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September 22, 2009

The Honorable John F. Kerry
218 Russell Senate Office Building
Washington, DC 20510

Dear Senator Kerry,

I am writing on behalf of the 22,000 physicians, students and residents of the Massachusetts Medical Society to thank you for your staunch advocacy to achieve comprehensive health care reform that protects and promotes quality health care in the Commonwealth and throughout the nation. As you know the Massachusetts Medical Society shares your goal of passing appropriate comprehensive reform this year. This letter reiterates our concerns about some provisions in the "America's Healthy Future Act of 2009" which we believe will undermine quality health care and impede our goal of providing affordable, quality health care to all Americans. In general we support provisions to provide long over due insurance reforms, expand access to care through Medicaid and pay for prevention and wellness. We support your efforts to insure that these protections are strengthened to ensure that all Americans have access to affordable health insurance

As you are well aware, Massachusetts has empirical data on the harmful impact of several of the proposals being considered by the Finance Committee. We are acutely aware of the damaging impact of physician payment and quality profiling programs when they are done the wrong way. As a state that has proudly achieved nearly universal health insurance coverage, we struggle with the problems caused by physician's shortages – a problem that would only be exacerbated by a number of the proposals under consideration. And in a state where running any business, including a medical practice, is an expensive proposition, we oppose simplistic amendments that would merely redirect funds to other regions. These provisions do little to improve cost efficient care and would undermine the foundation of health care reform in Massachusetts.

Medicare Physician Payment Formula

It is crucial that national health care reform legislation eliminate the current physician payment formula and develop a new methodology to pay physicians appropriately. I know that you share our concerns on this issue. While the MMS appreciates that the mark will stop the impending 21% cut, we believe a permanent repeal of the SGR must be passed this year. We also support language to increase primary care and general surgery payments but oppose financing those increases at the expense of other physicians. It is inconceivable that Congress would pass health care reform without correcting this fundamental problem. We also oppose the proposed Medicare physician enrollment fee which could further deter participation in the program

Value Based Purchasing Program – Expansion of Physician Feedback Program – Amendment to Reduce Geographic Practice Costs

The MMS opposes a series of amendments to the bill which would mandate physician cuts based on variety of flawed methodologies. These cuts would be in addition to those mandated by the existing physician payment targets and the proposed new Medicare

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Commission, discussed below. The MMS agrees that physicians share a role in implementing cost efficiencies. Congress needs to develop a rationale approach to deal with these issues that is based on a valid, reliable, scientific methodology that can be used to teach physicians about this issue before using it as a basis for sweeping payment changes.

The MMS opposes Senator Cantwell's amendment to create a new value based physician payment methodology. While the Senator has modified the amendment to include a consideration of appropriate geographic variations, we remain concerned that it would implement dramatic changes in Medicare payment policy without adequate study and testing. The issue of regional variations in spending, the reasons for the variations, and the impact of those variations, require further analysis. Even the respected authors of the Dartmouth Atlas, which has sparked much of this interest, noted that their data was not meant to serve as the basis for payment reform. Of equal importance, an emphasis on spending, which does not take into account rate of growth in areas and socioeconomic factors will do little to improve our national cost efficiencies. For example, while Boston is considered a high spending area, the rate of the growth in spending is lower than the national average.

We also oppose Senator Grassley's amendment which would reduce by half of the impact of geographic practice costs based on the national average. In our state this would result in nearly a 15% cut to Medicare payments to physicians. There is no justification for this approach. While we support efforts to make certain that practice costs are accurately calculated in all regions, including rural, we cannot support efforts to devalue these real costs and their impact on physicians' practices when determining Medicare reimbursement. By definition, this amendment penalizes physicians who live in high cost regions and would exacerbate existing shortages in those areas.

It is important to underscore that Massachusetts has some of the highest practice expense costs in the nation with some of the lowest reimbursements. Physicians have no control over these costs which include rent and prevailing wages. This amendment jeopardizes the viability of their practices and will clearly affect access to care. Moreover, by merely reallocating these funds to other regions, the amendment does not save Medicare funds.

Expansion of the Physician Feedback Program

The MMS and our colleagues in other states have extensive experience with Episode Groupers which are the basis for the proposed Physicians Feedback Program. These state experiences have produced flawed, inaccurate information that cannot be verified by physicians or used to accurately review physician performance. Legally, the issues of inappropriate attribution and lack of accuracy for episodic groupers are at the core of the MMS lawsuit against the Massachusetts Group Insurance Commission. In California, Medicare agreed to destroy the data because of the flaws in their program using this methodology. Nationally, researchers at Rand, in work presented at the annual Academy Health research meeting, reported on empirical analyses that demonstrated serious methodological issues with using episode groupers to create physician cost profiles. At the simplest of levels, it is extremely difficult to insure the data is being attributed to the correct physician and is accurately risk adjusted. In Massachusetts we have scores of physicians who were assigned to the wrong specialty or to the wrong patient. The MMS has detailed a number of specific recommendations that are crucial to making episode groups useful. These include: the data must be accurate on all levels, accurately risk adjusted, shared with physicians who are allowed to make corrections before the information is released to any source, based on specialty specific measurements and based on a statistically significant number of cases to make the analysis meaningful. Given the difficulty that individual states

have had with this methodology it is difficult to believe that CMS will have the time and resources available to make this program work.

The MMS strong opposes using this information to publicly profile and penalize individual physicians. Our experience in MA shows that inaccurate information can mislead patients and malign physicians without improving the quality of care or reducing costs.

Independent Medicare Commission

The MMS opposes the creation of an independent Medicare commission charged with making recommendations on health care delivery reform, quality measurements and payment without sufficient Congressional oversight and involvement. To do so would allow Congress to abdicate its responsibility to Medicare beneficiaries and providers. Clearly the Commission is an entity designed to circumvent the thorough debate and analysis that is an essential, if not difficult, part of policy making.

It is important to point out that the combination of mandated cuts to physicians in the Senate Finance draft, including the Medicare feedback program, the value index, specialty payment reductions, the Medicare Independent Commission cuts and projected 25% SGR cut in 2011 will devastate Medicare physician participation in our state and others where access to doctors is already a significant problem. We encourage the Committee to develop a path to health care delivery system reform that is based on proven, successful models from around the country that work for patient and physicians in all models of practice. It is our hope that Congress will fulfill the promise of increased coverage by ensuring that all patients have access to a doctor.

Defensive Medicine

The MMS supports efforts to incent state to pass laws to reduce defensive medicine. In early 2008, the MMS conducted a first-of-its-kind survey showing that the practice of defensive medicine is widespread and adds billions of dollars to the cost of health care in the Commonwealth. These are conservatively estimated to cost a minimum of \$1.4 billion in Massachusetts alone. Nationally multiple studies have estimated the costs of defensive medicine to account for 8-15% of all health care costs or 190 to 360 billion dollars annually. The Massachusetts Medical Society supports models which build in the recommendations of the Joint Commission on the Accreditation of Hospitals and have been implemented successfully by such organizations such as the University of Michigan. These programs include patient safety protections, apology and full disclosure, root cause analyses and mediation with trial court as the last option. At the University of Michigan this model has reduced the number of open cases from 300 to 60; reduced the average case resolution time from 20 months to 8 months; and significantly reduced physicians' premiums as well as overall costs to the system. Perhaps most importantly, the culture has changed, with less pressure to practice defensive medicine. We also support efforts to insure that non-adherence to clinical guidelines should not be misconstrued to represent a deviation from the legal standard of care for the purposes of medical malpractice actions. While we encourage the practice of evidence based medicine, physicians must be free to make decisions that, in their clinical judgment, are in the best interests of an individual patient's care.

The members of the MMS appreciate the work that you have done already to address these concerns and we look forward to continuing our work together on these crucial efforts.

Sincerely,

Mario Motta, MD, FACC

Mario Motta, MD

cc: Senator Max Baucus
Ali Bonebrake