office rent as a percentage of total expenses, or as a percent of total revenue.

- In the 2010 Medicare physician fee schedule, 71 percent of the practice expense GPCI was geographically adjusted. For 2011, CMS had proposed to reduce the percentage that is geographically adjusted to 58 percent, which would have produced significant swings in payments at the locality level. This proposal was withdrawn, and for 2012, CMS now proposes to geographically adjust 72 percent of the practice expense GPCI, including an adjustment for some portion of office expense that is not well-defined or substantiated. It is difficult to understand the rationale for this complex methodology with 10 categories of office expense when the percentage that is geographically adjusted is about the same.

AMA POLICY

The AMA has extensive policy related to the MEI and GPCI improvements, including several policies supporting improvement to the Medicare Economic Index and the Medicare physician payment formula. Policy H-390.855 assigns a top priority to the prevention of further Medicare

payment cuts due to the Sustainable Growth Rate (SGR) system and to seek replacement of the SGR system with payment updates that reflect increases in the cost of medical practice. Policy D-390.963 urges CMS and the Medicare Payment Advisory Commission to review the MEI productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice. Policy D-390.997 seeks legislation directing CMS to include in the RBRVS practice expense allocation all costs incurred by physicians, including those costs incurred in hospitals and ambulatory surgical centers. Policy H-400.966 states that the AMA will (1) aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare; and (2) work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index.

Several policies emphasize the need to use accurate data in the calculation of GPCIs. Policy D-390.989 seeks the elimination of the unfairness inherent in the current wide geographic disparity in physician Medicare reimbursement. Policy H-400.984 states that the AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate GPCIs and in determining geographic payment areas for use in the new Medicare physician payment system. Policy D-400.985 states that the AMA will: (1) use the AMA PPI survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the GPCI; and (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs). Policy H-400.988 reaffirms AMA policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-GPCI based adjustments as needed to remedy demonstrable access problems in specific geographic areas. Policy D-400.989 states that the AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

DISCUSSION

There are significant challenges in developing consensus within the physician community regarding improvements to the MEI and GPCIs. Therefore, the Council believes that the best alternative to address the ongoing concerns from the Iowa Delegation, and specifically to Resolutions 207-I-11 and 211-I-11, is to rely on long-standing AMA policy. The insistence on the use of consistent and reliable data provides the best strategy to ensure accurate geographic payment differentials. The Council therefore recommends that Policies H-400.984 and H-400.988 be reaffirmed.

Following significant pressure from the AMA, CMS has acknowledged that a technical advisory committee on MEI will meet in the near future. The Council recommends that the AMA continue to advocate for an improved index to measure the growth in physician expenses. Accordingly, the Council recommends that Policy H-400.966 be reaffirmed.

The 2011 MEI reflects the finding in the AMA PPI survey that practice costs consume a greater proportion of total revenue. Resolution 207-I-10 prefers that a larger proportion of payment relate to physician work. With Resolution 207-I-10, the Iowa Delegation asks that CMS revert to the 2010 revenue shares, and also asks for a new practice expense survey. However, the new 2011 shares of work, practice expense and professional liability were formulated from the AMA's PPI survey and are reflected in the 2011 MEI.

The IOM and CMS both acknowledge that apartment rental data must be used as a proxy to determine geographic cost variation for physician offices as physician specific data are not available. The IOM recommends that CMS consider a data collection effort be initiated to collect physician office data. Consistent with the intent of Resolution 106-A-11, the AMA should support such an effort if it is based on voluntary surveys, rather than mandatory cost reports.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolutions 207-I-10, 211-I-10 and 106-A-11, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy H-400.984, which states that: Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices and in determining geographic payment areas for use in the new Medicare physician payment system. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-400.988, which states that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI)-based adjustments as needed to remedy demonstrable access problems in specific geographic areas. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.966, which states that the AMA will (1) aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (Reaffirm HOD Policy)

4. That our AMA support the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should either be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices. (Directive to Take Action)

5. That our AMA provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $5,000 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.