

Hearing on MedPAC's June Report to Congress

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS
SECOND SESSION

June 18, 2014

SERIAL 113-HL14

Printed for the use of the Committee on Ways and Means

COMMITTEE ON WAYS AND MEANS DAVE CAMP, Michigan, <i>Chairman</i>	
SAM JOHNSON, Texas KEVIN BRADY, Texas PAUL RYAN, Wisconsin DEVIN NUNES, California PATRICK J. TIBERI, Ohio DAVID G. REICHERT, Washington CHARLES W. BOUSTANY, JR., Louisiana PETER J. ROSKAM, Illinois JIM GERLACH, Pennsylvania TOM PRICE, Georgia VERN BUCHANAN, Florida ADRIAN SMITH, Nebraska AARON SCHOCK, Illinois LYNN JENKINS, Kansas ERIK PAULSEN, Minnesota KENNY MARCHANT, Texas DIANE BLACK, Tennessee TOM REED, New York TODD YOUNG, Indiana MIKE KELLY, Pennsylvania TIM GRIFFIN, Arkansas JIM RENACCI, Ohio	SANDER M. LEVIN, Michigan CHARLES B. RANGEL, New York JIM MCDERMOTT, Washington JOHN LEWIS, Georgia RICHARD E. NEAL, Massachusetts XAVIER BECERRA, California LLOYD DOGETT, Texas MIKE THOMPSON, California JOHN B. LARSON, Connecticut EARL BLUMENAUER, Oregon RON KIND, Wisconsin BILL PASCRELL, JR., New Jersey JOSEPH CROWLEY, New York ALLYSON SCHWARTZ, Pennsylvania DANNY DAVIS, Illinois LINDA SÁNCHEZ, California
JENNIFER M. SAFAVIAN, <i>Staff Director and General Counsel</i> JANICE MAYS, <i>Minority Chief Counsel</i>	

SUBCOMMITTEE ON TRADE KEVIN BRADY, Texas, <i>Chairman</i>	
SAM JOHNSON, Texas PAUL RYAN, Wisconsin DEVIN NUNES, California PETER J. ROSKAM, Illinois JIM GERLACH, Pennsylvania TOM PRICE, Georgia VERN BUCHANAN, Florida ADRIAN SMITH, Nebraska	JIM MCDERMOTT, Washington MIKE THOMPSON, California RON KIND, Wisconsin EARL BLUMENAUER, Oregon BILL PASCRELL, JR., New Jersey

CONTENTS

[Advisory of June 20, 2014 announcing the hearing](#)

WITNESSES

Mark Miller
Executive Director, Medicare Payment Advisory Commission

Witness Statement [[PDF](#)]

Hearing on MedPAC's June Report to Congress

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:03 a.m. in Room 1100 Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. [Advisory](#)

*Chairman Brady. Good morning, everyone. I would like to welcome back the Medicare Payment Advisory Committee. Neither MedPAC nor its witness here today, Executive Director Mark Miller, is a stranger to this committee. MedPAC is the key non-partisan advisor with a lot of analytical firepower. There is bipartisan interest in this work.

MedPAC issues two reports annually to the Congress. Its March report focuses on the adequacy of payments made to the various Medicare providers. The committee pays close attention to those important findings, and has had MedPAC testify on them in past years. The June MedPAC report focuses on how to improve the Medicare program.

Improving Medicare, that is the focus of our hearing today. We are at a critical juncture. The program faces serious financial challenges. The Part A Trust Fund, which was paid out to more than it takes in over the past several years is slated to go bankrupt in just over a decade. The funding needed for the Part B Trust Fund will be in -- such an increasing drain on the treasury that it is sure to crowd out other priorities. According to independent researchers, this important program pays out, on average, three times the benefit it collects from workers over their lifetime.

We are in a state of flux on how we pay our health care providers in Medicare. The popular Medicare Advantage program faces severe cuts after several years of the White House delaying the damaging Affordable Care Act cuts. Providers increasingly have their payments tied to performance, whether in traditional fee-for-service or some alternative payment model.

The MedPAC June 2014 Report addresses a number of policy issues that are key to improving Medicare's viability and future direction. The report reiterates MedPAC's 2012 recommendation to improve the design of the confusing and outdated Medicare traditional fee-for-service benefit for seniors. It also discusses policy options that could help to ensure that the new benefit design works for low-income seniors.

MedPAC has outlined a design that brings clarity through a single deductible and uniform cost sharing and peace of mind by capping the amount that seniors have to pay out of pocket. The design would also reduce the need to buy a supplemental policy.

Benefit redesign is not a new issue. The Bowles-Simpson Commission appointed by President Obama, and the bipartisan Policy Center have also recommended it. The committee has called attention to it, even devoting a hearing exclusively to the topic last year.

At that hearing, I asked witnesses to conduct what I view as the most informative analysis: beneficiary impact over multiple years. The fact that a senior may pay a little more in any given year is not nearly so important as avoiding the years in which a senior may face frighteningly high costs. Any beneficiary who has high costs, such as those that come with a stay in the hospital, will see a significant reduction in out-of-pocket costs. Since we know the majority of seniors will have a hospital stay over the course of their lifetime -- some, many trips to the hospital -- this protects seniors from cost spikes in a year when they are particularly sick.

With a mom who relies on the confusing Medicare system, I am sold. If it were up to me, this common-sense change would already be done. Hearing MedPAC's views on how an improved design can work for low-income seniors furthers the discussion. I am confident that this reform can be done in a way that has net benefit for beneficiaries, even as it reduces future expenditures. Listening to those who have concerns, we must continue to work to make this happen.

The report also highlights the need to be able to compare traditional fee for service, Medicare Advantage, and the accountable care organizations. We owe it to our seniors to provide an apples-to-apples comparison of quality and cost of these options in their area. This effort can also provide vital information to set the stage for more sweeping reforms that further empower seniors and are more responsive to senior health care needs.

The report also examines how payments to in-patient rehab facilities and skilled nursing facilities differ for the treatment of similar patients. This is a continuation of a robust site-neutral payment policy discussion that has happened over the last few years. The House passed a site-neutral policy back in 2011. In fact, a provision establishing parity between in-patient hospital and long-term care hospital payments was signed into law late last year. This is a topic of great interest to members of this Committee, and has significant impact not only on health care providers, but seniors and taxpayers. MedPAC's work has been instrumental. We appreciate its continued focus.

The report looks at whether the method of accounting for expected patient costs or risk adjustment can be improved. This is important, because we need to make sure payments to Medicare Advantage plans and providers are as accurate as possible.

There is a lot of interest in the topic of medication adherence, which means taking medications exactly as prescribed by the doctor to result in better patient health and outcomes. The report examines the extent to which better adherence by seniors reduces overall Medicare spending.

Finally, the report discusses possible payment policy changes to bolster access to primary care.

Well, before we hear from Mr. Miller I want to say that this MedPAC report is not a book that will just sit on the shelf. For many of the issues, it represents an ongoing dialogue. This hearing is a valuable part of that conversation. I look forward to working with the members of the committee and MedPAC to enact policies that make the Medicare program work better for beneficiaries, for providers, and taxpayers.

*Chairman Brady. 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.

[No response.]

*Chairman Brady. Without objection, so ordered.

I now recognize the ranking member, Dr. McDermott, for five minutes for the purposes of his opening statement.

*Mr. McDermott. Thank you, Mr. Chairman. Welcome, Dr. Miller, for coming today to discuss MedPAC's most recent report. It is an important hearing, and I hope that we can have a constructive conversation this morning that focuses on finding solutions to the challenges that Medicare faces in a way that protects beneficiaries.

Through its expertise and non-partisan analysis, MedPAC in the past has helped Members of Congress come together to discuss options for reform that improve the payment system, cut down costs, and improve the quality of care that beneficiaries receive. Now, we may not always agree, but reports like the one we are discussing today often start as a good point for a starting point of a discussion.

Unlike previous reports, the MedPAC has submitted to Congress a report that does not contain any recommendations. Instead, today's report represents a number of ideas we can use as a framework for today's discussion. We do not need to leap to any conclusions, there is no crisis. We should hear, listen, question, analyze what we hear, and, after a careful review of the issues, we can then determine what proposals to move on.

Whatever changes we make, we need to focus on some key principles.

First, we need to make sure that beneficiaries are protected from having to bear an increased financial burden. Current Medicare beneficiaries pay a greater share of their income for health care than the average American. And yet, often the Republicans say they need more skin in the game. They pay taxes during their working years to earn eligibility, and they continue to shoulder a share of the load through premiums, co-pays, or co-insurance and deductibles.

Second, we must get health care costs under control. We did a lot of great things through the Affordable Care Act, particularly in the protecting of consumers and expanding access to affordable health care coverage for millions of Americans. The ACA improves Medicare's benefits by improving coverage of preventative care, and increasing prescription drug coverage. And the ACA helped constrain Medicare spending such that we have record low-per-capita spending growth, below inflation in the years following enactment of health care reform.

We must continue this work by focusing on controlling costs and improving outcomes. Just this week a report from the Commonwealth Fund found yet again that the United States spends more per capita than any other country on health care, yet we don't get the best results. We have to fix that.

Third, we must make sure that payments are accurate and fair. This involves a careful review of how Medicare pays doctors and hospitals, with an eye towards overpayments, which need to be eliminated, and fraud, waste, and abuse in the system. This will allow us to strengthen the program without harming the beneficiaries.

Finally, we should focus on saving money through innovative payment models. The ACA introduced a number of promising reforms to Medicare, including accountable care organizations and the Medicare shared savings plan, which will cut costs without harming beneficiaries. We need to continue to remove barriers to setting up these innovative programs.

I am concerned that my Republican colleagues will use today's hearing to suggest radical changes in Medicare. Whether it is a proposal to eliminate the program's defined benefit through a voucher program, or increasing cost sharing for seniors, I have heard a lot of bad ideas in the past. MedPAC has not suggested we make any of these changes in its report, and I hope our conversation doesn't use this hearing as a cover for those kind of bad ideas. I know that the chairman is interested in making changes to make Medicare stronger, and I hope to work with him. Thank you very much. And I yield back the balance of my time.

*Chairman Brady. Thank you, Doctor. And we will now hear from Mr. Miller. And you are recognized five minutes for the purpose of your oral statement.

*Mr. Miller. Chairman Brady, Ranking Member McDermott, distinguished committee members, thank you for asking the Commission to testify today.

As you know, Congress created MedPAC to advise it on Medicare issues. And in the June report you will see themes that we have often repeated: moving the Medicare program away from a fragmented, volume-driven system to one that is coordinated across providers and settings, and focused on patient outcomes; rewarding providers and plans that take risk and improve quality with higher payments and reduced regulatory oversight; assuring that Medicare's payment systems don't favor one payment model over another; and assuring that traditional fee for service remains an option, but at the same time assuring that that payment system is accurate, accountable, and as fair as possible.

Medicare now has 3 payment systems: 30 million beneficiaries are in traditional fee for service; 5 million are in accountable care organizations; and 15 million are in private plans. The Commission's June report discusses synchronizing Medicare's payment, quality measurement, risk adjustment, and regulatory oversight across the three payment systems. Our motivations are to protect the patient by setting common risk adjustment and quality standards, to assure fairness among plans and providers within a market by setting common financial and quality standards, and to protect the taxpayer by assuring that Medicare supports the lowest cost, highest quality payment system in any given market.

Regarding this last point, we used data from 31 markets to compute current payments and to simulate a common benchmark for Medicare across ACOs, traditional fee-for-service, and private plans. There is a lot of technical details here, but here are two take-aways. A common benchmark could make ACOs and MA plans more competitive with fee-for-service. And, most importantly, the simulations show that driving volume to any one model may not be desirable because no one model is always the most efficient in a given market.

Just as an aside, I would also note that on Monday we put out new guidance to the Congress and HHS on the next generation of ACOs that we believe is consistent with these longer-run goals.

Moving on to quality measurement, the Commission has become concerned that Medicare's quality programs are overbuilt, burdensome, focused on process, rather than outcomes, and out of synch with the private sector. To address these issues, the Commission discussions have evolved towards an alternative view that would focus on a small set of population-based outcomes and patient experience measures, and then to compare and report quality across traditional fee-for-service, ACOs, and private plans. For the purposes of rewarding and penalizing, our conversations are incomplete. But the direction of the discussion is around using those population measures for ACOs and managed care plans, while continuing to use provider-based outcome measures for fee-for-service.

Moving on to modernizing fee-for-service, in this report we explore three ideas. With respect to beneficiaries, we provide information on the Medicare support programs and reiterate the Commission's recommendation to increase eligibility for the program up to 150 percent of poverty. This recommendation should be viewed in the context of the Commission's broader recommendation on reforming the traditional fee-for-service benefit in order to rationalize that benefit design, to protect the beneficiary from high and

unpredictable out-of-pocket costs, and to create price signals to discourage first dollar supplemental coverage. The MSP expansion will offer greater out-of-pocket assistance to low-income beneficiaries under the reform benefit design.

With respect to provider payments, the report discusses primary care services, which the Commission believes are under-valued in the physician fee schedule. The policy idea would maintain the primary care add-on in a budget-neutral manner, but would move to paying for these services on a patient basis, rather than on a service basis. We believe that this would give physicians, advance practice nurses, and other qualified professionals the resources and flexibility to provide non-face-to-face services, and to provide coordination services.

Finally, we continue the discussion of our site-neutral payment policy. As this committee well knows, MedPAC has made recommendations to narrow payment differences in the ambulatory setting and between the in-patient hospital and the long-term care hospital setting. In this report we begin the discussion of narrowing payment differences for in-patient rehab and skilled nursing facilities -- again, focusing on trying to identify comparable patients, where this makes sense.

I would like to thank you for asking the Commission to testify today, and I look forward to your questions.

*Chairman Brady. Thank you, Mr. Miller. I want to talk a little about -- or ask you a little about -- the recommendation to redesign the Medicare fee-for-service benefit. The current -- for seniors, the current benefit design is very confusing. It really is, essentially, two different insurance products, one for the hospital nursing facility care, another one for physician services and other out-patients. Every one has its own deductible cost-sharing requirements, adding in a Part B medicine benefit and often a supplemental plan. You know, it is tremendously confusing.

So, I am pleased the Commission wants to address these problems. Can you explain the benefits to seniors of a redesign? And my thinking is, you know, the current system works fine as long as you never go to the hospital, you know. But seniors are going to go to the hospital. And some -- many times in their lifetime. And so, having a redesign that provides, you know, one clear deductible that creates a co-payment, rather than co-insurance, so there is more, I think, limits to those, and then an out-of-pocket cost where, in those years where you are ill and in the hospital, you are not going to go lose your life savings as a result of it.

Can you talk a little about sort of the context we ought to be viewing this? And we all want to make sure that we are protecting low-income seniors, as well.

*Mr. Miller. Okay. So I think, if you want to talk about it from the beneficiaries' point of view -- and I think that that was a motivation for a lot of the Commission's work here -- the first thing is that the benefit, as it is designed, doesn't include a catastrophic cap. And the market has changed significantly on that point over time. The managed care plans all provide catastrophic caps, for example.

And so, the first benefit to the beneficiary is to have a catastrophic cap, where their out-of-pocket would stop at some point. You know, we have modeled different options, but let's just say \$5,000. So that is the first thing.

The second thing is line of sight on their out-of-pocket costs. So right now you have a couple different deductibles, as you have said, and you also have percentage-based co-payments. I am going to pay 20 percent of something. And so, the Commission would rationalize those deductibles and move from co-insurance percentages to a co-payment amount for a service. And the hope here is that the beneficiary has a clear line of sight on what their out-of-pocket will be.

And then that, coupled with catastrophic, brings me to the third point, and make the need for the supplemental insurance significantly less, because they have greater protections and greater certainty about what they are going to be paying out of pocket. And so, the need for supplemental insurance, if that becomes much less, you have just relieved the beneficiary of the premium for -- that they pay for the supplemental insurance.

And then a final point, which you have also referred to, is if you have protections up to, say, 150 percent of poverty for low-income, then you are helping beneficiaries with any of their premium costs.

*Chairman Brady. Two things to that point. Should we be looking at the Medicare savings plan program in the context of this redesign?

And, secondly, are there benefits to continuation of care by redesigning the Medicare benefit?

*Mr. Miller. Yes, we are talking about 150 percent in the context of the broader re-benefit design. I am not sure if I followed the continuation of care --

*Chairman Brady. And the re-design is -- by this providing clarity and line of sight, in looking at your recommendations there seems to be a suggestion that this also helps seniors as they experience a continuation of care, from leading in the hospital and --

*Mr. Miller. Right, I now follow your point. I am sorry I missed it.

Yes, and we did -- actually, we did some analysis for this committee very directly on this question and gave it to you a while back. But for example, there are numbers like, you know, nine percent of beneficiaries have a hospitalization in a single year, but over multiple years -- say 4 years -- you can get up into 40 and 50 percent of beneficiaries having a hospitalization. And so, the benefit, the insurance value benefit, if you will, to a redesigned, you know, benefit, is that it also provides protection over a longer run.

*Chairman Brady. Can I switch about MedPAC's discussion measuring quality by focusing on the entire patient population, as opposed to assessing each individual provider? Being able to compare quality in an area between fee-for-service, Medicare Advantage, and other options, I think, is a very important thing. I understand the Commission's reluctance to adjust provider fee-for-service payments, because it makes them accountable for things outside their control.

My question is, in the context of how Medicare pays physicians, considering that the current sustainable growth formula adjusts payments based on the collective actions of physicians nationwide, wouldn't adjusting payments to physicians in a relatively small area signify an improvement?

*Mr. Miller. I think this is something of a trade-off in the sense that at the national level it seems very clear that you have sort of a tragedy of the commons type of situation. So I might -- if volume increases as a physician, I might be concerned about a fee reduction. But if that fee reduction is shared across the entire country, then I might benefit more in the short run by increasing volume, and then have the fee reduction shared by all physicians.

It is arguable that doing that on a smaller basis would do two things: make the physician more aware of the pool of physicians that they are actually at risk with, and perhaps give them more of a jump-start to moving into more organized systems. Say, as long as I am being judged with other physicians, maybe I want to pick those physicians and go to an accountable care organization.

However, it is really important for me to say this: the Commission was concerned that in that circumstance, in a fee-for-service environment, there is no unified entity, so they were concerned about judging providers on that basis because of that. But that is kind of your trade-off.

*Chairman Brady. No, I appreciate it. A final point, not a question, but I appreciate the Commission's work on trying to create an apples-to-apples comparison across all three of the payment models: spending benchmark, quality measurement, risk adjustment, regulatory oversight. I think for us to continue to improve the Medicare system, it is really critical we have an apples-to-apples comparison. So thanks for the work you are doing there.

*Mr. Miller. Thank you.

*Chairman Brady. Dr. McDermott?

*Mr. McDermott. Thank you, Mr. Chairman.

You made a passing comment about paying primary care physicians for per-patient amount, rather than per-service. I have always thought that we would have a much better system if everybody had a medical home, some general medical person who knew them and knew their situation. And it sounds to me like you are talking about a plan where you would give a fixed amount to a doctor to pay to do the general medical things that are necessary. They could then refer out for the rest of their care to the more general system.

I would like you to talk a little bit about what you meant by that.

*Mr. Miller. Yes. That is what we meant by that, that the notion would be that, instead of a primary care physician or advanced practice nurse, or whatever the professional is that is providing the primary care service, in order to get reimbursed they have to see the patient and they have to -- you know, face to face, and provide a service.

But I think the Commission's view is that, particularly and more coordinated systems, you want that professional to have the flexibility to do things like make phone calls, deal with the patient through email and phone calls, and also the flexibility to coordinate their care, which they aren't directly paid for now. So, the notion is moving to a payment for a population that you have responsibility for, rather than paying them service by service.

To your medical home point, this concept is not inconsistent with that thought. We are not saying it has to be a medical home, but we are saying that the payment should move more to a patient-based payment, which then gives resources for the professional to be flexible.

*Mr. McDermott. Are you talking, then, to a large organization getting a certain payment to cover, let's say, 30,000 people that get \$100 a month for each one of -- I am just picking numbers out of the --

*Mr. Miller. Doesn't have to be a large organization. We would see this as, you know, this is how we would pay primary care providers and services in Medicare, whatever their situation is. So, no, it is not you have to be organized to do this.

*Mr. McDermott. I mean most seniors -- 8 out of 10 -- don't go to the hospital in a given year -- moreover, a four or five-year period, as Mr. Brady has said. Aren't they protected by their supplemental insurance from the co-payment problems?

*Mr. Miller. Yes. If I understand your question, yes. If you have a supplemental product, you can purchase products that cover your first dollar, your deductible in your hospital case, and you can purchase products that have a back end catastrophic coverage. That has produced a supplemental market.

And without being, you know, too unpleasant about it, there is a lot of questions about the value of some of those products -- the premiums people pay in exchange for the value that they get. And those products

also impose additional costs on the taxpayer, because they generate services. There is fairly clear evidence on that.

And so, the thinking is --

*Mr. McDermott. Tell me about the evidence that that --

*Mr. Miller. Say again.

*Mr. McDermott. -- having this supplemental policy generates --

*Mr. Miller. Yes, what we --

*Mr. McDermott. -- services, where is the data that says --

*Mr. Miller. Okay, and we have published it, and we can make sure that we, you know, re-deliver it to you. There is a fair amount of evidence that when you -- and not just a beneficiary, any person -- of first-dollar coverage in their consumption of health care, utilization increases. And the issue with these products is the price I pay to get that product is about the actual wrap-around services, and the price doesn't contemplate the additional cost to the program that the product imposes.

*Mr. McDermott. Is it -- am I correct in thinking that 90 percent have supplemental coverage, about 90 percent?

*Mr. Miller. Yes, and that is composed of three types. One is employer-sponsored insurance. One is the private Medigap -- individual Medigap market. And then another number is their Medicaid supplemental.

And the kind of comments I am making, and what the Commission is talking about with this benefit redesign pertain to the employer-provided and the Medigap products. And our view there is the beneficiaries should have the choice of accessing those products. But the products' price should more fully respect -- or reflect the full cost of purchasing that product, which is the wrap-around services and the additional costs that they impose on the program.

*Mr. McDermott. Thank you.

*Chairman Brady. Thank you. Mr. Johnson is recognized.

*Mr. Johnson. Thank you, Mr. Chairman. Mr. Miller, the Commission report talks a lot about how Medicare under-values primary care services, including the fact that average compensation for specialists can be more than double what primary care practitioners earn.

It is also my understanding that cognitive physicians, like neurologists and rheumatologists, are in a similar position to primary care in income, recruiting, and even -- cognitive providers perform care coordination for beneficiaries with multiple chronic conditions, often for an aging population.

My question is, does the Commission have any plans to also recognize cognitive providers, along with primary care providers, in its recommendations?

*Mr. Miller. Okay. And this is a matter of degree, rather than philosophical difference.

So, if you think about the Medicare physician fee schedule, I think what the Commission -- you know, if all 17 were here -- would say to your answer -- to your question is this. There is great concern that the

procedural side of the fee schedule is over-valued. If you go to the cognitive side, there is concern that that is under-valued, because we are talking about time-based services. You don't have as much ability to generate volume and compensate yourself.

And so, cognitive becomes more of the concern. But if you have to pick priorities, and there is limited amounts of dollars, then the Commission's point is the first and primary -- or first concern is the primary care sets of services, and I will stop in just one second. And I think part of that reasoning is they see that as so critical to the care coordination that many people are looking for in the system.

So it is not -- you know, I completely -- you know, the Commission disagrees, it is really a matter about -- of priorities.

*Mr. Johnson. Okay. But you are looking at it.

Mr. Miller, the June report repeats a previous finding that Medicare Advantage beneficiaries who dis-enroll and return to fee-for-service Medicare have a 16 percent higher fee-for-service spending. Does that mean that Congress ought to build in extra incentives to keep beneficiaries in Medicare Advantage?

*Mr. Miller. We haven't made a recommendation on -- a direct recommendation on this point yet, but you are picking up on, decidedly, what -- the issue that is being raised in the report. The actual number these days -- we have re-estimated it using some later data -- it is about 12 percent. But your point still stands. And I think there is some concern here that if you find a plan that has excessive dis-enrollment relative to what you see out there in the environment generally, you might want to contemplate some kinds of incentives or penalties to forestall that kind of action.

And one of the things I would relate that to is we can always try and prove risk adjustment. It will probably be imperfect for a long time, and maybe forever. There are other administrative actions that you can take to try and get the behavioral response that you are looking for, and that is one of them.

But, yes, you get about a 4 percent dis-enrollment occurring every year, and those people tend to be about 12 percent more expensive than average. And I just don't want to vilify the plans here. Beneficiaries dis-enroll for their own reasons, as well. So this is both the beneficiary and the plan that are involved in the dis-enrollment.

*Mr. Johnson. Thank you. I appreciate your comments.

*Mr. Miller. Can I say one thing really quickly? I forgot to say to Mr. McDermott the other supplemental coverage is managed care. I didn't mention that in answering your question. Sorry about that.

*Chairman Brady. No, thank you.

Mr. Thompson?

*Mr. Thompson. Thank you, Mr. Chairman.

And, Mr. Miller, thank you for being here. I would like to touch on the under-value of primary care, as well. And specifically, in the ACA, we put in provisions to provide incentive payments for primary care docs. And in your report you state that access for beneficiaries seeking new primary care physicians raises more concerns than access for beneficiaries seeking new specialists. And I hear that in my district, as well. Folks tell me that they have long wait times for appointments, there is few docs, primary care docs, who will take new Medicare patients.

And why is this problem persisting? And have the incentive payments helped to reduce this -- the extent of the problem?

*Mr. Miller. Okay. I don't -- going to the last part of your question first, I don't want to overstate that the primary care add-on payment, which we recommended -- and we, you know, accept responsibility for, and the Congress enacted, and so we think that that is the right direct -- I don't want to overstate that this will correct the primary care, you know, wait times and difficulties that people are experiencing.

But we think it is a really important signal to primary care providers about the value that they can potentially provide in care coordination in a reformed system. And we think that it is important that that signal persist.

We do think that the fee schedule is out of balance for these types of services, and we are trying to say there is some attention to trying to rectify it.

Last thing I will say and I will stop is we have also talked about other things to get greater value in that fee schedule, but I won't go into them in the interest of your time.

*Mr. Thompson. So we should continue --

*Mr. Miller. Yes.

*Mr. Thompson. -- after the 2015 date when the incentives expire, we should continue to do those?

*Mr. Miller. The Commission has not made a hard recommendation on that, but the conversations that they are having, and that they are going to pick up with in the fall are all headed in that direction.

*Mr. Thompson. So thank you for being respectful of my time --

*Mr. Miller. Trying to.

*Mr. Thompson. -- but let's go into those other things that we should be doing --

*Mr. Miller. Okay --

*Mr. Thompson. -- in addition to the incentive payments.

*Mr. Miller. No, no problem. I just didn't want to get you off your point, and you may have had another one.

So, for example, in our SGR recommendations that we have made to the Congress -- and you know, these are not popular, but none of our stuff is -- so one of the things is we have made a set of recommendations on data collection and requirements for the secretary to identify over-price procedures in the fee schedule. We think that most of those over-price procedures reside on the procedural side of the fee schedule. Then you would have resources that you could re-balance to the cognitive or to the primary care side of the fee schedule, as you saw fit. That is one thought.

A second thought is that -- and again, this is somewhat unpopular -- in solving the SGR issue, in order to keep the cost of the SGR fix down -- and, remember, it used to be a lot more expensive than it was -- you can differentiate the conversion factor for primary care or cognitive, or whatever the Congress decided, relative to the procedural services. And that is another way to get a re-balancing effect.

*Mr. Thompson. Is there anything else that Congress should do to try and get a handle on this problem?

*Mr. Miller. I am sure I am forgetting something, but those are certainly the things off the top of my mind.

*Mr. Thompson. Okay. If you remember, why don't you drop me a line?

*Mr. Miller. We will do that. And we talk to your people all the time.

*Mr. Thompson. Thank you. I yield back.

*Chairman Brady. Thank you. Dr. Price?

*Mr. Price. Thank you, Mr. Chairman, and I want to thank you again for holding this hearing. I appreciate MedPAC's work in so many areas to try to make a health care system that works for patients. As I often times say, we tend to forget the patient in many of these discussions. We talk about money, we talk about other sorts of things, but often times forget the patient.

I want to thank MedPAC for what appears to be a further maturation of and appreciation that patients in various medical specialties are actually different, that one-size-fits-all doesn't often times -- doesn't work hardly at all, in terms of health care.

To that end I want to talk a little bit about medical specialties and the difference that they have, and specifically pathologists, as it relates to meaningful use requirements and electronic health records. You are familiar with that program, are you not?

*Mr. Miller. A bit. I am not real deep right at the moment, but I will do my best.

*Mr. Price. The kind of rewards, incentives that are being provided for physicians as it relates to electronic medical records and meaningful use are pretty much standard across the board. So we have got pathologists who, candidly, look at slides all day, or lab results all day, and are being asked to figure out whether or not that slide has an allergy or whether it smokes. And that doesn't make a whole lot of sense, does it?

*Mr. Miller. To the extent that I understand what conversation I am in the middle of, no.

*Mr. Price. Well, all right.

[Laughter.]

*Mr. Price. Maybe I could ask MedPAC to take a look at that, because this is resources that are being utilized and caring for Medicare patients in a way that, frankly, doesn't make a whole lot of sense for either the patients or the physicians that --

*Mr. Miller. And the question is whether there should be differential requirements across specialties on the EHR --

*Mr. Price. Exactly.

*Mr. Miller. -- meaningful --

*Mr. Price. Exactly.

*Mr. Miller. I can take that question back.

*Mr. Price. Let me come to something that you have been pushing on for a long time, and that site-neutral payments in the surgical setting. Obviously, ambulatory surgery centers, you mention that we ought to be looking for the lowest cost and the highest quality. And ASCs often times provide the highest quality at the lowest cost, and you have been a champion on that.

I want to touch on the site-neutral payments that you have mentioned here in this report on SNFs and IRFs, skilled nursing facilities and in-patient rehab facilities. And I am curious as to whether or not CMS has given you any feedback on your recommendation.

*Mr. Miller. And we have not made a recommendation yet. We are exploring this. We have just entered this particular area. They are aware that we are working on it. I don't think I have gotten feedback as in, "Way to go," or, "Stop what you are doing," nothing like that.

*Mr. Price. Can you imagine any reason why CMS ought not be supportive of site-neutral payments for various facilities providing similar care to patients, regardless of that site?

*Mr. Miller. Oh, and I didn't mean to imply that they were broadly hostile to this at all. I was thinking very narrowly about the in-patient -- or, sorry, the rehab and the skilled nursing facility. I haven't gotten a lot of feedback on that.

I think there is a sense and an understanding at CMS that this is an issue. I think there are some differences about how they would go about it, but I don't think they are ignoring it. Let's put it that way.

*Mr. Price. I think it is a healthy discussion to have, and I think we are actually having some admission on the part of CMS that, again, that one-size-fits-all doesn't actually work.

I want to also commend MedPAC for the work that you are recommending, or the discussion that you are having around quality measures. Those of us who have been physicians and practice clearly understand that one patient and another patient, even though they have exactly the same diagnosis, the quality treatment for each of those patients may be significantly different. Is that not true?

*Mr. Miller. Agreed. And we are trying to not only get a more consistent set of quality measures, there is a very strong motivation on the part of the Commission to relieve the burden on the provider.

*Mr. Price. And to that end, wouldn't it be most -- do you think it would be helpful to have the quality measures be determined primarily by those folks actually providing the care, the specialty societies, and not have them be a -- the kind of duplicative and often times contradictory measures that we currently have in place?

*Mr. Miller. Well, this was going too well to last, and so here we are.

[Laughter.]

*Mr. Miller. I think the Commission has great concern that the quality measures, if they are determined entirely by the specialty societies -- there is two concerns. Number one, that it creates and reinforces silo types of approaches to care: "Here is my set of metrics for the thing I did," as opposed to what was the general outcome for the patient throughout the entire episode; and I think the second concern that the Commissions have -- and this is with all respect, but the specialty societies all say it about each other -- some of them have rigorous standards, some of them less so.

*Mr. Price. And my time has run out, but I look forward to having -- maybe we can get another round, Mr. Chairman, as we move forward. Thank you.

*Mr. Miller. And, if not, we are happy to get on the phone and talk to you about this, as always.

*Chairman Brady. Thank you. Mr. Kind?

*Mr. Kind. Thank you, Mr. Chairman. Thanks for holding this hearing.

Mr. Miller, thank you for your testimony today, and for the work MedPAC does. I wasn't going to ask you this in my question period, but since Dr. Price raised it, I have teamed up with him in regards to the whole meaningful use with certain specialties, especially as it relates to pathologists. So maybe we can follow up with you in regards to legislation that we specifically introduced to try to get MedPAC's response to it, as well as a letter that we are doing to CMS to try to highlight this issue. There have been some extensions, we are not sure if there is going to be another extension in the future. But, nevertheless, it would be nice to get MedPAC's incentive on it.

You know, in past MedPAC reports to this hearing, I have been not so much critical, but impatient with MedPAC's recommendations in regards to payment reform. So I want to ask you yet here today -- I mean there are a lot of tools out there, a lot of different payment models that are moving forward, a lot of experimentation taking place. But from MedPAC's perspective, where can we be accelerating this payment from fee-for-service to a quality or value-based reimbursement system?

Where are there some very promising initial results coming back that is showing us that we can get much better quality of care, but also at a much better price?

I think -- I forgot who it was, Dr. McDermott or someone just cited the Commonwealth study that just came out this week, showing that we are still, by far, spending way too much per beneficiary in health care, as an entire system. And often times, getting worse results compared to most of the other developed countries around the world.

And I think part of this is being driven by this archaic payment system that rewards volume over value. And I know MedPAC has had recommendations in the past. But right now, from, you know, where you see us today, where do you think we can be pushing more aggressively to get to a value or outcome-based reimbursement system?

*Mr. Miller. Okay. That is a pretty -- you know, broad and complicated. But I would say a few things.

I think, you know, we are going to be living with fee-for-service for some period of time and, you know, perhaps forever. And I am not sure that that is a bad thing, because fee for service can be efficient and high quality in some parts of the country. But I think there are pursuits inside fee for service that can produce better quality results. Here is one.

The re-admissions penalty, which is, again, not a popular idea, but it is -- it looks like re-admissions are falling, and people are paying a lot more -- hospitals are paying a lot more attention to it.

On more of a systems-wide basis, you know, the ACO concept is still a concept, still entirely unproven, but we have been talking a lot to accountable care organizations on what is going on out there, and decidedly -- at least for some of them -- it changes the underlying dynamic. You know, generating services is working against you. And as long as the quality standards are clear and present, they move more in that direction.

And I think another area that we are talking about in this report is the notion of population-based quality measures. So get out -- and I know there is some conflict over here -- but get above the individual process-based, "I did this particular thing," and say, "Is this population avoiding admissions that are unnecessary? Are they staying out of the emergency room? Are they not being re-admitted?"

A concept that we are only breaking ground on is the notion of can we count how many healthy days they have at home. That is what everybody wants. Can we start to construct measures that say, "This is really where you want to be"?

And then, finally, I think, you know, bringing both the beneficiary and the provider into the -- we, MedPAC, I think the Congress in general, have spent a lot of time on trying to design payment systems and measurement systems to incent the provider, but also bring the beneficiary into that process too, so that you have both actors at the point of contact involved.

*Mr. Kind. And that is -- I would love to be able to follow up with you and see what we can explore and move forward on.

But one other thing before my time expires. Obviously, we had the CMS data dump on physician reimbursements recently. And, yes, it does provide a glimpse, but it was an incomplete picture, because it also didn't explain what results were happening, what the protocols of care -- and I also discovered during that that you have multiple doctors using the same billing number. I mean, does that make sense? Don't we want to dis-aggregate that information if we want to really drill down to find out where the reimbursements are going, and if there is perhaps some over-utilization occurring?

*Mr. Miller. Yes. I think the ability -- I mean there are 10 tax identification numbers, and then there are individual provider numbers. And I think it probably makes a lot more sense to be able to track through to the individual provider, because if there is a particular provider who is ordering a bunch of services that are really out of synch with general accepted practice, it is hard to get at that if you can't get to the individual.

*Mr. Kind. All right, thank you.

Thank you, Mr. Chairman.

*Chairman Brady. Thank you.

Mr. Smith, you are recognized.

*Mr. Smith. Thank you, Mr. Chairman.

Dr. Miller, thank you for joining us here today. Medicare Part D, we are learning that there is cost savings, that costs are less than originally projected. Can you speak briefly to that, and how and why you have seen that take place?

*Mr. Miller. I think probably the single most important reason that that is the case is that there was a fairly heavy move to the use of generic drugs that was driven inside the Part D program that may have resulted in the expenditures that were less than what was being projected when the program was implemented. But if there was one thing to point to, I think it is probably that.

*Mr. Smith. And how about the penalty that is -- rather than mandating seniors have Medicare Part D, there is a provision that is a penalty if they don't sign up during the open enrollment period.

*Mr. Miller. Which is pretty true throughout Medicare. If you don't sign up for Part B, it is kind of the same --

*Mr. Smith. Right, but there is no individual mandate, if you will. Correct?

*Mr. Miller. There is no individual mandate. That is correct.

*Mr. Smith. And can you speak to the effectiveness of that provision?

*Mr. Miller. In lowering cost?

*Mr. Smith. Well, not necessarily just in lowering costs, but in incenting individuals to sign up.

*Mr. Miller. Well, I think the existence of a penalty probably focuses the attention of the beneficiary, if that is what you mean. And I think it was put into Part D and into Part B because of the concern about selection. If you don't move broad ranges of the population into these programs, what you get is the sickest, and then the premiums become unsustainable over time, and the program collapses -- in the extreme. It is death spiral in the -- you know, kind of the actuarial terms.

So, those things are created to draw the beneficiary or whoever the person is, his attention to purchase the insurance, so that you get a relatively broad representation of risk.

*Mr. Smith. Very well. I thank --

*Mr. Miller. Is that what you are asking?

*Mr. Smith. Yes. Thank you very much.

*Mr. Miller. Okay.

*Mr. Smith. I yield the balance of my time to Dr. Price.

*Mr. Price. Oh, thank you. Thank you very much. I was -- I am sorry Mr. Kind left, because I was remiss in not thanking him for his assistance on this issue of some specialties, especially pathologists, and the meaningful use in electronic medical records.

And you did make a comment to -- in response from Mr. Kind, though. You said that re-admissions were falling. Have you looked at the change in observation status in hospitals?

*Mr. Miller. Observation status has been increasing. We have looked at the relationship between those two. We don't think that that is driving the impact that we are seeing on admissions. But we are looking at observations. We do think that there are some real issues there. We are looking at the to-midnight rule, which I think has been a subject of some conversation.

I am not in a position to give you, you know, data and analysis, although I may have some fact points. But the Commission -- the staff right now -- I haven't rolled it out in front of the Commission -- is looking at an alternative approach that would change -- I don't want to get too deep here -- the in-patient payment system to make it more clear when a person is in-patient, and to pay on a more rational basis, so that there is not as much need for this observation spike --

*Mr. Price. I think that would be extremely helpful, because all you have to do is go to an emergency room and you ask them where their observation beds, and they have increased -- well, now that we have observation beds. The only reason for that is because of a payment system that we have put in place, as you know.

I want --

*Mr. Miller. This fall we will have some of this information out in our public meetings, and you and your staff can start paying attention.

*Mr. Price. Great. I would like to touch on the recommendation or the comment that you made in the report about paying -- using a per-beneficiary payment. Some people have called that capitated payment system. How does what you envision to be appropriate differ from what some folks call concierge medicine, or personalized medicine? How does the paying a primary care physician or a medical home physician differ from what you are envisioning?

*Mr. Miller. Well, I --

*Mr. Price. Or does it?

*Mr. Miller. Well, I think I see the linkage that you are making.

The -- I think the first distinction -- and maybe it is the only one I can think of off the top of my head -- is that what a concierge payment usually gets you is exclusive access to a physician. And generally, physicians use it to lower their panel counts, and then focus more attention on an individual patient.

This wouldn't have any exclusivity to it. The payment would be attached to the provider on the basis of a preponderance of contact with a patient. And we would say, "Okay, you seem to be seeing this patient for their primary care. Here is a block of dollars for you to coordinate and, you know, have non-face-to-face service with that beneficiary." That portion does sound like the concierge type of experience. The exclusivity, I think, would be a difference, though.

*Mr. Price. Maybe we can take a peek at that.

*Mr. Miller. Yes, absolutely.

*Chairman Brady. Thank you. Mr. Pascrell?

*Mr. Pascrell. Mr. Chairman, thank you. This year's June MedPAC, Director Miller, reaffirmed -- in my mind, anyway -- that we don't have to scrap the current system in order to save Medicare. I think it is conclusive evidence to that effect.

We are talking today about strengthening Medicare. The Affordable Care Act is already hard at work actually testing the new payment system and the delivery system. That will lead to innovation, not only for Medicare, but everybody in the entire health care system.

The point I would like to make is that health care reform is already moving Medicare, I think, in a new direction. That is my estimation of what is going on. And we should always be open to new ideas. There is no two ways about that. But I think my colleagues need to take a look at the work happening today that is making and moving Medicare towards paying for the quality of services, not necessarily the quantity of services, for our seniors.

Here is my first question to you. Health care, to me -- health care reform is entitlement reform. Not only did the Affordable Care Act reduce costs for Medicare, it also reduced costs for beneficiaries. Mr. Miller, can you discuss the ways in which the Affordable Care Act has helped the solvency of Medicare?

*Mr. Miller. Well, I mean, I think a couple of things. The changes in the basic payment rates for the fee-for-service providers that were restrained as part of the ACA meant that there would be lower spending for

that reason. So, you know, the reductions in the market basket, I think, you know, might be a way to talk about that vocabulary.

I think a second reason is the reduction in the managed care payments, which the Commission did a lot of work demonstrating that we were basically subsidizing and paying more than we needed to to get that benefit. And I think that lowered expenditures.

What I think the jury is still out on is, for example, take ACOs. You now have five million people in ACOs. So decidedly, there is change occurring. There results are mixed, which, actually, I think everybody expected them to be.

*Mr. Pascrell. Right.

*Mr. Miller. So the ACOs are actually saving money. There seems to be increases in quality, pretty broadly, but some are saving money, some are not.

*Mr. Pascrell. Before we get into out-of-pocket expenses -- I am very concerned about that -- you don't disagree that the life of Medicare has been extended about eight years because of the ACA?

*Mr. Miller. Well, I am not sure I have walked through that thinking for myself. I know the trust fund is extended. There is lower expenditures in Medicare rates right now. That is extending the life of the trust fund. There is big discussions about how much of that is secular and how much of that is ACA.

But to your question, the things I pointed to did reduce Medicare's spend.

*Mr. Pascrell. The average Medicare beneficiary has an average annual income of less than \$23,000. I am concerned that if it doesn't provide adequate financial assistance for lower income beneficiaries, benefit redesign puts these beneficiaries in a very, very vulnerable financial situation. And they may -- it may discourage them from assessing -- accessing the care they need because of the cost. I am very concerned about that.

We discussed this when putting the bill together. While the intention of setting an out-of-pocket maximum is to protect beneficiaries from high out-of-pocket spending, it would only be effective for those who have the financial means to reach that threshold. When MedPAC proposed Medicare benefit redesign back in 2012, which was also referenced in the most current report in June, does MedPAC envision redesigning the benefit for the purposes of achieving cost savings of the program? Is that the reason why you have suggested that?

*Mr. Miller. No, but I am going to parse my way through this answer carefully.

The benefit redesign portion of our proposal is explicitly -- and we say this very clearly -- designed not to increase the aggregate liability for the beneficiaries. We all understand the distribution --

*Mr. Pascrell. Right.

*Mr. Miller. -- can change, but the aggregate liability.

However, we have said that the first dollar coverage should have an additional charge to it. And our hope is that people see that they don't need it, and then they drop the first dollar coverage, and that frees up more resources for them. But if they choose to hold on to it, then they would pay more for that product.

*Mr. Pascrell. Right, because, Mr. Chairman, we have talked about this several times about out of pocket. So we need some kind of a balance here so that, you know, we don't cut off our noses to spite our faces.

*Chairman Brady. Let's see if we can find that common ground as we go forward.

*Mr. Pascrell. Thank you.

*Chairman Brady. Which is why the recommendations are, I think, helpful in this discussion. So thank you.

Mrs. Black?

*Mrs. Black. Thank you, Mr. Chairman. And I appreciate your allowing me to be sitting in on this committee.

Thank you, Mr. Miller, for being here today. This is such an important subject matter, and we need to continue to make sure we are discussing it. In your June report you discuss the quality in fee for service and in the Medicare Advantage program, and I would like to discuss just a few concerns about how the quality is measured in Medicare Advantage, especially among that dual eligible population.

I don't have to tell you, you know that dual eligibles only account for about 19 percent of Medicare beneficiaries, but they account for about 34 percent of all the Medicare spending. So this is an important population. And having been a nurse for over 40 years, and having worked with this population, I certainly recognize that they are the most vulnerable, they have the highest rates of chronic illness, of disability, mental illness, and frailty than the rest of the Medicare or the Medicaid populations. And this means that Medicare Advantage will play a critical part in getting those services that they so critically need, and the larger services in coordinated care and benefits to access those services that beneficiaries most in need of, and especially in care management, in managing their care, since they have so many issues.

Would you agree that we need to take into account these fragile populations when we make comparisons across the fee-for-service and the accountable care organizations with Medicare Advantage plans to make sure that we are really comparing apples to apples in both our costs and our quality.

And then, if so, I would like for you to speak to how you think we might be able to do that.

*Mr. Miller. Okay. So let me take this through a couple of steps here.

So, the plans in managed care that take a lot of dual eligibles, the special needs plans, are -- take a lot of these populations, although these populations are throughout the plan types.

What we have done is we have looked at the risk adjustment system. And a way to think about it is, if this is your distribution of your population -- expensive people, not expensive people -- the risk adjustment system overpays a bit for not expensive, underpays for expensive people. And then, if you, as a managed care plan, kind of go after this end of the distribution, you could be potentially disadvantaged.

We made three recommendations recently in which we said, "If you make these technical changes" -- and I will take you through them, if you really want to glaze over -- but, "If you make these three changes, it will move a little bit more to this balance." So we think that that is a way to approach these kinds of payments and quality measurement in a way that is a bit more equitable.

Now, as everything in health care, things get a little bit complicated. When you look at these plans' financial performance, they aren't really on a profit basis. That disadvantage -- I mean, in some cases, have

the highest profits relative to other plans. And so, you know, what we think should happen here is that there should be a common suite of measurements across any plan type, so that the beneficiary can look at it and say, "This plan does well, this plan doesn't do well," whatever the -- or fee-for-service, whatever the case may be.

I have talked to these plans many, many times, and they say, "You know, the way you do it in" -- or, "The way Medicare does it in managed care, it is not fair to us." And I say to them, "What measures would you add to this suite that capture your line of business better than is happening now?" And I have to say they have not come forward with those measures.

And so, I see your point. I -- we have made these recommendations for the risk adjustment. We think if there are measures that this portion of the industry can come forward and say, "This is really what we are about," the Commission's view is let's evaluate them and make them part of the measurement process. But, to date, there hasn't been a lot forthcoming.

*Mrs. Black. Do you have any research that you are currently doing, or plan to do, in being able to put forward some measures that you think would be applicable?

*Mr. Miller. See, we are a very small operation. There is 30 of us at the -- on staff anyway, and we don't really view ourselves as the people who create the measures. We try and draw them from the environment, evaluate them, point them out, and say, "Here is a good set of work that is occurring." We can try and put effort into that.

But to date, no, we have not come up with a set of measures that at least those special needs plans would say, "Yes, that is the set-up measures." We have talked to them a bit about them, but we haven't gotten a lot of traction.

*Mrs. Black. I was just curious, because there are certainly areas such as the chronic illness, and the disability, and the mental illness that set a stage for saying, "Here are the disease processes that are going to cost more," as to whether you have actually seen any measures out there that you think would be applicable for what is already there.

*Mr. Miller. Now, to those types of things, at least, our risk adjustment recommendations should address some of that. So, if -- one of the measures is basically a chronic condition count. And when you enter that into the model, it makes this risk adjustment system more balanced.

So, to the extent that those are conditions that are present, we have made recommendations, and we have done research. I thought you were asking more about this is an activity that we are engaged in, and we should be measured on this activity. That is where we haven't brought new information to the conversation.

*Mrs. Black. I think it is both areas.

*Mr. Miller. I agree with you. And one we have standing ideas. One we are trying to work with the industry to identify them.

*Mrs. Black. Thank you. Thank you, Mr. Chairman.

*Chairman Brady. Thank you, Mrs. Black, for joining us. If anyone thinks this is a check-the-box hearing, they are wrong -- MedPAC does a report, we hold a hearing, that is it. Truth is, this committee has spent, as you would imagine, a lot of time on the rollout of the Affordable Care Act, and spent a lot of good time, and I think a fairly historic agreement on how we fix permanently how we reimburse our doctors in Medicare.

Now we are turning to how do we improve the Medicare program. There is a lot of challenges to it, there is a lot of opportunities. And it is my hope that we will build on some of the recommendations, adjust them, and, on a bipartisan basis, find a way to improve Medicare for our seniors.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, Mr. Miller, I ask that the witness respond in a timely manner. And I thank you for your testimony on behalf of MedPAC here today, and the hearing is adjourned.

[Whereupon, at 11:09 a.m., the subcommittee was adjourned.]

Public Submissions for the Record

[AHCA](#)