



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Institute of Medicine Study on Geographic Variations in Medicare

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Good Morning.

I am Dr. Alice Tolbert Coombs, a board certified internist, anesthesiologist and critical care physician, practicing in the southeast region of Massachusetts. I am affiliated at a number of urban and community based hospitals in Massachusetts. I am president of the Massachusetts Medical Society, the statewide professional association of 22,000 physicians and medical students, and have served in a leadership capacity for the American College of Chest Physicians, American Medical Association and National Medical Association. Perhaps most relevant to our discussions today, I serve on the AMA Commission to Eliminate Health Care Disparities and the AMA Minority Affairs Consortium Governing Council. I also served on the Massachusetts Special Commission on the Health Care Payment System. A copy of my complete curriculum vitae is available.

I would like to thank you for inviting me here today to speak on behalf of Massachusetts patients and physicians, to address the issues involving the geographic adjustment factors in the Medicare fee schedule and the impact on urban areas. We welcome a thorough and scientific analysis of the underlying methodology and data sources used to determine the geographic variables, as well as the impact of these factors on access to care. Our goal is to ensure that all our patients, including Medicare beneficiaries, have access to quality health care. To that end, our underlying objective is to preserve the viability of physician practices and to ensure that the Medicare payment formula accurately reimburses physicians for their fixed costs and for the value of the care they provide.

When the Institute of Medicine published “Unequal Treatment” in 2002, it provided unshakable proof of the existence of racial and ethnic health care disparities. Most importantly, it ignited the House of Medicine to eliminate these disparities. For this I thank you.

I believe there are two questions before us today:

- 1) How do we accurately determine and reimburse all physicians for their fixed practice costs?
- 2) How do we address issues impacting access to care?

We believe the Medicare physician payment formula can achieve both of these goals if done correctly.

I am going to address you today from my areas of expertise: as a practicing physician who cares for Medicare beneficiaries, as president of the Massachusetts Medical Society, and as an advocate for the underserved. This issue directly and dramatically impacts each of these constituencies. While my comments focus on Massachusetts, the issues I will document are relevant to all urban areas.

My testimony will focus on three main areas:

1. Data on the Massachusetts Physician Practice Environment
2. Impact on Access to Care for Patients in Urban Areas
3. Recommendations

I. The Massachusetts Physician Practice Environment

For nearly a decade the Massachusetts Medical Society has chronicled the costs of practicing medicine and the supply of physicians in our state. The facts are clear: The physician practice environment in Massachusetts has been consistently worse than the United States average and has declined 16 of the last 18 years. Stated otherwise, the cost of practicing medicine in Massachusetts, like many urban areas, is higher than the national average. At the same time, while operating costs are higher in Massachusetts, studies show that physician compensation is lower compared to the rest of the country. This is particularly significant in underserved areas, due to lower reimbursements through Medicare and Medicaid. The overall result is a crisis in access to care across our state due to physician workforce shortages, particularly in primary care.

The *2010 MMS Physician Practice Environment Index* shows that the cost of doing business is higher in Massachusetts compared to the United States, as evidenced by higher staff wages, more expensive office space, and higher medical malpractice insurance premiums.¹ This is not a recent phenomenon; between 1994 and 2009, Massachusetts practice expenses rose 95 percent, compared to 53 percent nationally. The difference between Massachusetts and the United States is even more pronounced when the average annual change in cost of doing business is combined with the average change in malpractice insurance costs. Specifically, combining the cost of wages, office space, medical supplies, and medical malpractice insurance premiums demonstrate that Massachusetts physicians experienced a 3.2% increase in the total cost of doing business between 2008 and 2009 compared to a 1.0% decrease for U.S. physicians.² Although medical malpractice insurance costs are specifically not part of this IOM study, we believe it is important to consider this calculation when crafting a payment formula that accurately reflects practice costs which vary regionally.

We have also found that wages for non-physician medical practice personnel are higher in Massachusetts than the national average. Current average hourly wage rates for practice personnel, including registered nurses, accounting specialists and secretaries, are approximately 25 percent higher in Massachusetts compared to the U.S., and over last 15 years have been rising in Massachusetts at a rate two to three times faster than the national average (see Table 1 below).

¹ 2010 MMS Physician Practice Environment Index.

² 2010 MMS Physician Practice Environment Index.

Table 1.

Average Hourly Wage Rates in Massachusetts and the US in 2009 and the Percent Increases for 1994 – 2009				
	Average Hourly Wage Rate		Percent Increase 1994 - 2009	
	MA	US	MA	US
Registered nurses	\$40.78	\$32.76	74%	43%
Accounting specialists	\$21.79	\$17.10	95%	34%
Secretaries	\$25.07	\$19.73	63%	33%

The *MMS Physician Practice Index* also provides detailed data on Massachusetts office space costs compared to the United States³. The most recent report found that average office space rental rates in Massachusetts are 17% higher than the United States average, or \$24.75 per square foot in the Boston metropolitan area, compared to the United States average of \$21.17. And while United States rental space costs decreased by 8.8% between 2008 and 2009, Boston's rate increased by 3.2% during the same period.

Rent and wages represent a significant portion of all Massachusetts and urban physicians practice costs. We estimate that overall rent and wages account for about fifty five percent of the costs for running a medical practice in Massachusetts.

It is critical to underscore that these are fixed costs over which a physician has **no control**—these are the embedded costs of doing business in our state. It is essential that this discussion be separated from an equally important but different study of health care costs related to utilization. We understand that the IOM will also be studying issues involving regional utilization and costs of care. We would welcome the opportunity participate in that study as well.

This information is consistent with recent studies which show that the overall Massachusetts business environment is more costly than national averages. A 2010 CNBC study showed that the cost of doing business in Iowa, Arkansas, Oklahoma, and South Dakota is lower than in more urban states such as Massachusetts, New Jersey, California and New York. The study included such costs as tax burden, including individual income and property taxes, business taxes, gasoline tax, and utility costs. The study also looked at the cost of wages and state workers' compensation insurance, as well as rental costs for office and industrial space.⁴ This issue also impacts

³2009 MMS Practice Environment Index citing data from Grubb & Ellis Company.

se⁴ CNBC. Retrieved on September 9, 2010 from <http://www.cnbc.com/id/37516039>.

physicians' ability to provide a competitive benefit package for their employees. Overall wages are higher in Massachusetts than in the rest of the nation. During 2009, the average annual pay for private sector wage and salary workers in Massachusetts covered by unemployment insurance laws was \$56,635, compared to only \$45,146 for all covered private wage and salary workers in the U.S. The average annual pay of Massachusetts wage and salary employees exceeded the national average by \$11,489 or 25.4% in 2009.⁵

Massachusetts Physician Workforce Shortages

Due to these economic conditions, physicians in Massachusetts currently face a difficult practice environment at a time when the state's health care reform has made near universal health care coverage a reality. These factors have contributed to physician workforce shortages and longer patient care wait times negatively impacting patient access to care.

According to data from the forthcoming the *2010 MMS Physician Workforce Study*, 10 specialties are in critical shortages: family medicine, internal medicine, dermatology, emergency medicine, general surgery, neurology, orthopedics, psychiatry, urology, and vascular surgery. Seven of these specialties are experiencing chronic shortages, having been in short supply for at least four of the last six years. These shortages are occurring in many urban areas of Massachusetts, including Worcester, Springfield, and New Bedford. As our colleagues from the AAMC would attest, urban teaching hospitals are also having a difficult time finding physicians to fill their workforce.

The negative impact of workforce shortages on access to care in urban areas can be measured by increasing waiting times to see a physician and increased visits to hospital emergency departments.

- Nearly half (49%) of Massachusetts internists are not accepting new patients and those that are report an average wait of 53 days for a new patient appointment.
- Nearly two-thirds (64%) of family medicine physicians are not accepting new patients and the average wait time for new patient appointments is 29 days.⁶
- Wait times for gastroenterology and OB/GYN physicians are over one month long. Increasingly urban areas are experiencing longer waiting periods with Boston, Los Angeles, Washington D.C., New York and San Diego patients reporting at least 24 days to get an initial appointment with a family practice physician.

⁵ The data source is the Quarterly Census of Employment and Wages, U.S. Bureau of Labor Statistics retrieved on September 9, 2010 at <http://www.bls.gov/cew/cewover.htm>.

⁶ 2010 MMS Workforce Study. Scheduled for publication in October 2010.

- On a related note, the Massachusetts Department of Health Care Finance and Policy found that there were 2.5 million outpatient emergency department visits in FY 2008 – up 10% from FY 2004.⁷ This is further evidence that the supply of physicians in Massachusetts is inadequate to meet the need for health care services in our area.

These shortages affect the quality of care both ambulatory and emergency coverage. For instance, it is critical to have a neurologist available for administration of important time limited interventions for strokes, particularly to administer TPA (clot buster) medication. We do not want to create a two tier system for urban medicine. Medicare patients suffer when optimal therapy is unavailable.

II. Impact on Underserved Populations

Our concerns about the failure of Medicare to accurately reimburse urban area physicians for their costs only deepen when we consider the impact on underserved populations such as Boston and parts of western Massachusetts⁸, where residents report higher rates of fair or poor health, including asthma and HIV/AIDS, compared to other parts of the state, and where physicians serve a disproportionate number of lower income residents and minority populations.

Misdistribution of Resources in Urban Areas

Residents of the Boston area depend on public insurance coverage at a significantly higher rate than other areas of Massachusetts. More than one in four (29%) Boston residents reported having Medicare, Medicaid, or state-subsidized coverage through the Commonwealth Connector, compared to 22% in the Western region, 17% in the Central region, 19% in the Northeast, 11% in the Metro west, and 13% in the Southeast.

The hardships of life in Massachusetts inner cities is underscored by the fact that 19% percent of Boston residents had income below the poverty level in 2008, including 37% of female-headed households with children under age 5. Thirty-seven percent of Latino adults had less than a high school diploma. The unemployment rate of Black males was 13%, almost three times the rate of White males (5%). Thirty-one percent of the Boston's homeless population last year were children.⁸

Such hardships continue when Boston-area residents seek services from our health care systems. The Massachusetts Division of Health Care Finance & Policy found that access to

⁷ Mass. Department of Health Care Finance and Policy: Emergency Department Volume by Hospital FY04-FY08. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/ED_Volume_2004-2008.pdf

⁸ Boston includes Boston, Brookline, Chelsea, Revere, and Winthrop.

primary care; particularly for low-income residents is already an issue as evidenced by the following⁹:

- In 2010, 40 areas in Massachusetts were categorized as medically underserved areas¹⁰. One in four of these underserved areas are located in Boston.
- One in five Boston residents reporting difficulty obtaining appointments for primary care when needed. Problems obtaining care related to both access to providers and health care costs were more common in Boston.
- Overall, Massachusetts residents with public insurance are more likely to have difficulty obtaining health care.

Inner City Minority Populations

- In 2008, approximately 27% of Boston residents were foreign-born, originating from a wide array of countries such as the Dominican Republic, China, and Haiti. This diverse population has brought with it fluency in a variety of languages including Spanish, French, Chinese, and Vietnamese.
- The percentage of Latino residents in Boston has continued to increase from 6% in 1980 to 16% in 2008. Of residents, who identified as Latino, 31% noted their specific origin as Puerto Rico and 27% noted their specific origin as Dominican Republic.¹¹⁾

Incidence of Poor Health in Inner City Areas

For the purposes of these comments I will focus on two chronic health care conditions prevalent in underserved areas: Asthma and HIV/AIDS. In 2009 Boston had the highest percentage of adults reporting a fair or poor health status at 17% compared to all other Massachusetts regions as well as compared to Massachusetts overall (15%).

⁹ Sharon K. Long and Lokendra Phadera. Urban Institute. *Barriers to Obtaining Health Care among Insured Massachusetts Residents*. May 2010. Prepared for the Massachusetts Division of Health Care Finance & Policy.

¹⁰ Note: Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.

Asthma

From 2005 – 2007, the three-year average rates of hospitalization due to asthma were not evenly distributed among the Community Health Network Area's (CHNA) in the state. The CHNA's with a rate higher than the statewide rate (14.1 per 10,000 residents) were:

- CHNA 25: Partners for Healthier Communities (Fall River) (29.3 per 10,000)
- CHNA 19: Alliance for Community Health (Boston/Chelsea/Revere/Winthrop) (25.5 per 10,000)
- CHNA 26: Greater New Bedford Community Health Network (22.5 per 10,000)
- CHNA 22: Greater Brockton Community Health Network (19.0 per 10,000)
- CHNA 8: Common Pathways (Worcester) (16.6 per 10,000)
- CHNA 4: The Community Health Connection (Springfield) (16.1 per 10,000)
- CHNA 5: Community Health Network of Southern Worcester County (16.0 per 10,000).
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HIV/AIDS:

- Although one-third (32%) of people living with HIV/AIDS were living in the Boston Health Service Region as of December 31, 2009, just 12% of all Massachusetts residents were living here in 2000, according to the US Census.¹²
- Communities of color have been disproportionately affected by HIV/AIDS in Massachusetts since the beginning of the epidemic. While only 6% of the Massachusetts general population are black (non-Hispanic) and another 7% are Hispanic, 28% of people living with HIV/AIDS in Massachusetts are black (non-Hispanic) and 25% are Hispanic. People of color are affected by HIV/AIDS at levels disproportionate to their representation in the population at all disease stages from diagnosis of HIV infection to death with HIV/AIDS.¹³
- Communities with high rates of HIV infection diagnosis are also urban areas with large minority and/or underserved populations (see table below):

¹² Massachusetts Department of Public Health Office of HIV/AIDS. 2009. *Massachusetts HIV/AIDS Data Fact Sheet. Who is currently living with HIV/AIDS?*

¹³ Massachusetts Department of Public Health Office of HIV/AIDS. 2008. *Massachusetts HIV/AIDS Data Fact Sheet. Communities of Color.*

Table 1. Twenty cities/towns in Massachusetts with the highest rate of HIV infection diagnosis: average annual rate per 100,000, 2005–2007 and average number per year¹⁴

Rank	City/Town	Average Rate per 100,000	Average Number
1	Provincetown	301.2	10
2	Boston	35.8	211
3	Holyoke	32.6	13
4	Springfield	30.9	47
5	Lawrence	24.5	18

1 Cities with fewer than 5 average annual HIV infection diagnoses from 2005–2007 are excluded
2 Reflects year of HIV infection diagnosis among all individuals reported with HIV infection, with or without an AIDS diagnosis

Data Source: MDPH HIV/AIDS Surveillance Program (percentages may not add up to 100% due to rounding), data as of 1/1/09

- HIV/AIDS prevalence rates per 100,000 were about 2.5 times higher in Springfield and more than three times higher in Boston compared to Massachusetts.¹⁵ See table below.

HIV/AIDS prevalence rate on 12/31/09	Rate per 100,000	Number of people living with HIV/AIDS
Springfield, Mass.	735.1	1,118
Boston, Mass.	906.2	5,339
Massachusetts Total	284.2	18,045

Saving money by cutting physician reimbursements in urban areas is short-sighted given that it may, not only disrupt access to care and worsen health disparities, it may also increase long-term costs. For example, according to a recent study by the Joint Center for Political and Economic studies, “eliminating health disparities for minorities would have reduced direct medical care expenditures by \$229.4 billion between 2003 and 2006. Costs are based on direct costs associated with the provision of care to a sicker and more disadvantaged population, as well

¹⁴ Massachusetts HIV/AIDS Data Fact Sheet. What is the geographic distribution of the HIV/AIDS epidemic in Massachusetts? June 2009. Massachusetts Department of Public Health Office of HIV/AIDS

¹⁵ Regional HIV/AIDS Epidemiologic Profile of Massachusetts: 2010. Retrieved on September 13, 2010

as the indirect costs of health inequities such as lost productivity, lost wages, absenteeism, family leave, and premature death.”¹⁶

III. The Role of the Geographic Adjustment Factor in Medicare: Our Experience and Recommendations

For several years the Massachusetts Medical Society has been engaged in a legislative debate over how to accurately calculate the geographic practice cost index and other geographic adjustment factors as part of the Medicare fee schedule. As you know, in 2003 Congress agreed to establish a work Expense GPCI floor of 1.0 to assist rural areas. Congress made this decision in an effort to increase access to care in rural areas. The MMS and other urban based state medical societies supported that change in the hopes it would help our physician colleagues and improve access to care. Over the past several years Congress has agreed to several interventions and payment increases to address access problems in rural areas. This summer we commented extensively on CMS’s proposed rules regarding the 2011 Medicare Physician Payment Fee Schedule which proposed significant changes to the calculation of the Medical Economic Index and the geographic adjustors. (MMS Comments attached). The problem we are now faced with is increasing pressure to discount the costs of practicing medicine in urban areas in an effort to continue efforts to improve access in rural communities. I believe this dynamic is in part a function of the Medicare’s mandated budget neutrality and flawed payment methodology. As you are also well aware only 34% of the Medicare fee schedule is adjusted currently for practice costs in a region. And, as my earlier comments detail, physicians and patients in urban areas, which include the entire state of Massachusetts, are now facing increased access problems with well documented shortages in physician workforce. So that we now find ourselves working with a Medicare payment formula that does not accurately reflect the basic costs of practicing medicine in Massachusetts and a policy which ignores, if not harms, increasing access problem in urban areas.

From our perspective, the Medicare payment formula needs to accurately and precisely account for the varying practice costs in regions. Geographic cost variations are real and must be reflected in both Part A and Part B Payments. Although well intended, we do not believe altering the calculation of practice costs adjustors should be used to further policy goals. The geographic adjustors are critical to provide an accurate and precise baseline of the cost of practicing medicine in each region. Given that most private payers follow the Medicare fee schedule, it is critical that these real costs are reflected in the reimbursement methodology.

At the same time we support including other enhancements in the Medicare payment formula to support policy objectives such as increasing access to care and addressing practitioner shortages. For example, we support new financial supplements to increase payments to areas

¹⁶ LaVeist TA, Gaskin DJ, Richard P. September 2009. *The Economic Burden of Health Inequalities in the United States*. Joint Center for Political and Economic Studies.

with physician shortages. Congress could also consider methods to reimburse for other factors such as the time spent traveling between hospitals and practices for physicians in rural areas. We believe that the Medicare fee schedule can be a useful tool to address problems in both rural and urban areas without distorting the actual costs of providing care in these areas.

Clearly much of this debate also has been about the accuracy of data sources. We support the recommendation from Dr. Larry deGhetaldi, my colleague from the California Medical Society and a recognized expert in this area. At a minimum we believe there must be a scientifically and statistically valid data source that includes verified and current data. We do not support using data sources which are based on voluntary disclosures, are not scientifically valid and represent a limited sample size.

As we meet today I also want to underscore Dr. deGhetaldi's comments that these discussions are taking place at the same time that we are all examining the development of new delivery systems and payment methodologies. I was honored to serve on the Massachusetts Special Commission on the Health Care Payment System. A key point in our discussions focused on the imperative need to support and build the infrastructure to help physicians transition to new delivery system models. Our ability to accurately and precisely account for and support the costs of building and maintaining the infrastructure of physicians' offices will be even more critical to our future success.

As you deliberate, please consider the impact of Medicare funding on physicians who are committed to taking care of urban and underserved patients, the increasing financial burden on providers who possess social accountability and choose to care for the less fortunate. Maldistribution of resources in urban states is a reality.

In conclusion:

1. The cost of practicing medicine in Massachusetts is unequivocally higher than the national average. This has contributed to chronic physician workforce shortages and reduced access to primary care physicians and other medical subspecialties across our state.
2. Massachusetts inner cities, which are heavily populated by the medically underserved and minorities, are currently in a fragile state. Failure to recognize the basic costs of doing business will further erode physicians' ability to practice medicine, and negatively impact the health status of inner city patients, their access to care, and the availability of physicians to care for them.
3. The Medicare Physician Payment formula must accurately and precisely reflect the real costs of providing medical care in a region. Congress should consider other enhancements to address policy issues such as access to care and workforce shortages. Our responsibility to ensure access to quality care applies to all Medicare beneficiaries and should not juxtapose one group against the other.

The Massachusetts Medical Society looks forward to working with the IOM on this and other deliberations to help improve access to quality healthcare for all.