Statement for the Record

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Rural Health Care: Challenges and Lessons

Rural health care has both unique challenges as well as lessons that can assist in reforming government health care policies.

Thank you for inviting me to speak with you. I am President-elect of the Iowa Medical Society and a practicing neurologist at McFarland Clinic, a multi-specialty group in rural Iowa. We are physician-owned and an organized, integrated group of 167 physicians in 33 specialties. We have 21 office sites in central Iowa, with about one million patient visits per year. We have physicians on staff in eight hospitals throughout Iowa.

Rural Health Care

The health of many rural citizens is fragile, and rural access is even more fragile due to a number of issues that threaten our health care system.

Rural Americans are generally older and poorer than other areas of the country. Compared to urban areas, more rural citizens report fair or poor health. Almost one half of rural adults suffer from chronic diseases.

There are higher percentages of Medicare and Medicaid patients in rural areas. Medicare and Medicaid reimbursement of rural physicians is generally much lower than private insurance, resulting in severe stress on physician practices.

Problems with Access

Access to health care is a problem in rural areas largely due to physician shortages. Rural citizens make up over 20% of the nation's population, but only 9% of our nation's physicians reside in rural areas. With less than half the number of physicians per population, rural physicians are under far greater stress. Surveys by **Medical Economics** have shown rural physicians see up to 30% more patients per physician, and their hours of work are longer. The same survey showed rural physicians' practice expenses are $250,000/yr. per physician compared to $180,000/yr. for inner city physicians and $210,000/yr. for urban physicians. So the data show that rural physician practice expenses are significantly *greater*, though Medicare reimburses us *less*.

Another complexity for physicians in rural America is the on-call effort. With half the number of physicians per capita, the days on call are more frequent. Lower reimbursement and greater call burden makes physician recruitment nearly impossible, as

physician recruitment is national in scope. For the last four years I've been on call every third night, and some of our physicians are on call every night or every other night.

At McFarland Clinic over the last ten years there has never been a time that we had fewer than 25 openings for physicians. Many times it has taken 4-6 years before we could fill a physician opening. Recruiting of physicians for rural areas will continue to get worse unless the payment system changes.

Physician shortages in rural areas are largely caused by Medicare payment policies that geographically penalize rural physicians. Geographic penalties (called the **Geographic Practice Cost Index** or GPCIs) continue to reduce access to physicians in rural areas and create extreme variations in utilization across the nation. Congressman Braley, Senator Grassley, and Senator Harkin have all sponsored legislation to reduce these geographic penalties, and **President Obama** has expressed his support for geographic equity.

Geographic Equity

Geographic equity has been a major concern of rural physicians for many years. These geographic penalties (GPCIs) reduce fees for physicians because of where they live.

GPCIs reduce Medicare fees rural physicians are paid in three ways. One is by reducing the "work effort" portion of the fee. The work effort payment in rural areas is less than in urban areas. Only by enacting a 1.0 floor for the work GPCI in 2003 was this geographic penalty reduced, but there is still a differential of 8%.

Another GPCI adjustment is for physician office rent, which Medicare measures by proxy, using HUD data on local apartment rentals. CMS has used a proxy that bears little resemblance to the amount physicians actually spend on office rent. CMS has incorrectly given it far more weight than empirical evidence proves should be assigned, resulting in severe penalty to physicians in sparsely-populated states.

The Challenges

Rural physicians have not only had their work and practice expenses geographically adjusted by Medicare, our quality and e-prescribing payments have also been **geographically devalued**. Our **quality** payments are 30-34% less than the highest areas of the country. **E-prescribing** payments are also geographically adjusted, despite identical costs for rural areas.

With the geographic devaluation of payments, rural physicians are left with little capital to invest in innovation and technology. For example, imaging equipment costs are the same throughout the country, yet the Medicare payment for the technical component of these procedures is almost half as much as in some urban areas. Medicare payment for certain services is actually lower in some areas than the cost of those services, and if further cuts occur, some services will be discontinued.

The challenge in rural America is to find ways to maintain and improve health care access despite shortages of physicians and services.

I hope Congress will agree with **President Obama**: there should be **geographic equity**.

SGR Formula Cuts

The Sustainable Growth Rate (**SGR**) formula has threatened nationwide cuts for physician Medicare payment for many years, and a 20-21% SGR cut in Medicare fee payments is a huge threat for access to care in rural areas. Many rural physicians would be forced out of business by cuts of that magnitude.

Medicare fee payment rates for some specialty physicians are currently1/3 of what private insurance fees are paying for the same service. In Iowa private insurance companies are paying 40% to 300% (depending on the service and insurance company) **more** than Medicare for the same service. Clearly, cutting Medicare payments or expanding Medicare without increasing payment is a potential disaster in rural areas.

Quality and Value: The Lessons

Despite the long history of payment disparities, many rural areas of America have had high quality, cost-effective care. The Commonwealth Fund has rated the Iowa health care system as the highest in health care for children and second highest for adults. Iowa hospitals and physicians have been leaders in high quality care and cost-effective care. With our very efficient and high quality healthcare providers, we have the highest **value**. Unfortunately there have been problems with Medicare's program to reward physician quality and value.

If there are cuts in Medicare reimbursement for the efficient and cost effective areas unfortunately there could be a decline in services, access, and quality.

Our country needs a new payment system that is based not on use of resources or volume/intensity of services, but on **payment for the value** of the care delivered. The reformed payment system should hold physicians **accountable** for their quality and their cost-effective care.

The **American Medical Association** (AMA) has sponsored the Physician Consortium for Performance Improvement (PCPI or the **Consortium**), and the Consortium has taken the lead in developing measures to help improve **quality** in health care. To improve quality one must be able to measure it, and the AMA's Consortium has developed over 250 new quality improvement measures for physicians. The Consortium will continue to develop more measures that are helping to facilitate improvement as well as to measure and reward quality improvement.

Dartmouth research on variation in Medicare spending and quality of care has shown that there is a relationship between high quality and more efficient, cost-effective care. Unfortunately our current physician payment system rewards **more** tests and treatment

rather than the **right** tests and treatment. Physicians should be rewarded for keeping their patients healthy and out of the hospital. With the current payment system physicians who do a better job actually get paid **less**.

Paying for Quality

The Medicare program called **Physician Quality Reporting Initiative (PQRI**) is a failed attempt to reward physician quality, as only 16% of our nation's physicians participated, and only 8% of the nation's physicians succeeded with PQRI. Some physician leaders have labeled the PQRI program a "disaster". PQRI has had many problems including poor feedback and methodological problems. Many high quality physicians who participated in PQRI failed to earn the bonus not because they were low quality but because the reporting was too complex and contorted. PQRI doesn't actually reward quality, it only rewards reporting. Even the **lowest** quality physician could report to PQRI that they **never** did any quality improvement, and they would be rewarded by this failed program.

In contrast to PQRI, the Medicare quality rewards program for hospitals has been successful in promoting better quality and team work in care process improvement. Though PQRI has been a failure so far, I am in complete support of programs by Medicare to promote and reward physician quality.

A better way to reward physician quality would be to measure and reward teams, groups and systems. Individual physician measures are typically inaccurate because of attribution problems, and patients often see multiple physicians.

The **Iowa Medical Society** has collaborated with the **Iowa Hospital Association** since 2006 in the **Iowa Healthcare Collaborative** to continually measure, report, and improve the quality of all health care providers in Iowa. This collaborative and team effort is a great example for our nation of how to improve quality in health care.

Iowa has also had a tradition of primary care physicians taking responsibility for the coordination of comprehensive and continual care for their patients in a **medical home** type of model. The concept of a medical home "team based care" for patients is something Iowa's primary care physicians understand and hope will become recognized and rewarded because it is of **value** to the patient.

Quality Work is Team Work

Quality and patient safety initiatives have all used team, group, or system-based care. The emphasis in quality improvement is in **team work**, not **individual** physician or fragmented care.

Our health care system should do much more to promote and reward quality for **all** physicians and **all quality measures** in a group or system. Instead of picking out "bad apples" or "superstars" like the individually based PQRI reporting measures, we should

promote **team** and **system** improvements, raising the quality of care for the entire group or system, and benefiting more patients.

The current payment system needs reform. It does not reflect the expenses and work effort of rural physicians nor does it promote value. Changes are needed to bring about **geographic equity**, **reduce costs**, and **improve** the **quality and value** of our health care system. We hope our nation can learn about **the value of teamwork and accountability** from the high quality, highly efficient Iowa health care system.

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