MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

Physicians Caring for Texans

July 29, 2009

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| The Honorable Henry Waxman | The Honorable Joe Barton |
| Chairman | Ranking Minority Member |
| Energy and Commerce Committee | Energy and Commerce Committee |
| 2125 Rayburn House Office Building | 2322A Rayburn House Office Building |
| Washington, DC 20515 | Washington, DC 20515 |

Dear Chairman Waxman and Congressman Barton:

As you proceed with consideration of HR 3200, the undersigned physician organizations urge you to oppose the Braley amendment or any similar efforts which would diminish the importance of geographic practice costs and other variables, such as socioeconomic factors and health status. We support the sections in the legislation creating an IOM study, as currently written, and believe that the final recommendations should be submitted directly to Congress for action. It is important to underscore that the current methodology recognizes regional differences in geographic practice costs which we believe are legitimate factors in calculating an accurate payment methodology. Our specific concerns are detailed below.

## Minority Medicare Patients Will Face More Barriers to Care

The Braley amendment would disproportionately harm access to care in our states by arbitrarily imposing significant Medicare physician reimbursement rate cuts. The value index does not take into account our states' inherently high costs to practice medicine (high office rents and nursing staff wages) and the low-income, racially and ethnically diverse patient populations our physicians serve. This amendment will drive physicians out of high cost states where our diverse Medicare patients are more difficult to treat and have already faced enormous barriers to care.

## Dartmouth Researchers Did Not Adjust for Practice Costs and Socioeconomic Status of Patients

While we agree that the Medicare program should be restructured to ultimately deliver more efficient care for Medicare patients, the proposed value index is seriously flawed. While the Dartmouth Atlas is a notable resource outlining variations in medical spending by region, it does not account for why the spending varies. A number of credible researchers have cast doubt on the magnitude of the geographic spending variations and the source of the variations as reported by

Dartmouth researchers. This year, Robert Berenson, MD (a former CMS Administrator) presented preliminary findings of the Urban Institute to the Ways and Means Committee which showed that variations in individual characteristics, particularly a patient's underlying health status, and a range of socioeconomic factors, including income and the presence of supplemental insurance, may account for almost all of the explainable geographic variation in spending. He stated, "There remains too much uncertainty about the Dartmouth findings to ground public policy on them."

The Dartmouth researchers did not take into account the practice costs in each region. For instance, in many of our states, physician rent charges are twice as high as the rural states. Once our states are adjusted for practice costs, they are some of the more efficient, low-spending regions in the country. A reimbursement methodology which fails to account for the costs of practicing medicine in a region, costs which are beyond a physician's control, will ultimately undermine our health care delivery system.

Moreover, our states have extremely diverse patient populations. Many low-income, ethnically diverse patients in our states have been uninsured until reaching Medicare age. There is a great deal of pent-up demand for services and overdue care. Numerous studies have concluded that for a variety of reasons, low-income, racially and ethnically diverse patients have a lower health status and can be more costly to treat. The disparities in care for these patients have been well-documented. Changing Medicare law based solely on cost data without a more thorough understanding of the socioeconomic factors could harm patients and penalize those who care for the most complex cases. This index creates more barriers to care for our most vulnerable patients.

The Congressional Research Service recently reviewed the value index proposal and concluded that "it could be viewed as failing to accurately reward high quality highly efficient providers… and could arguably introduce inefficient and questionable payment outcomes."

**<u>Proponent States have Higher Rates of Health Care Spending Growth</u>**

Finally, the proponents argue that "pay for value" is the best approach to "bend the cost curve" in U.S. health spending." This approach, which is based on level of spending, fails to account for the rate of growth, which many experts have agreed is a threshold issue. For example, while cities such as San Francisco, Boston, and Manhattan are considered high spending areas, their rates of growth are lower than the lowa spending regions. Minneapolis, MN has a health care spending growth rate of 4.3%; Rochester, MN 4.13% Marshfield, WI 4.02%; Milwaukee, WI is 3.6% and all of Iowa at 4.1% - all above the 3.5% average growth rate. In contrast the following "high spending" spending cities, have lower than average growth rates - San Francisco, CA 2.4%; Los Angeles, CA 3%; Boston, MA 3%; Albany, NY 3.5%, As currently drafted, we believe the amendment would harm these areas with a lower growth rate.

It is no coincidence that Los Angeles, Manhattan and Dallas – cities with the highest rents/practice costs and numbers of low-income minority patients in the country – are also three of the highest spending regions in the country. Yet their rates of health care spending growth are less than the states proposing the value index. Therefore, we would urge Congress to further study the geographic variations and focus reform efforts on the areas with highest rates of spending growth.

We support Congress' efforts to reform Medicare. However, the geographic variations in Medicare spending must be thoughtfully addressed. HR 3200, as introduced, starts this process in a responsible way. The bill calls for a report from the Institute of Medicine. There is also a 5% bonus payment for efficient physicians practicing in low-spending regions. And finally, the demonstration projects to incentivize physicians to coordinate and manage the care of their patients under a local spending budget will help to reward value and dramatically change the health care delivery system.

We urge you to resist amendments that could harm patient care in our states without more appropriate study as already called for in HR 3200.

Sincerely,

California Medical Association
Connecticut State Medical Society
Massachusetts Medical Society
Medical Society of the State of New York
Texas Medical Association