

**\*\*THIS TESTIMONY IS EMBARGOED UNTIL 2:00 PM ON  
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Testimony

Before the Subcommittee on Health,

Committee on Ways and Means,

House of Representatives

**CONGRESS SHOULD NOT EXTEND EXPIRING EXCEPTIONS  
TO MEDICARE PAYMENT POLICIES WITHOUT  
COMPELLING EVIDENCE BASED ON BENEFICIARY NEED**

Statement of A. Bruce Steinwald

President, Bruce Steinwald Consulting

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Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to participate in your hearing on expiring Medicare provider payment policies. I am Bruce Steinwald, head of a small consulting practice consisting of myself and a home office where I prepared this statement. I also serve as a member of the Institute of Medicine's (IOM) Committee on Medicare's Geographic Payment Adjustments and as co-chair of the National Quality Forum's (NQF) Steering Committee on Health Care Resource Measures. Until early last year I was with the Government Accountability Office (GAO) Health Care Team. I directed many health care -related studies and testified before this committee and other congressional committees on Medicare payment and health care spending issues.

I have held several positions both inside and outside of government for decades, including serving as Deputy Director of ProPAC, one of the Medicare Payment Advisory Commission's (MedPAC) forerunners, in the 1980s. I became a health economist about the same time that Medicare was enacted in the mid-1960s and now I am a Medicare beneficiary myself. I feel very strongly about getting Medicare on a sustainable path, not only for my own benefit but also for the sake of future beneficiaries and current and future taxpayers.

My remarks today consist of three principal parts: first, a brief statement about the severe financial situation that the Medicare program faces as backdrop to any discussion of Medicare payment policy; second, reasons why Congress should be very cautious about extending exceptions to Medicare's payment rules; and third, specific examples pertaining to selected Medicare payment policies. My remarks are confined to fee-for-service payments under the traditional Medicare program and exclude discussion of Medicare's Sustainable Growth Rate policy pertaining to the physician fee schedule.

**Affordability Should Be an Important Factor in Medicare Payment Policy.** As you well know, Medicare has a huge spending problem. Because the links between Medicare spending and our deficit and national debt problems have

been well established by CBO and others, I will not go into the details here.<sup>i</sup> However, I believe that the unsustainability of current levels of Medicare spending needs to be kept in mind in all discussions of Medicare payment policy, including the issue before the Subcommittee today. For years we have used criteria such as quality of care, beneficiary access to services, provider equity, and, more recently, value of services to guide Medicare payment policy discussions. In light of Medicare's spending problem, I believe we should include another criterion in all such discussions – affordability.

**Congress Should Be Reluctant to Extend Exceptions to Medicare's Payment**

**Rules.** Congress should be very skeptical about extending exceptions to Medicare's payment policies for three reasons:

First, extenders, as they are called, are costly. Individually, they may not appear expensive given Medicare's overall level of spending, but when added up, as indicated in the Chairman's hearing advisory, their combined level of spending totals more than \$2.5 billion per year. The Chairman also pointed out that Congress has frequently changed the expiration date without much analysis or debate. Consequently, the actual budgetary cost of the extenders is far more than their one-, two-, or three-year lifetimes. If you look at the extenders as a group and consider them as permanent changes rather than temporary, and evaluate their budgetary impact as you would potential new legislation, their impact in a ten-year budget window would be \$25 billion, not \$2.5 billion. Even that is an underestimate considering that many of these policies have a lifetime more than ten years.

Second, exceptions and their extensions tend to undermine the integrity of Medicare's payment systems. Since the creation in 1983 of the hospital Inpatient Prospective Payment System (IPPS), Congress has worked very hard to replace inflationary cost reimbursement with formula-based payments that vary according to patient condition and provider costs of doing business. These formulas permit providers to know in advance what they will get paid for a particular service so that they can manage their costs to prosper, or at least survive, within Medicare's contribution to their bottom lines. Exceptions tend to undermine providers' incentives to be as efficient as possible. Further, if one

provider or group of providers obtains an exception, other providers quite naturally say, “Where’s my exception?” At the same time, those who obtain exceptions become dependent on them, leading to the ongoing demand to extend them indefinitely. I believe Congress should encourage Medicare providers to improve their efficiency rather than seek exceptions to Medicare’s payment rules.<sup>ii</sup>

Third, exceptions tend to exacerbate the incentives in Medicare’s fee-for-service payment systems to drive volume and complexity of services upward. I have been impressed (or depressed) over the years with the strength and dependability of these incentives to increase Medicare spending per beneficiary.<sup>iii</sup> Medicare’s payment formulas have a limited number of checks and balances to ensure that the services it pays for are “reasonable and necessary” for patient care. It makes little sense to further weaken these restraints on spending by fostering exceptions to Medicare’s payment rules.

**When is an Exception or Extension Justified?** Given these reasons for restraint, it is natural to ask when, if ever, an exception or its extension is warranted. I believe that two conditions should be met. First, there should be compelling evidence that a substantial beneficiary interest is at stake. By “compelling,” I mean that the evidence of should be clear that providers cannot furnish adequate access or quality of services to Medicare beneficiaries without an exception or its extension. By “substantial,” I mean that the beneficiary need should be widespread and not just isolated, atypical cases. Given Medicare’s financial situation, I believe the bar should be set very high for providers to demonstrate compelling evidence of a substantial beneficiary need in extending an exception to Medicare’s payment policies.

Second, if a demonstrable problem exists, can it be rectified through an improvement in the payment formula rather than through an exception? The accuracy of many of Medicare’s payment formulas can be improved with better methods and data. It is far more preferable to update these formulas periodically, making them more accurate for providers as a whole, than to grant some providers exceptions to an imperfect payment system. I will say more

about the need to improve payment systems in my discussion of the hospital wage index below.

**Medicare Needs Savings, Not Offsets.** Before going on to examples, let me say a word about offsets. Given the choice, I would prefer that the Congress find offsetting savings if it decides to extend a payment policy exception, compared to an increase in spending. But Medicare needs savings more than it needs offsets. The Congressional Budget Office, among others, annually publishes a report detailing potential options to reduce Medicare spending and the consequences of failing to do so.<sup>iv</sup> If there are ways to achieve savings, by all means take them and reduce Medicare's contribution to the deficit. The availability of offsets, however, should not reduce your skepticism about the continued need for these costly extenders.

**Several Examples Illustrate the Difficulties Created by Payment Exceptions and Extensions.** Certain of the payment exceptions and extenders due to expire are illustrative of the dilemma they create for policy makers seeking to rein in excessive Medicare spending. I will cover a few of these policies as examples, but it should be understood that the difficulties they create pertain to all such policies, not just those mentioned below.

***Improving the accuracy of the hospital payment formula could eliminate the need for Section 508 and other exceptions to the Hospital Wage Index.*** The IOM committee to examine the geographic payment adjustments in Medicare's fee-for-service payment formulas took a fresh look at the Hospital Wage Index adjustment, which was instituted in 1983 when the hospital PPS was created. Since then, many hospitals have been reclassified for payment purposes and many other types of exceptions have been granted, including the Section 508 provisions due to expire October 1, 2011. At present, fully 37 percent of hospitals are paid under exceptions to the basic payment formula. The IOM Committee made several recommendations to improve the accuracy of the payment adjustments, including a refined process for "smoothing" the differences in payments to hospitals that lie on different sides of geographic boundaries.<sup>v</sup> The

Committee concluded that if these improvements were made, the need for most, if not all, of the reclassifications and exceptions would disappear. This is the best example of the case for improving a payment system rather than piling exception on top of exception until the integrity of the payment formula is dangerously undermined.

Not surprisingly, IOM Committee expects that its recommendations will be met with some resistance from hospitals that would do less well under a more accurate system of payment adjustments than under a continuation of whatever exceptions they have been granted. Almost all of the Committee's recommendations would require new legislation. Exceptions like the Section 508 policy create constituencies for their continuance and expansion, and that works against efforts to improve the payment systems as an alternative to extenders.

***Many rural provider provisions undermine payment formula integrity.*** Many of Medicare's exceptions and extenders appear to be designed to prop up payments to rural providers. These provisions include ambulance add-on payments, pathology and clinical laboratory payments, outpatient hold-harmless payments, and payment floors in both the hospital and physician fee schedule geographic adjustments. I believe that the Congress should be skeptical about the need to increase payments to rural providers and apply the criterion I'm suggesting of a "compelling and substantial beneficiary need." In addition, I believe it is harmful to alter payment formulas to, for example, improve beneficiary access to care in rural areas. If subsidies are needed to improve access, and I am not convinced they are, it would be much better to address the matter directly rather than undermine the integrity of Medicare's payment formulas. Imposing floors in the geographic adjustments, in particular, makes no sense. It not only perpetuates a Lake Wobegon-like world in which no one can be below average, it also reduces the accuracy of payments to all providers because of the need to readjust all provider payments in order to "pay for" the floors. Although there are ways to improve the accuracy of the payment formulas, floors and other exceptions, if extended, tend to reduce the value of such improvements.

***Medicare needs a payment system for outpatient therapy.*** Several years ago, in response to a mandate in the Medicare Modernization Act of 2003, GAO

conducted a study of outpatient therapy services – physical therapy, occupational therapy, and speech-language pathology services.<sup>vi</sup> Congress had established per-person spending limits (“caps”) in 1997 in response to rapid spending increases, but then placed a moratorium on the caps for several years. GAO recommended that, while the Centers for Medicare & Medicaid Services (CMS) worked on the development of an outpatient therapy payment system, it develop an interim process for granting exceptions to the caps. A process was put in place and today such exceptions are routinely granted, and the process routinely extended. What’s missing is a payment system that bases limits on outpatient therapy on individual patient condition, which GAO recommended in 2005. Without such a system, Congress is faced with the prospect of extending an expensive policy without knowing whether, and to what extent, additional services are “reasonable and necessary” or simply add to Medicare’s spending problem.

***Medicare should not pay twice for the same services.*** Another congressionally-mandated study by GAO examined the widespread exception to the hospital PPS payment rules that allows laboratories that provide outsourced pathology services to bill Medicare directly.<sup>vii</sup> Because the PPS payment is supposed to cover all of a patient’s services, this exception constitutes double payment for the outsourced services. GAO could find no evidence of an effect of this policy on beneficiary access to services and recommended its discontinuance in 2003. Like many others, however, this policy has been extended multiple times.

**Congress Should Encourage CMS to Improve Its Payment Systems and Providers to Become More Efficient Rather than Grant and Extend Exceptions.** The examples cited above as well as others not discussed today make me very skeptical about the need to grant and extend exceptions to Medicare’s payment systems. The extenders are not only expensive in their own right, but also have the unintended consequence of undermining the integrity of the payment formulas and exacerbating the incentives of fee-for-service payment to drive volume and spending upward. I believe that Congress should apply a high standard in determining which, if any, of these policies are both affordable and meet a compelling beneficiary need.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or Subcommittee members may have.

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<sup>i</sup> See, for example, Elmendorf, D. “Confronting the Nation’s Fiscal Policy Challenges,” Testimony before the Joint Select Committee on Deficit Reduction, U.S. Congress, September 13, 2011.

<sup>ii</sup> Providers often assert that Medicare payments are inadequate to cover their costs, but see Anderson, G., et al., “It’s the Prices Stupid: Why the U.S. is so Different from other Countries,” *Health Affairs*, Vol. 22, No. 3, 2003, pp. 89 – 105, and Laugesen, M.L., and Glied, S.A., “Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries,” *Health Affairs*, Vol. 30, No. 9, 2011, pp. 1647 – 56, for evidence that providers are paid more in the United States for similar services than in other countries.

<sup>iii</sup> See, for example, Government Accountability Office, “Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices.” Washington, DC: GAO, 2008, which presents evidence on the relationship between fee-for-service incentives and expenditure growth. See also Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care Delivery System,” Washington, D.C., June 2011, and MedPAC’s prior annual March and June reports to the Congress for discussions of how fee-for-service incentives drive health care spending.

<sup>iv</sup> Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options.* Washington, D.C.: CBO, March 2011.

<sup>v</sup> Institute of Medicine, “Geographic Adjustment in Medicare Payment: Phase I: Improving Payment Accuracy.” Washington, D.C.: The National Academies Press, 2011.

<sup>vi</sup> Government Accountability Office, “Medicare: Little Progress Made in Targeting Outpatient Therapy Payments to Beneficiaries’ Needs.” Washington, D.C.: GAO, November 2005.

<sup>vii</sup> General Accounting Office, “Medicare: Modifying Payments for Certain Pathology Services Is Warranted.” Washington, D.C.: GAO, September 2003.