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Data Fuel Regional Fight on Medicare Spending

By [ROBERT PEAR](#)

WASHINGTON — For years, health policy experts have said health care spending is much higher in New York City and Boston because doctors and [hospitals](#) there provide more services, practicing medicine in a more intensive way.

But new government data show that [Medicare](#) costs per patient in those cities are slightly below the national average when the numbers are adjusted for the cost of living and other factors.

The new numbers add fuel to a raging debate over what Congress should do to reduce geographic disparities in Medicare spending. The debate involves a combustible mix of health policy and money.

As part of any bill to revamp health care, [President Obama](#) and Democratic leaders in Congress say they want to reward doctors and hospitals for providing higher-quality, lower-cost care. But their efforts have touched off a fight within the [Democratic Party](#), pitting urban lawmakers against rural lawmakers and creating a major new hurdle for health legislation.

Mr. Obama says the nation could save huge sums if all doctors and hospitals were as efficient as those in lower-cost states like Iowa, Minnesota, Washington and Wisconsin. Lawmakers from those states have reached an agreement with House Democratic leaders that would increase federal Medicare payments to health providers in their states. Higher-cost states, which could see their Medicare payments reduced, are fighting back.

Dr. Denis A. Cortese, president of the [Mayo Clinic](#), based in Rochester, Minn., said Medicare wasted billions of dollars a year because it “pays the most to health care providers and geographic areas that provide the lowest-

quality care at the highest costs.”

But Dr. Steven M. Safyer, president of [Montefiore Medical Center](#) in the Bronx, said: “Our Medicare expenditures reflect the low socioeconomic status of the population and the very high cost of doing business here. Many of our patients do not receive regular care before becoming eligible for Medicare and have no one to care for them after they leave the hospital. Our construction costs and wages are also much higher than the national average.”

The Medicare Payment Advisory Commission, an independent federal panel that advises Congress, has found that geographic variation in Medicare spending is substantial. But it told Congress recently that much of the variation could be explained by local differences in the cost of providing care and in the health status of beneficiaries, as well as by extra payments, authorized by Congress, for hospitals that train doctors or treat large numbers of low-income patients.

After adjusting for those factors, the commission said, Medicare payments per beneficiary were 92 percent of the national average in New York City and 95 percent of the national average in Boston.

Under federal law, Medicare payments reflect local labor costs, office rents and similar expenses. Health status is also important, the commission said, because areas with sicker beneficiaries tend to use more services than areas with relatively healthy beneficiaries.

The agreement with House Democratic leaders is to be incorporated in legislation that goes to the House floor. The plan calls for studies by the [National Academy of Sciences](#) and action by the secretary of health and human services to reduce geographic disparities in Medicare spending. The goal is to base payments on “value,” defined as the efficient delivery of high-quality care.

Among those who championed these changes are Representatives Bruce Braley of Iowa, [Jay Inslee](#) of Washington and Ron Kind of Wisconsin, all Democrats, as well as the Mayo Clinic and the Marshfield Clinic, in Wisconsin. They contend that Medicare has shortchanged their areas, where Medicare spending is relatively low but the

quality of care is high.

“In 2006, Medicare spent \$6,671 on the average beneficiary in Waterloo, Iowa, compared with \$16,351 in Miami,” said Mr. Braley, who lives in Waterloo.

Representative [David R. Obey](#), Democrat of Wisconsin and chairman of the House Appropriations Committee, recently told the administration, “These reimbursement disparities are outrageous.”

Dr. Karl J. Ulrich, president of the Marshfield Clinic, said Medicare’s payment system rewarded inefficiency and poor quality while punishing places like Marshfield for their “conservative medical practices.”

The federal [Agency for Healthcare Research and Quality](#) uses more than 100 measures to assess how well states do in treating [cancer](#), heart disease, [diabetes](#) and other conditions. In the agency’s latest report, Wisconsin and Minnesota were listed as the “best-performing states,” while Louisiana and Mississippi had the lowest overall scores.

In an e-mail message describing how Mr. Braley had brokered the agreement with House leaders, his legislative director, Michael T. Goodman, said, “This is a tremendous success for Iowa.”

House Democratic leaders desperately need the votes of moderate Democrats from rural areas, like Representative Earl Pomeroy of North Dakota. In the Ways and Means Committee in July, Mr. Pomeroy voted against the health care bill, saying it would not correct the underpayment of hospitals in his state.

The agreement with House leaders has provoked alarm among some lawmakers and health care executives in urban areas.

Representative Joseph Crowley, Democrat of New York, said: “We are a high-rent, high-wage area. We are treating a poorer clientele. Patients come to the hospital in later stages of illness. The outcomes won’t be as good as when you have a healthier clientele to begin with.”

Dr. Darrell G. Kirch, president of the Association of American Medical Colleges, said the proposed redistribution of Medicare money could have “catastrophic unintended consequences” for teaching hospitals and their patients.

Some health policy experts say that when doctors invest in hospitals, they have financial incentives to perform more tests and procedures, driving up costs.

“The profit motive may contribute to overuse of health care in some regions,” Dr. Safyer said. “But at Montefiore, the vast majority of our physicians are employees on salary and are not rewarded for doing more.”

In paying doctors, Medicare recognizes 89 localities. Some cover entire states; others cover some counties within a state.

Mr. Kind and Mr. Braley laid out their objectives in [a bill](#) they introduced in June, several weeks before the agreement with House Democratic leaders. The bill, like [one offered by Senator Amy Klobuchar](#), Democrat of Minnesota, would inject a new factor into the calculations, a “value index,” defined generally as the ratio of quality to cost in an area.

A study by the nonpartisan Congressional Research Service suggested that the proposal “would not accurately identify and reward” individual doctors.

Indeed, it said, under the proposal, Medicare might penalize efficient doctors providing high-quality care just because they were in a region where per capita spending was high and the quality of care, on average, was low.

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