

**THE CALIFORNIA MEDICAL ASSOCIATION  
THE MASSACHUSETTS MEDICAL SOCIETY  
THE TEXAS MEDICAL ASSOCIATION**

September 21, 2009

The Honorable Maria Cantwell  
511 Dirksen Senate Office Building  
U.S. Senate  
Washington, D.C. 20510

RE: Amendment #D-1 Value Modifier to America's Healthy Future  
Act of 2009  
Senate Finance Committee

State Medical Assoc Position: Oppose-Recommend Further Study and  
Demonstration



Dear Senator Cantwell:

We are writing to express our concern about your Value Modifier amendment to the Chairman's Mark, America's Healthy Future Act of 2009.



**MASSACHUSETTS  
MEDICAL SOCIETY**

While we appreciate your changes to the Medicare Value Index proposal to ensure that any new "Value Modifier" be adjusted for geographic differences in input practice costs as well as demographic characteristics and health status, we remain concerned that it would implement dramatic change in Medicare payment policy without adequate study or testing. It could result in major payment cuts to physicians in our states where seniors already struggle to find physicians. We concur with you that the Medicare program should be restructured to deliver more efficient care. However, the Senate also must take care not to adopt policy that will drive physicians out of high-cost regions and further exacerbate access to care for already vulnerable poor and minority patients in our states.



We believe the approach in HR 3200, which calls for an Institute of Medicine study, is the appropriate first step to understanding all of the reasons for the geographic variation in spending across our country. These reasons need to be understood before radical new payment policy is adopted. Moreover, such a change should be pilot tested so that the impact is well known prior to implementation.

We also believe that the amendment discriminates against solo and small-group physicians in all regions of the country who are providing high quality low-cost care.

At the very least, amendments are needed to specify that the value modifier be adjusted for “regional” differences in input practice costs as well as “regional” demographic characteristics, which include income, race/ethnicity, percent of uninsured, as well as age and sex. Moreover, the modifier incentive for medical groups is duplicative of the Accountable Care Organization model incentives in this legislation and should be eliminated.

We believe the goal should be for all physicians to be paid for providing quality, cost-effective care regardless of their mode of practice. And finally, under the amendment, we believe any permanent plan adopted by Congress should be subject to the same adjustments and protections outlined in the payment formula for 2011. Therefore, paragraph four is not necessary.

It is also 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, the specialist payment reduction, the Independent Commission’ cuts and a projected 25-percent SGR cut in 2011, will devastate Medicare physician participation in states where access to doctors is already a significant problem. Our states are facing serious future physician shortages. Instead, we urge the Committee to set a path to health care delivery system reform that is based on proven, successful models from around the country that work for patients and physicians in all modes of practice. Congress must fulfill the promise of increased coverage by ensuring that all patients have a doctor.

We thank you for your consideration of these issues.

Sincerely,

Dev GnanaDev, MD, President  
California Medical Association

Mario Motta, MD, President  
Massachusetts Medical Society

William H. Fleming III MD, President  
Texas Medical Association