

May 21, 2013

The Honorable Kevin Brady  
Chairman  
Subcommittee on Health  
Committee on Ways & Means  
1135 Longworth  
Washington, DC 20515

The Honorable Jim McDermott  
Ranking Member  
Subcommittee on Health  
Committee on Ways & Means  
1135 Longworth  
Washington, DC 20515

Dear Chairman Brady and Mr. McDermott:

Thank you for the opportunity to add to the record of the House Ways and Means Health Subcommittee hearing of May 7, 2013 regarding reform of the Sustained Growth Rate (SGR). We support and appreciate the committee's efforts to bring changes to the manner in which physicians are paid in the Medicare system, especially as it relates to making the fee schedule more accurate, more transparent and more flexible to the dynamics of health care costs.

As part of the Committees' SGR examination we respectfully request changes to the California Geographic Practice Cost Index (GPCI) localities be included to further accuracy in payments to Medicare doctors.

The GPCI is applied at county-level jurisdictions – localities – that are designated as “urban” or “rural” based on local physician charging patterns in 1966. Rural localities are generally paid less because traditionally the cost of doing business there is less. Though the law calls for regular updates in locality payments, CMS has only once, in 1997, changed locality boundaries and then only modestly.

The failure of CMS (Centers for Medicare and Medicaid Services) and its predecessor agency HCFA (Health Care Financing Administration) to regularly update the localities has resulted in massive discrepancies in payment patterns in many states. In California the problem is particularly egregious with CMS officially considering San Diego County – a robust community of 3,177,063 (2012 estimate) – to be a rural county. Because of this outdated designation under the current payment formula Medicare doctors in San Diego County are collectively underpaid by approximately \$24 million.

This low reimbursement rate has created doctor access problems for senior citizens and denies the Medicare program the skills and services of talented physicians. It also creates financial

problems for hospitals that must accommodate low reimbursements from CMS for Medicare doctor services in their facilities.

California is not the only state with this problem. Florida, Texas, Illinois and Washington State also have similarly inappropriate payment applications to their localities. For example, in Texas doctors in Collin and Rockwall counties are underpaid by 8.72% and 8.03%, respectively. CMS pays Medicare doctors in Snohomish County in Washington 6.95% less than the formula requires due to the rural locality label applied to that county. Overall there is a \$29.1 million discrepancy in doctor payments in Texas, a \$12.6 million discrepancy in doctor payments in Washington and a whopping \$60.7 million discrepancy in doctor payments in Florida.

California has worked for a number of years to correct the locality designation problem. Language to correct the California locality problem was a part of the CHAMP Act (HR 3162) passed by the House in the 110<sup>th</sup> Congress. It was also part of the Affordable Health Care Act (HR 3962) as passed by the House in the 111<sup>th</sup> Congress. It has been the subject of a GAO report (2007, GAO-07-466), an Urban Institute study (2008), a CMS-commissioned study by Acumen LLC (2008) and an Institute of Medicine (IOM) report as mandated by PPACA (Pub. Law 111-148, Sec. 1157) that was issued in 2011 and further updated in 2012 ([http://www.nap.edu/catalog.php?record\\_id=13138](http://www.nap.edu/catalog.php?record_id=13138)). All these reports documented the locality problem – especially its significant mismatch in California – and recommended fixing it with an approach that used metropolitan statistical areas (MSA) as the geographic locality instead of the current county-based locality.

Under CMS regulations any shift in locality designations must be budget-neutral in its result. In addition, the CMS regulations require “sign-off” by the state medical association to effect a change. In California we have come up with a solution that is budget neutral and has the official endorsement of the California Medical Association. It comports to the recommendations of the GAO, Acumen and IOM studies and has the further added benefit of instituting a locality payment system that parallels the system CMS uses to pay hospitals, ie., one based on a geography of MSA economic drivers.

In the outline of the SGR fix this subcommittee has put forward one of its guiding principles is payment accuracy and transparency. We agree that these are absolute necessities for any SGR reform legislation. By extension, we respectfully submit that a correction to the GPCI locality problem should be included in the SGR reform package for the same reasons: payment accuracy and transparency. It makes no sense to attempt partial payment reform; reform has to encompass all aspects of the payment formula. As your outline states: accuracy is fundamental to a new payment regimen.

Attached is draft legislative language to update localities in California from the current county-based designation to one determined by MSA. It acknowledges that in making this re-designation there will be doctors in some counties that see reimbursement levels inch downward (which is the result of the mandated zero-sum budget neutrality regulation) but we protect those doctors by instituting a “hold harmless” for four years. The hold harmless is paid for by accompanying legislation that creates a County Operated Health System (COHS) in Alameda County,

California. In short: we fix a California locality problem with a California MSA fix paid for by a California COHS. No other state is impacted.

While we suggest this solution, we stand ready to work with the Committee and our California colleagues to develop a solution that is satisfactory to all parties.

Sincerely,

DARRELL ISSA  
Member of Congress

SAM FARR  
Member of Congress