

adjustment was made as a proxy for uncompensated care and asserted it was rather a generic measure to address the low practice expense per hour for emergency medicine. The specialty society commented that it would be difficult to design a supplementary survey to capture the needed data on the levels of uncompensated care.

Response: It is amply clear from reading our entire response in the November 2, 1998 final rule that we considered the adjustment to the indirect costs to serve as a proxy for the uncompensated care experienced by emergency medicine physicians. We believe that, if this adjustment is seen by the specialty as insufficient, the best recourse is for the specialty to undertake a supplementary practice expense survey. By working with our contractor, the Lewin Group, the specialty society should be able to modify the survey in such a way that more accurate data on uncompensated care could be obtained. The data from such a survey could then take the place of the current adjustment to the practice expense per hour for emergency medicine because a proxy for uncompensated care would no longer be needed.

Comment: We received comments from a provider of extracorporeal photopheresis therapy, CPT code 36522, requesting a refinement of the practice expenses of this service in the office setting. Believing this service to be undervalued, the commenter supplied a comprehensive listing of the direct inputs, for the labor, equipment and supplies deemed necessary for the provision of this in-office service. Of particular note among the various suggested supply items was the inclusion of a photopheresis procedural kit.

Response: We want to thank the photopheresis provider for the practice expense suggestions. At this time, we do not have sufficient information regarding the typical resources needed to proceed with a comprehensive refinement of the practice expenses for the in-office provision of photopheresis. However, in reviewing the commenter's various practice expense proposals, we were struck by the obvious absence of the photopheresis procedural kit in our supply database. Consequently, this kit has been added to our CPEP database on an interim basis. We note that there are general similarities between the commenter's proposed inputs for clinical labor and equipment and our current data. We would anticipate a future discussion regarding this service in order to fully refine the practice expense direct cost inputs for photopheresis.

B. Geographic Practice Cost Index Changes

1. Background

The Act requires that payments vary among Medicare physician fee schedule (MPFS) areas according to the extent that resource costs vary, as measured by the Geographic Practice Cost Indices (GPCIs). Section 1848(e)(1)(C) of the Act requires us to review, and, if necessary, adjust the GPCIs at least every 3 years. This section of the Act also requires us to phase in the adjustment and implement only $\frac{1}{2}$ of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, the second review was implemented in 1998, and the third review was implemented in 2001. As explained in the August 15, 2003 proposed rule, the fourth GPCI review and revision was scheduled for implementation in 2004. However, because the work and practice expense GPCIs rely primarily on special tabulations of U.S. Census data not yet available, review and revision of only the malpractice GPCI component would occur for implementation in January 2004.

2. Malpractice GPCI Proposal

The malpractice GPCI is the most volatile of the three indices with relatively large variations existing between geographic payment localities. We proposed using actual 1999 through 2002 malpractice premium data and forecasting the malpractice premium rates for 2003. We were unable to include proposed malpractice GPCIs based upon this revised malpractice premium data in the August 15, 2003 proposed rule because we were still in the process of collecting the data. We stated that the revised malpractice GPCIs published in this year's final physician fee schedule regulation would be considered interim and subject to public comment.

3. Collection and Review of Malpractice Premium Data

For purposes of the 2004 update to the malpractice GPCIs we collected actual malpractice premium data for years 1999 through 2001. For 2002 we were able to obtain actual malpractice premium data for 32 states plus Puerto Rico. Where actual malpractice premium data were obtained, premiums were collected from the 20 physician specialties with the largest share of total Medicare RVUs for 2002. Premiums were collected from those insurers with the largest market share and those insurers that when summed with other

large insurers comprised at least 50 percent of the state market share for claims-made policies with a \$1 million individual case limit and \$3 million aggregate case limit.

For those 18 states plus the District of Columbia for which we were unable to obtain actual 2002 premium data, we estimated the 2002 premium based upon an examination of growth rates from 1999 to 2001.

Malpractice premium data were not available for 2003. Two statistical approaches were examined to forecast 2003 malpractice premiums, simple extrapolation and projections based upon the average of historical year-to-year changes (mean rate of change). In most instances, the forecast 2003 premiums were similar using either approach. There was a tendency for the linear extrapolation method to yield slightly more extreme values (positive and negative) so the more conservative, mean rate of change approach was chosen.

Comment: Several commenters expressed concern about the continued use of proxy data, especially HUD residential rent data and nonphysician professional wage data, in the GPCI methodology.

Response: This final rule does not update the work or practice expense GPCIs. Any questions related to the use of proxy data in the calculation of the work and practice expense GPCIs will be responded to as part of future rulemaking.

Comment: One commenter stated that there should be no geographic differences under the physician fee schedule. This commenter felt that the data sources utilized for the construction of the locality specific GPCI indices do not accurately reflect legitimate differences in physician practice costs and that the current methodology did not appropriately reflect the variation that might be caused by case mix, availability of health care resources, and individual practice styles.

Response: Section 1848(e)(1)(A) of the Act requires that payments vary among areas as resources costs vary as reflected by the GPCIs. We agree that there will be some variation in case mix and practice styles between different specialties and individual practitioners. The physician fee schedule was established in 1992 to eliminate the large unjustifiable payment differences that existed among services, specialties, and geographic areas by establishing a national uniform payment system that can vary only as area resource costs vary as measured by the GPCIs. The GPCI component weights represent the