Hearing on Ideas to Improve Competition in the Medicare Program

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IMPROVING COMPETITION IN MEDICARE:
REMOVING MORATORIA AND EXPANDING ACCESS

Tuesday, May 19, 2015
House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:59 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding.

Chairman Brady. Welcome to today's hearing on improving competition, within the important Medicare program. This is the first in a series of hearings this summer and fall on identifying solutions to saving Medicare for the long term. Today we are going to explore how much competition exists in Medicare, its impact, its benefits and savings for Medicare patients, as well as potential for improving Medicare access in choices through more competition.

We are also going to hear about two ideas to make Medicare more responsive to seniors' needs, while also driving down costs and expanding access. Competition is a good thing, it drives down costs and increases access while improving quality. Most importantly it empowers consumers. Competition and the choices it offers is how we discover information on the prices and quality.

It gives families the power to decide what they want to buy and how to stretch their dollars further. Competition is a critical component of virtually every sector in our economy save one, Medicare. While more often than not, Medicare stifles competition and choices through legislative action and agency enforcement. Medicare sets prices and sets the standards by which it determines quality. Rather than empowering consumers, Medicare program limits choices.

This system is set up so that providers are more likely to fight rulemaking decisions handed down from government agencies than they are to compete with each other, to offer better services to Medicare patients. The Medicare fee-for-service program is a

perfect example. This fiscal year, Medicare's projected to pay $375 billion for part A and part B services, that is doctor and hospital services. The vast majority of that spending the Centers for Medicare & Medicaid Services is directly responsible for setting, implementing and managing these payments. In other words, the massive bureaucracy picks winners and losers among countless health care providers. Competition and choice and the preferences of Medicare seniors play little role in the administration of all that spending. It shows the program unfortunately is going insolvent.

By contrast, competition choices for seniors play a proven critical role in two successful programs, Medicare Advantage program, and Medicare part D, which provides prescription drugs. In these two extremely popular programs Medicare seniors are the ones in control, not the government. Plans compete fiercely for the health care businesses, offering services and benefits to fit the needs of Medicare patients, not Washington. If consumers are unhappy with their service, they can they can say no thanks and change their plan to one that meets their needs. It is that simple, and it works.

Right now, seniors have accessed more than 3,600 Medicare Advantage plans tailored to meet their specific needs. Competition is robust, and not surprisingly, patient satisfaction is high. The same is true of the part D prescription drug program, which is one of the few government health programs to actually come in under budget projections, and whose average base monthly premiums are as low today at $33, as when the program began in 2006 at $32.

Preventive care prescription plans seniors have dozens of choices in each State and can pick a plan that works for them. Studies show this very fact has led to a decrease in their out-of-pocket costs which is great news for seniors. Competition has proven to work in Medicare Advantage and it works on the part D prescription drug program. So how can it work in the larger Medicare fee-for-service system?

Today we will look at two proposals that do just that. The first is expanding seniors' access to local physician-owned hospitals. This is an issue Mr. Johnson of Texas has been working on for quite some time. Physician-owned hospitals are full service community hospitals that serve both rural and urban communities, they specialize and providing essential health services in areas that are considered underserved. But since 2005, these hospitals have been prevented from growing to meet the needs of their communities. As a consequence, there are just over 230 of these kinds of hospitals in operation around the country compared to 3,400 national acute care hospitals.

The questions before us include should seniors continue to be blocked from access to these high-performing hospitals? What are the impacts pro and con of this discrimination against one model of acute care? And is the current ban based on quality of service, or desire to restrain competition? At this point, a decade into the temporary moratorium, it is the right time to have a thoughtful discussion on this issue.

The second idea seeks to improve the way Medicare currently administers the durable medical equipment benefit, Dr. Tom Price of Georgia has spent a significant amount of

time looking at this issue, as well as other members of this panel and the Ways and Means Committee. He has been working on a reform that would inject a more market-based approach to help address some of the more serious concerns Members of Congress from both parties have all heard about from our constituents.

These two proposals have the potential for improving competition, end the benefits within Medicare. But ultimately, Congress needs to examine how we administer the Medicare program overall. The current program is critical, but unsustainable. It went from the program's own actuaries to nonpartisan scorekeepers like the Congressional Budget Office. Outside watchdog groups have worried about this, and warned us about this growing problem. Members of both Parties in Congress have a responsibility to save Medicare for the long term, improve and protect Medicare for today's seniors and for future generations.

We recently took the first important step by solving the way Medicare pays its doctors. The second step, we must turn immediately exploring how we improve the way Medicare pays its other health care providers, from the testing and evaluation leading into the hospital, to inpatient and outpatient care, and post-acute care after leaving the hospital.

The Health Subcommittee will continue to hold hearings on this topic over the course of this year. Developed reforms will put Medicare on a sustainable path.

So to help us get started, I would like to welcome today's witnesses, Joe Antos, from the American Enterprise Institute; Joe Minissale, president of Methodist McKinney Hospital in Texas; Robert Steedley, president of Barnes Health Care Services in Georgia; and Richard Umbdenstock, president and CEO of the American Hospital Association.

And before I recognize the ranking member, Dr. McDermott, for the purposes of an opening statement, I ask unanimous consent that all members' written statements be included in the record. Without objection, so ordered.

I now recognize Dr. McDermott for his opening statement.

Mr. McDermott. Thank you, Mr. Chairman. We are here today to talk about the second part of health care reform, that is, control of cost. Access under the Affordable Care Act is rising clearly where people have access to health care supposedly. The question is about how do you get control of costs? And we are talking today about improving competition in Medicare. Now I can't help but wonder, having sat here for a number of years, what this hearing is really going to accomplish. If this hearing were about competition, we would look carefully about how to drive down prices and get a handle on health care costs. That would mean reducing wastes and overpayment to industries that are profiting at the expense of the American public. The more the American medical industrial complexes enter the government pocket, the more it becomes our issue here.

Unfortunately, the proposals we will hear this morning won't control costs; instead, they are designed to appease the very interest that benefit from the waste in the system and contribute to higher health care spending. A hearing like this would make us ask ourselves, are we serious about controlling costs or would we rather just want to talk about it?

We are going to discuss ways to revise Medicare's competitive bidding program for durable medical equipment. Specifically, we will hear a proposal that will put a halt to the existing program, reduce competition and ultimately increase cost for Medicare and beneficiaries. The real irony of this hearing is, because I remember when it was Republicans who were the champions of competitive bidding. I have been on this committee long enough to listen to all of this, and the problem of health care costs in devices has been there. It was a Republican Congress that first introduced the concept to Medicare as a demonstration project in the Balanced Budget Amendment Act of 1997. And it was a Republican Congress that expanded the program in 2003 as a part of the prescription drug legislation.

Now despite some hiccups along the way, the programs it had remarkable success or at least measurable success. First round of competitive bidding saved over $580 million in 2 years, and HHS projects that over 10 years, we will save over $43 billion. Of course, we should continue to carefully oversee the implementation of competitive bidding, but proposals like the one that is before us today, to delay or undermine signals to the American people that Congress is more concerned about appeasing an industry than it is about controlling costs.

We are also going to discuss the moratorium on new and expanded physician-owned hospitals. For many years, specialty hospitals enjoyed a loophole in the STOCK Act that allowed doctors to make referrals to hospitals in which they had an ownership interest. As long as the ownership interest was in the whole hospital rather than subdivision of it -- you couldn't have just one department -- physicians could make referrals that otherwise would have been illegal. The result was a rapid growth in physician-owned hospitals which skewed the market in troubling ways. Nonpartisan experts of MedPac, GAO, the Office of Inspector General, for years have expressed serious concerns that these hospitals increased utilization of services and drive up healthcare costs.

Now, closing this loophole is a cost saving measure that has always had bipartisan support. We pass temporary moratoriums during the Republican-controlled Congresses, and we made it permanent as a part of the Affordable Care Act. This reform will save the American people $500 million according to the CBO. There is simply no good reason to reverse course and undue this progress. It will make the industry happy, but it will bring needless waste back into the healthcare system and ultimately harm the hardworking families of this country who are paying for this system.

Getting serious about controlling costs is more important now than ever. The Affordable Care Act continues to expand access, more and more people cover, everybody is clapping

their hands and popping the corks on champagne bottles about how many more people. When all is said and done, more than 30 million additional people have been brought into the system. As this happens, the healthcare system is rapidly changing, medicine is transforming from a profession into a business. Market powers consolidating in fewer and fewer hands as hospitals merge and swallow up independent doctors' practices. This raises a number of questions about competition, cost, and patient care that we need to answer. Until we take a careful look at what this trend means, we are sending a message to the American people that appeasing wasteful industry actors is more important than controlling costs.

I sent a letter to the chairman earlier about my concerns about consolidating hospitals and having less and less competition in various parts of the country, and I would ask unanimous consent to have that put into the record.

Chairman Brady. Without objection, so ordered.

[The information follows: The Honorable Jim McDermott Submission]

Mr. McDermott. I yield back the balance of my time.

Chairman Brady. Thank you. Mr. Antos, welcome today and you are recognized for the 5 minutes.

STATEMENT OF JOE ANTOS, WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. Antos. Thank you, Chairman Brady, and Ranking Member McDermott and members of the committee. Competition is central to obtaining good value for the dollars spent by beneficiaries and taxpayers in the Medicare program. Congress must avoid the temptation to smother competitive markets in Medicare through overregulation. Private plans must follow rules -- private plans and private providers must follow rules designed to protect consumers and ensure access to all necessary health services covered by the program, but the regulation should not be drawn so narrowly that healthcare delivery innovations cannot be adopted, or once adopted, cannot be altered or dropped. The rules should neither prevent the entry of new competing firms nor protect firms already in the market from competition. A competitive Medicare program must welcome change, while ensuring that beneficiaries and taxpayers are well served.

As the chairman said, the two leading examples of competitive markets in the Medicare program are Medicare Advantage and part D. Medicare Advantage is an increasingly popular alternative to fee-for-service Medicare. Even with payment reductions mandated by the Affordable Care Act, Medicare Advantage enrollment has grown from 11.9 million people in 2011 to 16.2 million this year. More than 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans. Clearly, for a growing number

of beneficiaries, competitive Medicare Advantage plans are a better deal compared to fee-for-service Medicare combined with separate Medigap and prescription drug plans.

Part D, as the chairman said, has also been a remarkable success, and its cost has fallen hundreds of billions of dollars below CBO estimates. I am going to focus my remarks on the Medicare Advantage, my written statement has more detail about both programs.

There is growing evidence that Medicare Advantage -- have I run out of time? The lights aren't lit.

Chairman Brady. I think you are in good shape on time.

Mr. Antos. Sorry, so evidence that Medicare Advantage plans provide higher value services, less cost to society than traditional fee-for-service. First of all, Medicare Advantage plans are more efficient in delivering care than fee-for-service. According to the Medicare Payment Advisory Commission, the average MA plan bid in 2014 was 98 percent of fee-for-service spending. In 2015, the average bid was 94 percent. That means that MA plans are willing to pay to deliver standard benefits, 6 percentage points cheaper than fee-for-service can on average over the country.

HMO plans were, of course, more efficient, their bids averaged 90 percent for fee-for-service spending. Now why are they being paid more than that? Well, the answer is the payment formula, of course. The plans are paid their bid, unless they bid below the benchmark. The benchmark was set to ensure that essentially everyone would have access to Medicare Advantage plans, so it tends to be higher than fee-for-service. Benchmark this year is 107 percent of fee-for-service, so the amount that MA plans are paid based on their quality performance is about 102 percent of fee-for-service spending. That doesn't tell you anything about the efficiency of delivering health care, that says something about the peculiarities of the payment system.

Second, MA plans have a spillover effect that lowers health care costs more generally. Turns out that studies have shown that for every 1 percent increase in Medicare Advantage enrollment in the market, there is a nine-tenths percent reduction in fee-for-service Medicare spending, and a general overall reduction in spending as well as on a per-person basis in the community.

Third, MA plans provide higher quality care. Beneficiaries in Medicare HMOs, for example, are consistently more likely than those in traditional Medicare to receive appropriate risk cancer screening, diabetes care, cholesterol screening, and so on.

And finally, the problem with favorable selection, which we have all been concerned about for many years, has largely been solved. This isn't just my opinion, this is Professor Joseph Newhouse at Harvard University and his colleagues pointed out the changes Congress made have improved the accuracy of payments in Medicare Advantage, and the lock-in procedure, the new method of risk adjustment, these are

things that have largely eliminated favorable selection so that the payments to MA plans are not -- aggregately reflect the costs to providing care to beneficiaries.

Competing private plans are strong incentives to provide health care efficiently and effectively to tailor the coverage and services of the needs and demands of their customers. By necessity, private plans are more flexibility and responsive to changing market conditions and consumer demands than fee-for-service Medicare. Satisfying your customers is a matter of survival. Doing so efficiently is the difference between a successful health plan and one that has failed.

Chairman Brady. Thank you, Mr. Antos, very much. Mr. Minissale, you are recognized for 5 minutes. I know as a constituent of St. Johnson, our colleague here you have great representation here now.

STATEMENT OF JOE MINISSALE, PRESIDENT, METHODIST MCKINNEY HOSPITAL

Mr. Minissale. Chairman Brady, Ranking Member McDermott, members of the Ways and Means Health Subcommittee, thank you for having me here today to testify. I am the President of Methodist McKinney Hospital, which is in McKinney, Texas. Methodist McKinney Hospital opened in February of 2010 just prior to the Accountable Care Act prohibition on physician ownership in hospitals.

Our hospital is a partnership with Methodist Health System, Nueterra Healthcare and local physicians.

Methodist Health System is a nonprofit health system that has for decades taken care of the underserved in Dallas, the indigent in the south part of the community. Over 51 percent of our profits go back to Methodist Health System to serve those in those communities. We accept almost all insurances, including Medicare, Medicaid, TRICARE, workers comp, most managed care plans, Medicare supplements. Our hospital employees are over 119 full-time employees. We have over 230 members on our medical staff, and only 22 of those members on the medical staff are physician investors.

We paid over $2.5 million in taxes last year, something that not for-profit hospitals do not share the burden in. Our services include inpatient care, internal medicine, emergency medicine, imaging, surgery, pain management, physical therapy, among many other things. We have a broad range of specialties that include pain management, gastroenterology, ENT, general surgery, medicine and more.

We have an ER average waiting time of just 76 minutes compared to over 2 hours at our competitors. The primary reason Methodist McKinney Hospital was developed was due to frustration with the local physicians over administration and health system management with the local hospitals. They wanted a hospital where patient care was

always put first, not just the bottom line. So they decided to take matters into their own hands and build a hospital that was driven by the principles that physicians who spent their lives taking care of patients held dearly.

Having spent my career managing hospitals, I know one of the keys to success in hospital administration is to have good alignment between the hospital and the physicians. In a physician-ownership model, I feel like we have that much more than I enjoyed when I worked in other ownership models.

This culture has allowed us to endear ourselves to local physicians, nurses and other clinical caregivers because we care about the patient first and bottom line second. But we also care deeply about our employees and our community. We have won some good achievements and accolades to represent that. We received a 4 out of 5 star rating on CMS' Hospital Star Program. We are consistently above the 90th percentile on the HCAHPS, patient satisfaction surveys. We have been named a Dallas, Fort Worth, top 100 employer in 2013, 2014. We have consistently been over 100 percent of baseline on the CMS value based purchasing program. And we receive the Joint Commission Gold Seal of Approval on Accreditation.

Thanks to strong support from the community, our hospital has been getting close to capacity in some areas. That is a good problem and a bad. We are in a growing community, Collin County in McKinney, Texas, have been expanding rapidly by growing more than 70 percent since 2000.

Patients can choose to go to a lot of good health care providers in our community, but many are choosing us. As a result, we are now at a crossroads where our board and our partners are going to have to decide, do we leave Medicare, Medicaid and TRICARE patients behind so we can grow the hospital and meet the growing demand and the growing community? Or do we just stop growing and stay where we are and just tell people we can't serve any more than we already are?

Twenty-seven percent of our current patient base has those insurances. It is very discouraging to think that we could spend years trying to meet the exceptions, and I am not sure anybody can meet the exceptions in accountable care. Even if you can meet it, it is going to be hard to prove and you are going to have to jump through a lot of hoops, yet our competitors do not have to do that. We don't want to leave the seniors and the military families behind so I would ask you to repeal section 6001 of the Accountable Care Act so we don't have to make decisions to not have access to those seniors and military families. Thank you.

Chairman Brady. Mr. Minissale, 5 minutes goes fast, but we have all your testimony for the record. So Mr. Steedley you are recognized for 5 minutes.

STATEMENT OF ROBERT STEEDLEY, PRESIDENT, BARNES

HEALTHCARE SERVICES, ON BEHALF OF THE AMERICAN ASSOCIATION FOR HOMECARE

Mr. Steedley. Good morning. My name a Robert Steedley, and I am the president for Barnes Healthcare Services, a regional home care provider based in Georgia. I also serve as the voluntary chairman of the board of directors for the American Association of Homecare, which is the national trade association for home medical equipment, providers, manufacturers and other stakeholders in the home care community.

I would like to thank Chairman Brady, Ranking Member McDermott and members of the House Ways and Means Subcommittee on Health for holding this hearing on improving competition and Medicare. I would also like to thank Congressman Tom Price and Congressman John Larson for introducing legislation that would create a state-of-the-art, market-driven auction system, an alternative to the competitive bid program.

I am here today to talk about flaws in the current bids program, how those flaws impact noncompetitive bid areas and offer a better budget neutral solution. Both the association and I fully support healthy and fair competition. My testimony also comes from firsthand experience with the bidding program at Barnes Healthcare. Opening in 1909, Barnes Healthcare Services has 106 years of experience, employs more than 300 people across 14 locations and serves 4 States. Experts in the past explain in great detail why CMS bidding program lacks transparency and restricts patient choice and access to the prescribed home medical equipment they need. I have also detailed these in my written testimony.

Fortunately, Congress recently passed legislation to help fix one of those issues of the program, the lack of a binding bid. AA Homecare would like to thank Congressmen Tiberi and Larson for introducing legislation that require binding bids. I would also like to thank the Ways and Means Committee for its consideration and approval of this bill which was included in the file SGR bill.

Requiring binding bids is a key provision in the Congressman Price and Congressman Larson's Market Pricing Program legislation, which is also known as MPP. The issues with the competitive bid program are not just limited to round 1 and 2. In October 2014, CMS also issued a final rule that applies the artificially low competitive bid raise to all non-bidding areas, including rural and underserved.

The artificially low competitive bid rates are only part of the problem of this final rule. The application of payment rates to non-bid areas is flawed and will disrupt Medicare beneficiary access to the home medical equipment items that they need.

In competitive bid areas, the suppliers try to make up for drastic cuts through increased volume. As a result of the CMS final rule, suppliers outside of those bid areas will receive the same drastic cuts without the exclusive contracts or increases in the volumes of business.

There is a better budget neutral way to achieve market prices for home medical equipment known as the Market Pricing Program. I have included more detailed information in my written testimony, but following are a few components of MPP. MPP includes the same items that are currently in the CMS bidding program, and it is also nationwide. There are two categories bid per geographic area, eight additional categories in that same area, would have prices adjusted based on auctions conducted simultaneously in comparable geographic markets.

Bid areas are smaller than the Metropolitan Statistical Areas, also known as MSAs and more homogeneous. Finding bids are required to ensure only serious bidders participate. The bid price is based on the clearing price rather than the median price of the winners. And finally, the same areas that are exempted from bidding under competitive bidding program from CMS will be exempted under MPP.

As committee members can see from my written testimony, MPP is simply a much better auction system than the current CMS competitive bid system. MPP uses auction principles supported by economists and auction experts. It is more transparent and efficient in the current program and it will achieve the goal of Congress to have true market prices for home medical equipment in Medicare.

AA Homecare was very thankful when Congressman Price and Larson introduced MPP, the Medicare DME Post Market Pricing Program Act in 113th Congress. This legislation has received strong bipartisan support with 180 cosponsors. AA Homecare strongly supports this commonsense legislation and urges the subcommittee and Congress to do the same.

I would like to thank the committee again for the opportunity to provide this testimony. AA Homecare and I look forward to working with the subcommittee to improve competition in Medicare while protecting patients' access to the needed home care equipment. Thank you.

Chairman Brady. Thank you, Mr. Steedley. I was just told that our normal lighting system that gives you the yellow light and the one-minute warning to wrap up isn't working today, so I apologize for that. We will get that back on track soon.

Mr. Umbdenstock, thank you for your leadership of AHA and you are recognized for 5 minutes.

STATEMENT OF RICH UMBDENSTOCK, PRESIDENT AND CEO, AMERICAN HOSPITAL ASSOCIATION

Mr. Umbdenstock. Chairman Brady, Ranking Member McDermott, members of the subcommittee. On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations I thank you for the opportunity to testify today. Community hospitals embrace fair competition where facilities compete over quality, price and

patient satisfaction. However, we are strongly opposed to the practice of self-referral, which skews the marketplace in favor of physician owners who self-refer the healthiest and wealthiest patients to their own facilities. Therefore, the AHA urges Congress to current law preserving the ban on physician self-referral to new physician-owned hospitals and retaining the restrictions on the growth of existing physician-owned hospitals.

Physician self-referral is contrary to competition. It allows physicians to steer the most profitable patients to facilities in which they have an ownership interest or potentially devastating the healthcare safety net in vulnerable communities.

Changing the current law would not foster competition. Instead, it would only allow these physicians to increase their profits. Current law represents a compromise that protects the current physician ownership of hospital arrangements and allows these arrangements to grow where increased hospital capacity is needed. However, some have proposed weakened significantly Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosened the restrictions on the growth of grandfathered hospitals.

The AHA strongly opposes these changes, any changes that would expand the use of the whole hospital exception, beyond grandfathered hospitals or that allow grandfathered hospitals to expand or increase their capacity beyond what is allowed in current law for three primary reasons: First, physician-owned hospitals provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care. HHS's Office of the Inspector General reported that, quote, "two-thirds of physician owned specialty hospitals use 911 as part of their emergency response procedures." And, quote, "most notably, 34 percent of specialty hospitals use 911 to obtain medical assistance to stabilize patients, a practice that may violate Medicare requirements."

Second, physician self-referral leads to greater utilization of services and higher costs, CPO, MedPac and independent researchers all have concluded that physicians self-referral leads to greater per capita utilization of services and higher costs to the Medicare program.

Third, physician-owned hospitals tend to cherry-pick the most profitable patients and services, jeopardizing communities access to full service care. GAO, CMS and MedPac have all found that physician-owned hospital patients tend to be healthier than patients with the same diagnosis of general hospitals. Further, MedPac and GAO found that physician-owned hospitals treat substantially fewer Medicaid patients. This trend creates a destabilizing environment that leaves sicker and less affluent patients to community hospitals. These selection practices place full service hospitals at a competitive disadvantage because they depend on a balance of services and patients to support the broader needs of the community.

The current payment system does not explicitly fund standby capacity for emergency trauma, burn services or the like, nor does it fully reimburse hospitals for the care provided to Medicaid and uninsured patients. Community hospitals rely on cross subsidies from better reimbursed services, the very services targeted by physician-owned hospitals to support these and other essential, but under-reimbursed health services. Resident loss to specialty hospitals can lead to staff cuts and reductions in subsidized services.

In addition, many of the physicians profiting from limited service hospitals will not serve on-call in the community's emergency department, or participate in wider quality improvement projects that benefit the community. These facilities duplicate services, further exacerbating the shortages of physicians and allied health professionals in some communities.

Furthermore, closing the whole hospital exception loophole in the Stark law reduced the Federal deficit by $500 million over 10 years, according to the CBO. Proposed changes to the current law would erase those savings and raise the deficit at a time when our Nation is trying to control increases in health care costs.

True, our competition could be fostered by making commonsense changes to law to allow greater care coordination and new delivery models. The health care field is rapidly changing, moving toward new payment delivery models that emphasize value over volume. As part of that change, hospitals are actively exploring clinical integration, a move away from working in silos toward emphasizing teamwork to coordinate care.

However, hospitals attempting to seize these opportunities to improve care and care coordination for Medicare beneficiaries and other patients face significant legal barriers. Chief among these are the outdated rules governing compensation relationships between hospitals, physicians and other caregivers. Portions of the anti-kickback statute, the Stark law and civil monetary penalty law.

Congress recently acknowledged the need for change to the CMP law through the work of this committee in the recent SGR bill, which limited the scope of this prohibition so that a hospital is only subject to CMPs for making payments that will reduce or limit medically-necessary care. We advocated for this change and are pleased that Congress lifted this barrier.

Chairman Brady. Mr. Umbdenstock, I apologize.

Mr. Umbdenstock. No problem, sir. Thank you very much.

Chairman Brady. Thank you very much. Mr. Antos, in Washington, we like to talk a lot of about cost control, Washington sort of setting prices and then determining whether it is the right amount, or if you deserve this. You talked about competition as a more patient-centered way to find savings and efficiency. Can you talk about briefly -- I have

questions for our witnesses -- can you talk briefly about which one better serves seniors while creating savings?

Mr. Antos. Well, thank you, Mr. Chairman. It certainly is the case that the fee-for-service incentives are to expand volume of services and to focus only on the part that you as the specific provider, whether it is a hospital or a physician or some other provider, but only your part of the patient's health care. So, in fact, I found that Mr. Umbdenstock's point about expanding services, I believe that that is endemic in the Medicare fee-for-service system. If you don't provide services, you don't get paid.

So as far as a competitive program doing a better job of serving patients and giving patients what they want, which is not only a good financial deal, but also good patient outcomes, then you really have to go to private plans, that I think we see in much of Medicare Advantage where they look at the whole patient.

Now short of that, fostering real competition, avoiding having CMS or Congress set prices, when, in fact, we don't know what the prices are, all we know is what the charges are. We need to introduce more competitive approaches in traditional Medicare, but ultimately, I think we are going to have to move to a more coordinated system, Medicare Advantage is not that way.

Chairman Brady. Mr. Antos, thank you. I notice in the prescription drug program, the Democratic alternative to the Republican plan set a monthly premium of $35 for Medicare part D. Here we are 10 years later after, and through cost increases, prices all that, the average price is still below the cost control price that originally buy the alternative through competition.

Mr. Antos. Well, that comes from several factors, perhaps the biggest factor is the competitive effect. The different drug plans know that if they are going to make money, they have to attract customers. If they are going to attract customers, they have to offer a good balance of access to drugs, including expensive drugs and low cost.

The remarkable thing about this program really, is, as you say, we have seen premiums basically stay level for the last 10 years or so. That is partly due to the fact that we have seen a slowdown in the introduction of expensive new drugs. But importantly, part D plans have really encouraged Medicare beneficiaries to use generic alternatives that has been very effective.

Chairman Brady. Thank you, Mr. Antos. Mr. Minissale, thank you for being here. We are told the problem with physician-owned hospitals is that they don't have an ER, that they self-refer so there is greater utilization among themselves at a higher cost, and that you cherry-pick the patients who come through your door. Can you talk a little bit about your experience? I think you served both in for-profit and nonprofit in our position on the House bill so you have seen the operations in all those models. Your thoughts?

Mr. Minissale. Yes, sir. First, I want to mention in terms of cherry-picking, it should be pointed out that we serve TRICARE, we are a TRICARE provider, our facility, and one of two largest health systems in Dallas-Fort Worth area, is not a provider, and I guarantee you, we are not doing that because of the high TRICARE payment levels. So that would be one example of cherry-picking.

We do have an ER, and we have advertised it since we have been open on an ongoing basis to try and get more people to come in and open those doors up.

Also, as you mentioned in previous positions, I have been responsible for facilities in the southwest side of San Antonio where we had physician ownership, and it was a very large indigent population there, underserved, the same situation in Congressman Eddie Bernice Johnson's district in north Houston where we had physician ownership, in Port Arthur, in Odessa. These are full service hospitals with physician ownership that were -- didn't have the opportunity to cherry-pick.

Chairman Brady. You are 4 star rated?

Mr. Minissale. Yes, sir. Yes, sir.

Chairman Brady. That star rating takes into effect the complexity of the patients you are serving, correct? So if you are cherry-picking, in fact, you are punished in that star rating, correct?

Mr. Minissale. Yes, sir. I would point out that many of the physicians that work at our hospital bring most of their patients to our facility. Obviously we are a 21-bed facility, so they can't bring 100 percent, but, yes, I think the -- in our circumstance, the cherry-picking is greatly exaggerated.

Chairman Brady. How many times have you called, your hospital called 911 for emergency services.

Mr. Minissale. Actually, we have a process for strokes, we have a code STEMI, which those are the situations where, like, there are certified stroke centers and certified heart centers where time is of the essence where we would need to get that patient transferred to the highest level of care possible. In fact, there are not a lot of stroke certified centers even among the larger hospitals in our area.

Chairman Brady. So when you dial 911, it is to get the patient to the highest certified and qualified local provider?

Mr. Minissale. Correct, correct. And that has been very rare, but that has happened a few times I would say probably three times in 5 years, maybe for us.

Chairman Brady. Thank you. Mr. Umbdenstock, you raised points. We have heard as concerns, that these hospitals don't have functioning ERs, they self-refer to each other as

physicians and they cherry-pick. Looking for common ground, in recognizing in the decades since this temporary moratorium was put in place, before profit and nonprofit hospitals have increased their beds easily more than double all the position on hospital beds in America. So you are allowed to grow to meet the needs of the community, which seems to me to make good sense.

So the common ground here with physician-owned hospitals, I can guarantee you they are not all in the best parts of town, while I have noticed nonprofit and for-profit do grow to meet the needs of the community. So would a compromise be if physician-owned hospitals had a functioning ER, that they are shown to not self-refer in high utilization like CMS, and their stars rating proved that they are not cherry-picking, but meeting the needs of their community. Is that an area where this discrimination against one model could end and we could have competition among all the hospitals? Is this a common ground you would consider?

Mr. Umbdenstock. Mr. Chairman, thanks for the question. Just a couple of points, first of all. As recently as the cab ride over here this morning, I double-checked the Web site for Methodist McKinney Hospital relative to the ER, and it says that our emergency department offers quick care for all of your bumps, sprains and minor injuries, 365 days, 7 days a week. That may be a very important urgent care function that is good for that community, but that doesn't sound like an emergency department to me.

Chairman Brady. Mr. Minissale, since this was raised, so you only treat bumps, scrapes and bruises in your ER?

Mr. Minissale. Absolutely not, sir. As I mentioned, we are not a stroke center, we are not a heart center.

Mr. Umbdenstock. From their own Web site. From the Medicare cost reports in 2012 and 2013, the percentage of Medicaid, talking to the question of patient and payment selection, in 2012, the Medicare cost report showed zero patient, Medicaid patient discharges and accrued to 0.4 percent in 2013. So a very, very skewed payment system.

So, that is the issue, sir. And that is what we are here to urge Congress to stay with, stay with a program that limits the growth of these hospitals where they are highly selective and picking off the most profitable services. You notice the services on which hospitals like this are focused. And I understand why. That is where the payment is.

Chairman Brady. Well let me ask you this.

Mr. Umbdenstock. Many hospitals don't have that opportunity.

Chairman Brady. One, I respect your opinion. Thank you so much for being here. But the stars rating program takes into account the types of patients these hospitals treat. So are they incorrect in their assessment, or are they fairly accurate?

Mr. Umbdenstock. No. Number 1, the stars rating program focuses on the HCAHPS scores, the experience of care or patient satisfaction as we commonly refer to it. If you have the opportunity to identify which patients are going to come to your hospital in advance, you can prepare those patients for that experience. A hospital, a general service community hospital, full service community hospital receive over 60 percent of their admissions through the ER; that is not a predictable source of who the patient is, number one.

Number two, if you are not treating a full array of patients from all socioeconomic strata, you are not likely -- you are likely to have a much higher satisfaction rate.

Chairman Brady. Is that the criteria for adding new beds, is that hospitals of all models should only go to areas that have broad, certain percentage of Medicare, Medicaid patients, that that ought to be a criterion to supplied, to physician-owned hospitals, for example? Should that be -- should this moratorium be applied to all hospitals equally to ensure that each facility meets a broad range of patients?

Mr. Umbdenstock. The current criteria for an exception recognizes several factors, but one is that the particular hospital in question serves at least the average or greater proportion of Medicaid patients as other hospitals in its area, that is already there.

Chairman Brady. I agree. Would that be a fair restriction on all hospital increases?

Mr. Umbdenstock. Well, it is not a matter of whether or not it has to be a requirement. Every --

Chairman Brady. But it is for a physician-owned hospital -- I am just trying to find again common ground, because hospitals are serving both areas of town that don't have necessarily good culture of health care, and they can serve areas, perhaps, with higher private pay. They do that as systems, again, to try to make ends meet and try to meet their missions, either nonprofit or for profit. The question is, why shouldn't this model be able to do the same thing?

Mr. Umbdenstock. I think you will find that if you look across the Nation's full-service community hospitals, on average, they have about 15 percent of their patients, plus or minus, that are Medicaid; about another 25 or more that are Medicare; probably about 10 percent prior to the ACA expansion and coverage -- admittedly, that number is going down -- but about 10 percent no pay. So those hospitals are already taking that type of mix of patients. I don't see a need to require it; they are already experiencing it.

Chairman Brady. So you would be comfortable with a requirement for those types of services for new beds in all hospitals? Should we apply this gold community, broad community service to all hospital beds?

Mr. Umbdenstock. I would like to go back to your context that you used to set up this point, sir, if I might. Which was that hospitals nationally have, I believe, you said opened

more beds than the total number of beds in the 250 or so physician-owned specialty hospitals. Number one, that is a very small percentage of the National bed complement. Number two, that may be true that some hospitals have grown at that rate, but we have also seen hospital closures across the full-service hospital spectrum in many areas, including in Texas, sir, as I know you are very familiar with. So I don't think that that is a rampant problem of hospitals adding more beds.

In fact, hospitals are trying to figure out how to skinny down their inpatient complement so that they can focus more and get more patients served in outpatient, and out into the community. So we are actually seeing the reverse phenomenon of the description. They are actually de-emphasizing inpatient care, particularly as they are more at risk.

Chairman Brady. I recognize that. I hope you will come to Houston some time and see the growth of hospitals. We are thrilled, in my community and throughout the area, and it tells a little different story. So again, looking to find common ground, I know what the concerns are, and I think we need to have a discussion on this.

Ranking Member McDermott, you are recognized.

Mr. McDermott. Thank you, Mr. Chairman. It is an interesting discussion we are having here, this is not to pick on one hospital, but it is an example we have in front of us here today, McKinney Hospital. Why would a hospital want to be a specialty hospital? Why would they just want to do certain things? Mr. Umbdenstock, I mean you have 5,000 hospitals, so why would a hospital specialize in only doing orthopedics or only doing cardiac or whatever?

Mr. Umbdenstock. Well, I assume there are several reasons, one of which might be that the focus of energy and resources, volume in order to improve technique and outcomes, but also, I would say that you have to recognize that the particular services that limited service hospitals focus on are the profitable services. I don't have a lot of competition for the non-profitable services inside full service hospitals.

Mr. McDermott. What are the profitable services for hospitals?

Mr. Umbdenstock. Well, certainly you see procedure oriented services, so surgeries, speaking broadly, other forms of procedures as opposed to medical services, certainly your own specialty of psychiatry would be at the other end of that spectrum.

Mr. McDermott. So if a hospital had 83 percent of its patients in for surgery, somehow they would be skewing it in that direction so that is not the average in most hospitals across the country?

Mr. Umbdenstock. That would not be reflective of the average complement, the average balance of services, that is correct.

Mr. McDermott. So in some way, they selected who comes in by the services that they offer; is that correct? Is that how a specialty hospital works?

Mr. Umbdenstock. With that kind of imbalance, one would have to assume.

Mr. McDermott. And if you talked about the emergency room. Now I, like you, use the Internet and I think all modern people use the Internet, it says here that for Methodist McKinney, if you were experiencing any of these conditions, please call 911, immediately: Life threatening conditions, heart attack or stroke, open fractures, severe bleeding, signs of heart attack or chest pain, head injury or other major trauma, one-sided weakness or numbness, loss of consciousness, severe abdominal pain, uncontrolled pain or bleeding, poisoning, call the poison control center.

Now, if an emergency room is not going to deal with those issues, can that be called full service -- what it says is they do take care of our stitches and staples for cuts, gashes and wounds, X-rays, fractures and sprains, abdominal pain for maladies such as appendicitis, colitis, pancreatitis. And general illness treatment virus, flu and dehydration. So it is kind of a doc in the box, it sounds to me. They say they have a doctor on call. Is that how that sounds to you when you listen to that description?

Mr. Umbdenstock. I would say, Mr. McDermott, that full service community hospitals run toward problems, trauma, emergencies, and want to be of immediate service to people. They have that type of condition; that is exactly the type of person we expect to see at our ER. That is our purpose and that is why we are there. Granted, we often have to then transfer the most acutely ill to the higher levels, full service hospitals or teaching centers. But yes, those are the kinds of things that we would expect to see and that we do see in full-service community hospital ERs.

Mr. McDermott. Explain to me how the Stark law operates in a specialty hospital? The doctors own everything, they own the MRI, they own the CAT scan, they own all the machinery. They can refer every patient they want to their own CAT scan or their own MRI; is that correct?

Mr. Umbdenstock. That is correct. They are free to do --

Mr. McDermott. And that Stark law prevents you from doing that if you are in another hospital where you have an MRI that is away from it that you own or own a piece of, you can't refer your patients to that MRI; isn't that correct?

Mr. Umbdenstock. That is right, it is called the whole hospital exception as was pointed out earlier. You have to own a share in the whole hospital.

Mr. McDermott. You have to own the whole thing. That is really what we are trying to stop. And have successfully stopped and saved a half billion dollars.

Mr. Umbdenstock. According to the CBO.

Mr. McDermott. According to the CBO. By the way, I want to say, I know this may be your last appearance before this committee, you have been working as CEO for AHA for us for 8 years, and we thank you for your service in this tough job that you had and we appreciate your work.

Mr. Umbdenstock. Thank you and thank you to the chairman as well for the sentiment.

Chairman Brady. I appreciate it. Thank you very much. Mr. Minissale, we are 1,200 miles from your ER, your and Mr. Johnson's witness. Do you want to address the claims you just heard about your ER.

Mr. Minissale. Yes, sir. First of all, I would certainly appreciate any ideas or support from Representatives McDermott or Mr. Umbdenstock on how we could grow our ER business. As I have stated, we have not been very successful. We have advertised and advertised and advertised, and that is how a lot of those admissions do come into the larger hospitals. We have also seen a proliferation of free-standing ERs open up in our community, HCA opened two in the area, there are several others. So anything we could do to grow the ER and get more admissions, medical or otherwise would be great.

Chairman Brady. Thank you. Mr. Johnson, recognized for 5 minutes.

Mr. Johnson. Thank you, Mr. Chairman. Mr. Minissale, thank you so much for testifying today. I appreciate hearing all the great things Methodist McKinney is doing back home. I want to ask, given your unique experience, what do you believe the biggest difference is between physician-owned and other hospitals?

Mr. Minissale. I think, really, the directive is when we are making decisions, there is kind of a hierarchy in physician-owned hospital where I am at is patient care is first; physician desire is second; employees are third; and profits fourth. In previous experiences where I worked for other company, we were usually driven by corporate health system goals and profits.

Mr. Johnson. Thank you. Mr. Umbdenstock, thank you for your testimony today. I have a handful of questions so in the interest of time, I ask you to please keep your answers to a yes or no, if you would. First, are you aware that your testimony refers to the GAO, MedPac and HHS reports that are 8 to 10 years old, and only studied specialty hospitals, not all physician-owned hospitals. Is that a yes or no?

Mr. Umbdenstock. This debate has been going on that long, and we try to reference all sources that we can find throughout the last.

Mr. Johnson. Well, you didn't answer my question. So in your testimony, you argue that physician-owned hospitals cherry-pick patients, but did you know that after the GAO and MedPac reports were released, CMS changed how hospitals are reimbursed so a hospital is paid based on the severity of the specific patient, which means you can't cherry-pick. Is that true or false?

Mr. Umbdenstock. You can't necessarily --

Mr. Johnson. You can't do that either. Thank you. I would also like to --

Mr. Umbdenstock. -- from the way you refer patients, not in the way a particular patient is paid for, sir.

Mr. Johnson. Okay. I would also like to refer you to the first quote on the screen from a Health Affairs study stating, "Physician ownership is not a driving force in referring patients to specialty hospitals." I request that the full article be submitted for the record along with additional references.

Chairman Brady. Without objection.

[The information follows The Honorable Sam Johnson 1:]

Mr. Johnson. Thank you.

Now, let me ask you: Do you believe that physician-owned hospitals destabilize community hospitals? Yes or no.

Mr. Umbdenstock. Yes.

Mr. Johnson. Okay. I would like to now refer you to the second quote on the screen by the Federal Trade Commission on the importance of competition in Medicare.

I would also like to highlight that the August 2006 MedPAC report your testimony cites stated that, "Profit margins for community hospitals in markets with physician-owned hospitals were higher than those in markets without physician-owned hospitals."

Next question: Do you believe that physician-owned hospitals lead to greater utilization of service and higher costs? Yes or no.

Mr. Umbdenstock. Yes.

Mr. Johnson. Thank you.

I would also like to submit for the record a list of cases with over $3 billion in fines paid by non-physician-owned hospitals for the very things you claim physician-owned hospitals do. I think you have those, Mr. Chairman.

[The information follows: The Honorable Sam Johnson 2]

Mr. Johnson. I would also like to submit for the record a statement by the Federal Trade Commission saying that physician-owned hospitals increase competition and reduce prices.

[The information follows: The Honorable Sam Johnson 3]

Mr. Johnson. Lastly, I would like to submit for the record a study that shows physician-owned hospitals save Medicare almost $10 million over 10 years.

[The information follows: The Honorable Sam Johnson 4]

Mr. Johnson. Finally, your testimony argues physician-owned hospitals should not be allowed to expand because they offer limited or no emergency service.

But isn't it true that Medicare does not require emergency departments, but actually only requires Medicare providers, including physician-owned hospitals, to comply with conditions of participation and the Emergency Medical Treatment and Active Labor Act? Yes or no. That is for you, Mr. --

Mr. Umbdenstock. For me?

Mr. Johnson. Yes.

Mr. Umbdenstock. Yes. When 60 percent of your patients come through the ER, the ER is a very important part of a, quote, "hospital." I would agree.

Mr. Johnson. Mr. Chairman, thank you for holding this hearing. And I am not here today to criticize one Medicare provider over another, but, instead, to discuss the important role physician-owned hospitals play in promoting competition in Medicare.

Instead of continuing the ObamaCare prohibition on these hospitals, which was included in the 2,000-plus-page law as a political favor to the American Hospital Association and others, we ought to allow patients access to the high-quality and lower cost care provided by physician-owned hospitals.

In America, we let competition pick winners and losers, not the government.

I will yield back the balance of my time.

Chairman Brady. Thank you.

Mr. Thompson, you are recognized.

Mr. Thompson. Thank you, Mr. Chairman.

Thank you to all the witnesses for being here.

Mr. Chairman, I would like to ask unanimous consent to enter a letter into the record from the U.S. Chamber of Commerce, who wrote stating that defending America's free enterprise system -- they are in opposition to the self-referral to physician-owned hospitals.

Chairman Brady. Without objection.

[The information follows: The Honorable Mike Thompson Submission]

Mr. Thompson. Thank you.

Mr. Minissale, I would like to follow up on the questions that both the chairman and the ranking member had asked you and give you an opportunity to respond. They were referencing the type of services that your particular hospital does or doesn't provide.

And the CMS data that I am looking at tells us that about 70 percent of physician-owned hospitals -- fewer than 5 percent of their admissions are Medicaid patients and a little over 20 percent admitted no Medicaid patients at all.

And your hospital -- and, specifically, I think that is what they were asking you about -- in 2013 had 24 percent Medicare discharges and 0 percent Medicaid discharges.

Can you kind of explain why these hospitals, in general, and yours, in specific -- and they are often located in proximity to full-service hospitals -- aren't treating Medicaid patients. And isn't there a need to do this in these underserved areas?

Mr. Minissale. I assume you are not -- I am not sure about the State of your citing, but I assume you are not referring to the hospitals in North Houston, Odessa, San Antonio, that had physician ownership that I have managed in my career.

Mr. Thompson. No. I am talking about the hospital where you are now, Methodist McKinney. You had 24 percent Medicare discharges and 0 percent Medicaid discharges.

Mr. Minissale. Yes, sir. That is geography. In my experience, the Medicaid population tends to go to the closest facility due to transportation challenges, and we happen to have built the hospital in an area where there is not an indigent population.

Mr. Thompson. So it is all geography as it pertains to your hospital?

Mr. Minissale. I cannot say it is all. We are a Medicaid provider. There is now a McKinney bus service that could bring them there, and we are happy to take care of them.

So other than advertise, have our doors open, let the bus come over, I don't know how you make patients come to your facility.

Mr. Thompson. Thank you.

In my home State of California, we have hundreds of community hospitals and there is no shortage of competition, competition that is operating on a level playing field. I have got some concerns about the self-referral model.

And in my full-service hospitals at home, they compete on the quality of their service, the geography, and their reputation, not on whether or not physician owners will win, you know, financial gain as a result of this. And I worry about changing this law and what it would do to destabilize the continuity of care that we have in my area and others.

Mr. Umbdenstock, I don't have any of these hospitals in my community right now, and from the testimony that I have heard so far today, I don't think I want any.

But if the law were weakened and they could come in, what do you think the impact would be on my constituents and the other constituents in other areas that don't have this type of unfair competition?

Mr. Umbdenstock. Well, I think it is the three things that I mentioned. One is that the patient mix and service mix that will shift in your community could very well jeopardize the ability of full-service community hospitals to continue to provide a full array of services. There is certainly the question of increased utilization and, therefore, increased costs. And there is competition for employees who are already in short supply, as we all know. So I think that we have got serious concerns about that.

And there is an exception process. So if a hospital feels that it needs to grow and it is in a growing area and there is a high inpatient census on utilization and they do take high proportion Medicaid patients, CMS has already approved one. I only know of two applications. They have approved one and one is pending. So there is a mechanism to handle that.

Mr. Thompson. What about the current law that requires physician-owned hospitals to report annually to CMS about the ownership and all the particulars? It is my understanding that that hasn't been done. And aren't we putting the proverbial cart before the horse with trying to do this legislation without first having all the data necessary to be able to assess what is actually going on?

Mr. Umbdenstock. I do know from what is up on the CMS Web site that they say that they have had a very low rate of response to their reporting requirements, so much so that they have yet again extended the submission deadline.

So, apparently, they are having trouble identifying those ownership and other indicators that they require. So one would think that that would be important information to have. Yes.

Mr. Thompson. Okay. Thank you.

Yield back.

Chairman Brady. Thank you.

Mr. Smith, you are recognized.

Mr. Smith. Thank you, Mr. Chairman.

And thank you to all our witnesses here today. I appreciate the insight that each and every one of you bring to the table here.

Certainly, as a representative of part of rural America, I can appreciate the challenges facing health care, facing the financing of health care. I have been here long enough to observe a lot of the arguments for and against various components of public policy as it relates to health care. And certainly, as a consumer from time to time of health care and as a patient, I think it is important that we observe what is going on.

Now, I get very concerned when there is an agenda of prohibitions and mandates. That could be inside ObamaCare or even beyond that, but I get very concerned. I know I have been working on an issue with critical-access hospitals in my district with a 96-hour precertification requirement that I think is burdensome, it is unnecessary, yet it is part of the long list of prohibitions and mandates that exist in health care.

And I would hope that we could have flexibility in our health care. I know that living in a community where we have, I think, a very vibrant community regional hospital, along with a Federally qualified health center and even some options for patients that would involve walk-in urgent care -- I see the flexibilities that allow those to be used by patients. That is a good thing.

It is hard to say, perhaps -- I mean, I don't know the exact financing mechanism of every patient, but I was just wondering if anyone could speak to the fact of prohibitions and mandates leading to actual cost savings. If any of our witnesses would like to answer that.

Mr. Umbdenstock. Yes, Congressman. I would be happy to.

Number one, this is an arrangement that has been arrived at over a discussion and a series of compromises over a dozen or more years. So this is an ongoing conversation in this industry.

Mr. Smith. But it is the result of a compromise, the prohibition?

Mr. Umbdenstock. Where we are today is the result of starting with new entries and limits on growth for the grandfather-in hospitals. Yes. This has been an ongoing conversation since at least 2003, that I am aware of, probably longer, number one.

Number two, the CBO has scored that this particular provision in the Affordable Care Act saved $500 million over 10 years. So, yes, it is a, quote, saver at the moment, and changing it would, obviously, in the CBO's opinion, unleash additional spending that would have to be paid for in some way under the Medicare program.

Mr. Smith. You said at least at the moment. So long term do you think that we need the current prohibitions and mandates that are currently in place?

Mr. Umbdenstock. Yes. And I think that we could ask CBO to score it again. But I don't see any reason why for the next 10-year segment they would come out with a substantially different answer.

Mr. Smith. Okay. Anyone else wishing to respond?

Mr. Minissale. Yes, sir. You mentioned cost and the prohibition. One thing that we have seen is our competitors employing physicians. Five of our original physician investors' practices have been bought out since we opened and many, many more in the community.

In my understanding, there is data showing -- I believe it is in California -- from CMS that that actually increases cost. It doesn't decrease cost.

Our competitors are spending a lot of money on paid medical directorships to the high-paid procedurals. We don't pay medical directorships. We don't employ physicians.

I believe those things are part of the reason the data shows costs are going up. We would tend to focus on competition and quality that would lower costs and provide better care in the end.

Mr. Smith. Okay. Thank you.

Anyone else wishing to comment?

Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Mr. Davis, you are recognized for 5 minutes.

Mr. Davis. Thank you very much, Mr. Chairman.

You know, for many, many years we have had a great deal of conversation relative to how do we improve quality and contain cost at the same time. If we are still experiencing 60 percent hospital admissions through emergency rooms, does that say that our system needs to do anything in order to try and get to this real notion of cost savings?

Mr. Umbdenstock. Yes, Congressman. Thanks for that question.

It does, indeed. And that is why the American Hospital Association and our 5,000 members are very much interested in new payment and new delivery system models.

It would indicate, as you say, that people are dropping into the healthcare system on an as-needed or ad hoc basis, not with any sort of long-term relationship to the system and certainly not a relationship that emphasizes early intervention, prevention, wellness, community-based services, and so on.

We believe that that is the right way to organize the system. We are trying to do that by coming together with other entities up and down the continuum of care.

As I mentioned in my oral statement and in our written testimony, there are significant legal barriers to doing that. But, ideally, that is what we would do. We would put the incentives for wellness and less utilization and align them between patients and providers.

Mr. Davis. Dr. Antos, can I ask you: Isn't it true that current law does not necessarily restrict or does not prevent increases in certain types of hospitals if they are needed in areas?

Mr. Antos. That is right, Congressman. There are exceptions that are limited. I assume we are talking about specialty hospitals now or physician-owned hospitals. There are some exceptions.

However, effectively, the provision under the Affordable Care Act effectively eliminates any chance that physician-owned hospitals can expand or that new ones can be created. The exceptions are very, very rare.

Mr. Davis. Is it not also true that, in many areas, many States, that locally determined decisions are made through health facilities, planning boards, and other entities that will allow or not allow a hospital to build or a new service to come in or a new service to start?

Mr. Antos. That is right. Certificate of need is the phrase. I live in Maryland, and Maryland has the certificate-of-need law.

I have to say my observation of the State of Maryland is that it is a difficult process and it is not at all clear that, in the end, you end up with decisions that would have been made in the market, decisions that would have been made by consumers as far as where they would choose to go for services.

Mr. Davis. Mr. Umbdenstock, let me ask you -- current law requires physician-owned hospitals to report annually to CMS on their status and to provide a detailed description of the identity of each owner or investor in the hospital and the nature and extent of all ownership and investment interest.

But the CMS Web site still does not include this information and CMS says that they are concerned about the accuracy of the data they have received.

So the agency has once again extended the deadline for submission. Of course, this means that the public has no data on how many of these hospitals actually exist or who the ownership actually might be.

Do you think we ought to have that information before making further decisions about the issue?

Mr. Umbdenstock. Yes, sir. Yes, Congressman. I do. Absolutely. Again, full-service hospitals are under very rigorous reporting and disclosure requirements to the government about such issues. And I think it is disappointing that a particular segment hasn't been able to come up with that information, at least, again, as I reference the cms.gov Web site.

So they are obviously concerned. And, yes, I would think that that is important information to have before any significant changes are proposed.

Mr. Davis. Thank you very much.

I see that my time is about to expire. Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Mr. Marchant, you are recognized.

Mr. Marchant. Thank you, Mr. Chairman.

I represent a district around the DFW airport. We are very blessed in that we have several major hospitals that would be represented by your organization, but we also have an explosive growth in very highly technical, customer-oriented, private physician-owned hospitals.

And in my particular district, there is a great demand for that hospital. They are responsive. They seem to be a little more agile in filling market niches. They seem to be more responsive, in whole, to parts of my community.

Mr. Umbdenstock, where one of your hospitals is a partner with one of these physician-owned hospitals, what is the AHA's approach to that? How do those partners deal with this situation where they, in fact, are providing the capital and many times the loan and everything to start this other hospital, which is the case in my area?

Mr. Umbdenstock. Yes, Congressman. Thank you.

First of all, I would point out that some of our member hospitals are in such partnerships, as is the case present here today. The Methodist Health System is an AHA member and a fine member and a fine organization. We are very pleased that they have maintained being an AHA member and participate in our broader discussions and debates.

When we formulated our position on this, it was through a very participative process of hospital members with specialty hospitals and those without. And, frankly, on this point, some of my members have agreed to disagree.

So the situation is the same, whether it is a freestanding or partnered entity, and our position is the same. It has not been an easy position for us to take. We respect all of our members, but it is one that the vast majority of our members support.

Mr. Marchant. But that would explain why the major hospitals in my district perhaps are not coming to me and saying that, "We are for this moratorium," where, in fact, many of them are telling me --

Mr. Umbdenstock. I haven't looked at it by congressional district, but more broadly on SMSA basis and so on where they have very different views. Some, as we saw during the debate of this particular provision, are very much opposed to it. Others had made investments and were supportive of it.

But I can tell you, sir, that the vast majority of our members are supportive of current law and not in favor of relaxing it. Not an easy position for us, but one that the members broadly support very strongly.

Mr. Marchant. Are you familiar with this group of hospitals across the Nation that, during the formulation of the Affordable Health Care Act, they started facilities, they had hospital wings or additions in various stages of construction and, when the Affordable Health Care Act was put in place, the Commissioner decided that, on a certain day, if those beds were not certified and accepted, that those beds would never be basically accepted for Medicare or Medicaid use?

Mr. Umbdenstock. The act was enacted in March of 2010, and people had the ability through the end of December of 2010 to bring these online and get a Medicare provider

number. So, in the law, there was a 9-month delay. In reality, there was a longer delay because this provision was always on the table and being debated.

I was having conversations with my own members, again, some of whom were making these investments in these organizations, who wanted to know what that date would be. So people were on notice because of the conversation for much longer than 9 months. That date was in the law. Yes.

Mr. Marchant. But the fact is that several hospitals were caught in this period of time and now have beds that they fully intended to use for Medicare and Medicaid patients, but because of the prohibition, because they were excluded, cannot use them for that purpose.

Is it the position of your organization that these hospitals never be recognized and never be allowed to use those beds for Medicare and Medicaid patients?

Mr. Umbdenstock. That was the provision of the act. We are supportive of that provision. And, again, it was several years in the making. So there was a lot of lead time in that respect. We were counseling our own members that it was a very high-risk proposition.

Given the support for this measure, it would be a very high-risk proposition to keep going. Some members actually got their hospitals opened in that period of time. Others found themselves not able to do so before the well-publicized deadline.

Mr. Marchant. Thank you.

Mr. Umbdenstock. Thank you, sir.

Chairman Brady. Mrs. Black, you are recognized.

Mrs. Black. Thank you, Mr. Chairman.

I want to thank all of the panelists for being here today. Very interesting conversation on three very important issues.

Mr. Antos, I want to turn to you particularly about the Medicare Advantage plans. Many critics have suggested that the Medicare Advantage plans were overpaid and they don't provide a service that is more valuable than the fee-for-service. We have seen enrollment in Medicare Advantage plans all the way across the country, and I know in my district it more than tripled over the past decade.

And I know that what I hear from folks that are in the plan and the survey showed that seniors are more satisfied with their Medicare Advantage than they are with their fee-for-service program. All this has occurred while the Medicare Advantage has been cut dramatically.

We see that continuing, and in some cases where they said they were going to cut it dramatically, we have seen a little bit of a reduction in that so they weren't cut quite as dramatically as what was talked about.

Do you agree that this competition -- that Medicare Advantage is overpaid for their services it provides? Do you agree with what is being said, that they are overpaid?

Mr. Antos. No. I don't agree. I mean, the fact is that Medicare Advantage plans do provide good value not just for the people who enroll in them, but, also, for the taxpayer.

You know, one of the interesting facts about this is that people say that it is the younger Medicare beneficiaries, the ones who are turning 65, who are the new enrollees in Medicare Advantage. Actually, that is not true.

It turns out that most people, when they turn 65, sign on to traditional Medicare and, after a few years, they often find out that that isn't the plan they want to be in. It is not a health plan as they know it because they have spent 30 years in more organized healthcare delivery systems.

So in terms of value, I mean, there is very little question here. The fact that the bids -- the amount that they bid is below the cost to fee-for-service across the country says that Medicare Advantage plans are able to provide full Medicare benefits at a lower cost than fee-for-service. The fact that they get paid more gets plowed back into additional benefits for beneficiaries.

Mrs. Black. And I am also interested -- I heard you at another event talk about this very subject matter. And, in addition to that, one of the things that you did talk about is the research that you have done that suggests that the effects of the competition have actually seen the Medicare Advantage programs have that spillover effect on the fee-for-service in both lowering the costs and the increasing of the quality.

Can you talk just briefly about what you have done as far as the research there and how that has affected the fee-for-service in lowering those costs and increasing quality.

Mr. Antos. So, you know, an important point, too, for all of us to remember is that seniors are, in fact, the biggest customers of the healthcare system. And so, if the treatment for the senior population becomes more efficient and more effective, that is going to spill over on everything else that the health sector does.

In essence, what is happening is that Medicare Advantage plans are introducing better systems of coordinating care. They are especially focusing on the people with serious chronic diseases, the people who are the most expensive in the system. And when you have a sufficiently large volume of patients who are in those organized systems, well, it turns out the physicians also operate in the fee-for-service sector as well.

They don't change their practices just because the paycheck, which is going to go to some business office, comes from someplace else.

Mrs. Black. And, Mr. Antos, if I may -- because I only have a couple of seconds left -- I think this really makes the point of what we have been talking about, that when we look at the Affordable Care Act, we talk about repealing and replacing with something that is more market-based and something that is more patient-centered.

And I think this is such a great model, when we look at the research that has been done, to say, when you do that, when something is more market-based and more patient-centered, we see a lowering of cost, at the same time an increasing of quality.

And so I am just really very interested to see more research done in this area that can show that, if you do that, the fee-for-service will actually follow because there is going to be competition on the other side to make sure the costs come down, but the quality is there.

Thank you so much, Mr. Chairman, for having this hearing today.

Chairman Brady. Thank you, Mrs. Black.

Mr. Kind, you are recognized.

Mr. Kind. Thank you, Mr. Chairman. Thank you for having this hearing today.

I thank the panelists for your testimony.

Mr. Chairman, the reason I was late getting to the hearing this morning was I had a few interesting meetings on the current long-term care system and market that we have in the country.

And I think this is another area ripe for oversight and some additional hearings so that we come to grip before the Medicare program absolutely implodes due to where we are going with long-term care in this country.

But, Mr. Umbdenstock, let me start with you. And staying on the self-referral physician-owned hospital track, you cite in your testimony, both written and oral here today, that there are numerous studies from CBO, from MedPAC, from other independent researchers, citing that, with self-referrals at least, they are seeing data that is showing that they have an increase in utilization in both services and, therefore, costs in the Medicare system.

My question is: If there are ways for us to accelerate reform within the payment area so that we are getting the value of quality outcomes as opposed to fee-for-service, whether that would help address the over-utilization that you cited and that apparently exists based on these numerous studies out there?

Mr. Umbdenstock. Thank you, Congressman.

Yes. Overall, the AHA is very supportive of the various payment demonstrations and experiments that are going on at the moment to try to figure out a better approach to financial incentives that will drive a better organized and more coordinated delivery system so that we can move toward that system.

Unfortunately, right now nobody has come up with an agreed-upon approach to do that. So we find ourselves with experiments and demonstrations and accountable care organizations and primary care medical homes and so on, all very important learning experiences. And, hopefully, based on that experience, we will come to more of a consensus on how to move off to the next payment system.

Mr. Kind. You know, I have enjoyed working with many of your members and those in Wisconsin, in particular, that have been moving to a more integrated coordinated patient center and been real drivers in value in the healthcare system and that.

But they share frustrations I have had for some time. They say, "Well, how can we accelerate this? How can we move from fee-for-service to a more value of quality and align the financial incentives done the right way?"

You mentioned the Accountable Care Organizations. Secretary Burwell just announced an expansion of the pioneer ACL program, which I think is helpful, the medical home models, maybe some bundling in that.

But are we just still in this era of experimentation and trying to find out what works and what doesn't or are there some payment reforms that really do show some promise that maybe we ought to be stepping on the gas pedal a little bit harder on?

Mr. Umbdenstock. Well, certainly, again, as you mentioned from your home State, very much one of an integrated delivery system, large groups connected to hospitals, connected to payment systems.

Just tomorrow I am going to meet with members from across the country who are in very similar models to that. We estimate that about 20 percent of our members at the moment -- maybe high teens getting to 20 -- have a health plan or have some sort of relationship to a health plan where they are starting to integrate payment and delivery.

So the more we see of that, the more we see coordinated, integrated systems of care emerging. And so we are supportive of that. The only problem is that that is not right for every market yet. It is very difficult to do on small population bases, for example. Very difficult to do if the payment isn't right in socioeconomically disadvantaged urban areas.

And so it is a concept that we are all very interested in and moving toward, I believe, but it is all a matter of markets and timing.

Mr. Kind. What are you seeing in the area of uncompensated care numbers right now? Obviously, there is some improvement in some States. But I hail from a State that has rejected the Medicaid expansion funds and has left us with a huge shortfall in that regard. But, overall, what have you been seeing?

Mr. Umbdenstock. It is much more favorable, as you might expect, in States that have chosen to expand Medicaid. Nationally, we believe that uncompensated care has dropped -- or charity care has dropped about $7.5 billion with the additional coverage, and about two-thirds of that, maybe about five in round numbers, is from Medicaid.

So we definitely continue to urge all States to take advantage of that option. And it works for the States. It works for communities and employers who have a backstop if people should lose insurance. And it is working and helping providers as well.

Mr. Kind. Finally -- I know I am running out of time -- but I would like to follow up with you in regards to one of your recommendations for improvement, the standardizing the merger and review process between the two Fed antitrust agencies. I think that is a huge area that is going to require more scrutiny by all parties involved. So I would like to follow up with you in the future with that.

Mr. Umbdenstock. We would be happy to. Big issue. Thank you, sir.

Mr. Kind. Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Ms. Jenkins, you are recognized.

Ms. Jenkins. Thank you, Mr. Chairman.

Like many Americans, I am concerned about the future of the Medicare program. The current trajectory of Medicare shows a trust shortfall in 2031, only 16 years from now. This impacts not just future beneficiaries, but many current beneficiaries as well.

Access to quality care is in jeopardy, and that is why this hearing really is so timely. Improvement of competition in Medicare has the potential to lead to lower prices, higher quality, and a more sustainable future for the program.

One area of Medicare that has already demonstrated these results is the Medicare Advantage program. And the latest numbers show that over 62,000 Kansans enrolled in a Medicare Advantage plan last year. These private plans compete against each other to offer beneficiaries increased coverage options.

Particularly in rural areas, a Rural Policy Research Institute study shows that 216,000 more rural beneficiaries chose a Medicare Advantage plan between 2013 and 2014. This

is despite the cuts to Medicare Advantage in the President's healthcare law and despite the shrinking rural population in America.

So, Dr. Antos, Representative Black already touched on a few of my questions. So maybe I will just pick up there. How do you explain this apparent discrepancy between the President's cuts to Medicare Advantage and the increased popularity of the program?

Mr. Antos. Well, I think it is a tribute to the poor performance of the fee-for-service program in Medicare. As I mentioned, part of the issue is that, once you get to know Medicare, you realize that it isn't the program you thought it was going to be. And I think this explains to a very large extent why there has been such an expansion of enrollment among the younger Medicare beneficiaries.

Now, it is the case that Medicare Advantage plans are much better organized as businesses than the various unconnected fee-for-service providers. And so one of the criticisms that is sometimes made is that, well, they are over-billing. But they are not over-billing.

They are, in fact, properly coding the maladies and the conditions of their customers. And they are not only properly coding that, but they are also fully incentivized to find ways to provide kind of 360-degree care rather than narrow focuses on hospital services or physician services or what have you.

Ms. Jenkins. Okay. Great.

Given the increased popularity of the Medicare Advantage particularly in rural America, what would you suggest that Congress do to spur this trend along?

Mr. Antos. Well, certainly one of the things that really should be done is even the sort of situation when people enter the Medicare program. When you turn 65, the default is fee-for-service Medicare. That is one of the reasons why you have so many people who then change after a couple years, change the default.

Another big, big factor that I think really gets at the rural issue is to change the basis of the bidding. Right now fee-for-service Medicare is treated as if it was a national program. Of course, it is not really a national program. It is different in every region. It is different in every locality. And, yet, there is a national standard, there is a national benchmark, and so on.

What really ought to happen is that we have full, fair bidding and, in rural areas, where cost conditions are vastly different than in urban areas, that the bids from Medicare Advantage plans are measured against the actual cost of Medicare providing services in those areas.

Ms. Jenkins. Okay. Thank you.

I yield back.

Chairman Brady. Thank you.

Dr. Price, you are recognized.

Mr. Price. Thank you, Mr. Chairman.

And I thank the panel. And I apologize for being late. And I am sorry if I repeat myself here.

I do want to focus in on the whole issue of competition in a particular area to start with, and that is the area of durable medical equipment.

You know, just because something says it is competitive doesn't necessarily mean it is competitive. And so it is important that you drill down and look at actually how programs run.

I would suggest, many of us would suggest, that the competitive bidding system for DME is neither competitive nor is it real bidding. And we have put forward a bipartisan solution to that that we call market purchase pricing that we think is superior.

But, Mr. Steedley, I want to have you reflect a little bit on the competitive bidding system in DME. What are your experiences? For those of us who were in health care -- I was a physician for over 20 years taking care of patients -- we oftentimes see a different example or different experience than what is relayed here in Washington.

So you and your peers who are trying to care for folks out there in the real world, what has competitive bidding meant to you all?

Mr. Steedley. Thank you, Mr. Price.

You know, Barnes Healthcare Services had the opportunity in round 2 to bid in Atlanta. And, surprisingly, we actually won the bid; yet, we declined that bid because the bid came in lower than our bid. And that is an important piece to hear here. 50 percent of winning bidders in competitive bidding actually bid less than the median price that is accepted.

It is about a standard of care -- there are certain costs that are built into taking care of patients at home. And, specifically, if we just talk -- if I narrow into the wheelchair example I just used, there is measuring these patients at home, there is working with the physical therapists, there is working with those physicians. It is making sure that these patients are in chairs that are appropriate.

And it is important to differentiate, to your point. I am not talking about just a broken hip or a sore knee that is going to need 2 or 3 weeks, sometimes, or 6 weeks of

healing. Some of these patients are terminally ill. Some of these have ALS, muscular dystrophy, quadriplegic, and these folks require specialization with their chairs.

And so, for us, when we are looking at our cost structure and the necessity to take care of these patients, the things that they are going to need, the current system for us doesn't bring in enough revenue, quite frankly, to take care of these patients in the way that they deserve.

Mr. Price. So what I hear you saying is that there are patients out there that need services, require services. And the system that is being touted here in this town by so many at CMS as being an improvement, it is, in fact, harming individuals' access to care. Is that an accurate statement?

Mr. Steedley. And, specifically, I can tell you we take calls from patients, quite frankly, for winners in those areas where they have called because they can't get their wheelchairs repaired timely.

Some of these patients now, and I can supply a couple of these names for you later if you are interested, have decubitus sores, where they were put in inappropriate chairs with the wrong support structure for them.

What is going on is at this point, because the payment system is down so much, that providers are trying to find equipment that is under the cost. And that is not always appropriate for these patients.

Mr. Price. See, Mr. Chairman, this is the challenge that we have. It is that you have got folks who are winning supposed bids out here, but they don't have the expertise or the ability to carry out the care for those patients in that geographic area.

And I want to commend you, Mr. Steedley, for what you are doing. We are going to continue our work on the market pricing program. As I say, it was bipartisan last year. Last Congress, we had 180 cosponsors, 49 Democrats.

There is also a push to expand the payment rates for competitive bidding into noncompetitive bidding areas right now, and I know that that is a concern.

In fact, we had a letter that was signed by tens of individuals of the House that I ask unanimous consent to insert into the record to have OIG investigate exactly what the consequence of this would be.

[The information follows: The Honorable Tom Price Submission]

Mr. Price. And the reason that that is important is that CMS uses claims data to determine whether or not folks get the kind of coverage or care that they need.

And, in fact, that is an inaccurate determiner of whether or not that patient is actually receiving the right care. So I am hopeful that the OIG will give us a report that actually reflects the sincere problems that are out there on the ground.

Thank you, Mr. Chairman. I yield back.

Chairman Brady. Dr. Price, thank you for bringing this idea forward.

Mr. Renacci.

Mr. Renacci. Thank you, Mr. Chairman.

I want to thank the witnesses. It is always interesting to come to these hearings and hear some of the concerns and issues. I, too, want to follow up with what Dr. Price talked about.

I am actually a member who had a DME company and went through competitive bidding before I came to Congress. I can tell you it was an interesting process because, as I thought I was doing a good job, I lost the competitive bid to another party.

I lost the bid to another party who then turned around and tried to sell me the bid back. And I know some of that cannot occur anymore with -- hopefully -- Mr. Tiberi's bill, which requires securing a security bond.

And with competitive bidding, again, the name sounds right, and I heard one of my colleagues talk about it being a Republican issue. Hey, Republicans and Democrats, it doesn't matter whether it is a Republican idea or a Democrat idea. It is a bad idea if it is not working.

And what I saw in competitive bidding, it was driving good companies out and, at the same time, it was not giving clients the adequate equipment that was needed.

And that is, Mr. Steedley, one of the things I know that you said. It is interesting. There was a company in Ohio that actually came to me. They had won a bid for a certain number of canes at a certain price.

And it was also ruining their reputation because, although they provided the certain number of canes at the certain price, it appeared that people, because there weren’t enough other competitive companies out there, were continuing to come to them. And they didn't want to provide any more canes at the price because it was not in their best interest.

Are you seeing some of those same instances in the business model that you are currently running?

Mr. Steedley. Yes, sir. And, to your point, the binding bid legislation is actually not going to go into effect for several more years. So that remains a little problematic.

To your point, there is a company in Orlando, Florida, that come to visit specifically -- and I met with these folks. So I am talking from my personal experience here.

They won every single bid in round 2, all 90 MSAs in every product category in those bids. And to what you said a few minutes ago, their intention was to just resell those bids to desperate providers. It is still going on.

Mr. Renacci. Well, see, I wasn't even aware of that. And that is an issue. I mean, I had to live with it, and it became a process where other companies were making money and actually driving the cost down, causing providers to have to sell their product at less than actually a price they could afford to pay.

Do you see that also in the current situation where pricing mechanisms are far below cost of actually providing the service?

Mr. Steedley. Yes, sir. That continues. You know, if you look at even from the Association perspective, we are seeing a contraction now in the industry. Some of those folks are being bought by larger companies.

Just from a financial standpoint -- and I think we are all businesspeople in the room -- I can tell you those businesses are being bought sometimes for pennies on the dollar.

But, unfortunately, there are other providers that are going out of business because they did not win the bid. And, at some point, because they lost all that business in that area, they are gone and then the other providers that are left don't have enough left to sustain themselves anymore. So they are now going out of business.

What we are seeing, in essence -- and competitive bidding is not the right word for this. What you are really seeing is a decimation of this industry. The lowest cost providers out there, the home care communities, are being taken apart slowly at this point.

And we talked a little about transparency. I said that in my opening statement earlier. We don't have good data from CMS that shows the correlation from the decrease in the part B spin here and what that translates into on the part A side.

I have spoken to patients that are telling me, because they can't get service, they are going to the emergency room or they are being admitted at some point for other problems subsequent to poor equipment or no equipment at all.

Mr. Renacci. I know you touched on this a little bit. But this practice does have -- for me, it has some concerns about patients and the actual care they are getting.

I know that, when I operated in multiple cities in rural and urban areas prior to coming to Congress -- health care, nursing home facilities -- and I can tell you that it is always more costly and many times in those rural settings.

Just briefly, what are you seeing with patients? You touched on that, but I want to make sure we hit home on that. What is happening to those patients that aren't getting the proper equipment?

Mr. Steedley. You know, I can tell you -- and I just saw this the week before last, I believe -- what you are seeing is, people say, "Well, there is no problem with these patients, no access issues. At some point, what is going on is some of these folks that would ordinarily have got a different piece of equipment now are getting equipment that is no longer the best for them.

For instance, the case I am referring to, the lady was an elderly lady that was walking around very ambulatory, COPD or CHF, whatever her issues were, but was carrying one of those great big, heavy e-tanks around with her. And when I talked to her about that, she has a closet full of them because the provider that won would not give her a smaller, lighter weight portable tank because the cost of that system was more expensive.

Mr. Renacci. Thank you very much.

Mr. Chairman, I yield back.

Chairman Brady. Thank you.

I would like to thank today's witnesses for their testimony today.

We are going to continue this discussion about competition within hospitals and community hospitals and physician-owned hospitals, as well as looking at are there better ways to create savings from a durable medical equipment bidding as well as high-quality service to seniors.

And before I finish, I can see Mr. McDermott is anxious to submit a document for the record.

Mr. McDermott.

Mr. McDermott. Thank you, Mr. Chairman.

For the record, I would like to submit a letter from Medicare Rights, which basically is in support of the competitive bidding process and ask unanimous consent.

Chairman Brady. Without objection.

[The information follows: The Honorable Jim McDermott Submission 2]

Chairman Brady. Going forward, in continuing the discussions we had today, we will also be looking at issues of physician shortages, of disparities in rural health care within Medicare, as well as looking at improved programs on inpatient, outpatient and other hospital payment systems. So we will be encouraging input from both these witnesses as well as those in the audience today.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any members submit questions after the hearing, I would ask that the witnesses respond in writing in a timely manner.

With that, the committee is adjourned.

[Whereupon, at 11:51 a.m., the subcommittee was adjourned.]

Public Submission For The Record