

**Hearing with MedPAC to Discuss Hospital Payment Issues, Rural Health Issues,
and Beneficiary Access to Care**

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Mark Miller

Executive Director, Medicare Payment Advisory Commission

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**Hearing with MedPAC to Discuss Hospital Payment Issues, Rural Health Issues,
and Beneficiary Access to Care**

Wednesday, July 22, 2015

House of Representatives,

Subcommittee on Health,

Committee on Ways and Means,

Washington, D.C.

The subcommittee met, pursuant to notice, at 10:06 a.m. in Room B-318, Rayburn House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding.

*Chairman Brady. Good morning. It is my pleasure to welcome Dr. Miller back to the Health Subcommittee to help us continue our discussion on payment reforms.

Earlier this year, Congress took the first step in this area and passed legislation to fix the way Medicare pays our nation's physicians. We did so in a broad, bipartisan, and bicameral way, and I was glad to see the President sign this important legislation into law.

Well, now we need to take the next step, and that means looking at Medicare's acute-care payment system. I want to raise the topic of site-neutral payment reforms. This is a policy MedPAC has highlighted for several years now. The President's most recent budget even included a site-neutral policy with respect to services provided in hospital outpatient departments. So this area of payment reform is not -- or at least should not be -- a new or contentious topic.

This year's June report brings us new information and data that could help elevate our discussion in this area.

MedPAC has found that, for some cases, we are paying as much as \$4,000 more per case, simply because there is a discrepancy regarding status. That is, was the patient supposed to be classified for inpatient status or outpatient status? Unfortunately, this is a real question that hospitals are faced with.

But because the inpatient and outpatient payment systems are so different, it is hard to get an accurate assessment of what is driving this trend. More to the point, the codes that are used to determine what Medicare should pay for inpatient services are entirely different from those used for outpatient services. Not only does this mean hospitals are responsible for managing two different billing systems, but it means Medicare has to do the same.

And the issues with payment disparity become magnified when we consider that Medicare is expected to spend more than \$130 billion on inpatient services, and \$40 billion on outpatient services this year alone. Clearly, this is an area ripe for reform. MedPAC has proposed some innovative solutions; I look forward to hearing more today.

Also, MedPAC's testimony focuses on indirect medical education, and disproportionate share hospital payments, two add-on payments that certain hospitals receive to help offset the cost of teaching medical students or treating a larger-volume of uninsured or under-insured patients. It is important to note that when we are talking about payment disparities between the inpatient and outpatient systems that these two add-ons, IME and DSH, are only included on the inpatient side. Outpatient discharges are not eligible to receive these payment adjustments. As a result, these important payments get caught up in a financial numbers game and end up driving incentives.

I believe both of these programs are critical and need to be designed to deliver the most targeted payments possible. As arbitrary add-on payments, they are not achieving their mission. As MedPAC notes in the June report, and as Medicare's own trustees tell us each year, the program is facing serious fiscal and demographic headwinds. Spending is out of control, and the current financial underpinnings will soon not be able to sustain the program for the long term. Congress needs to tackle these issues, and we need to tackle them now.

We have already started down this path by successfully reforming how Medicare pays our local doctors. My hope is that we can carry this progress over into other payment areas.

*Chairman Brady. With that, I would like to introduce today's witness, Mark Miller, the executive director of the Medicare Payment Advisory Commission, known as MedPAC. And before I recognize our ranking member, Dr. McDermott, for the purpose 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. And I will recognize our ranking member, Dr. McDermott, for his opening statement.

*Mr. McDermott. Thank you, Mr. Chairman, for holding this hearing today. I hope it will be a constructive conversation about how we can improve and strengthen Medicare.

I would like to thank our witness, Dr. Miller, for coming again today. We haven't seen you for a long time. We missed you, and we thought it was time to have a talk with you again.

The work that MedPAC does makes an invaluable contribution, really, to the legislative process. We may not always agree with the Commission's recommendations, but we can trust that MedPAC's reports are based on the facts, data, and thoughtful analysis.

Today's hearing is an excellent opportunity for the committee to carefully examine a number of issues that affect the future of the Medicare program. At the heart of the conversation must be the most important concern: that is, making sure that beneficiaries continue to have access to affordable, high-quality care. Any proposals that we discuss here, I think, should be seen through that lens. And any changes that we have to make have to be in the best interests of the beneficiaries.

Medicare is really about beneficiaries. It isn't about providers, it isn't about drug companies, it isn't about hospitals, it isn't about anybody else. It's really about beneficiaries. Medicare is a key component of the social safety net in the country. It provides core health care benefits to 54 million seniors and people

with disabilities. And I hope this Committee will join me in looking at ways to strengthen, not cut the program, to ensure that it remains strong in the future.

If we are looking to achieve savings, the first place we should look is to make sure that payments are appropriate and accurate. We should proceed with caution before radically cutting payments at the expense of hospitals that serve the most vulnerable patients, and the teaching hospitals that train the physician workforce.

As we discuss the potential policy issues today, it is important to remember that many are not formal recommendations by MedPAC. They are thought-provoking ideas that provide us with starting points for discussion. It is the role of the committee to carefully consider these ideas and ask tough questions about what they mean for Medicare and the beneficiaries.

I am hopeful that this hearing will serve as an opportunity for us to highlight a transformation that is radically shaping the health care system and practice of medicine. Across the country at this moment we are seeing a rapid and dramatic trend of hospitals merging together into massive health systems that exert tremendous market force. We count on our system to be working on the basis of competition, but it is increasingly questionable whether that occurs. We are witnessing hospitals purchasing small physicians' practices. As a consequence, more physicians are now hospital employees, something that was almost unthinkable when I went to medical school. This trend raises a question about the future of the medical profession, health care spending, and patient care.

As policymakers, our role is to ask these questions. The committee needs to hold a hearing on this issue and other topics related to health care consolidation. It is not a partisan issue, and I believe that we can work together to ask these questions and find out how to address this issue and move forward. And I hope this morning will be sort of a beginning.

So, welcome, Dr. Miller, to the committee.

*Mr. Miller. Thank you.

*Chairman Brady. Thank you, Dr. McDermott. And thank you, Dr. Miller. You are now recognized for five minutes.

STATEMENT OF MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

*Mr. Miller. Chairman Brady, Ranking Member McDermott, distinguished committee members, I am Mark Miller, executive director of the Medicare Payment Advisory Commission. On behalf of the commissioners, I would like to thank you for asking us to testify today.

The Commission's work in all instances is guided by three principles: to assure that beneficiaries have access to high-quality, coordinated care; to protect taxpayer dollars; and to pay providers in a way to accomplish these goals. I will start off today by reviewing some hospital trends.

Hospital inpatient admissions are declining, both in Medicare and among the privately-insured population. This has been a trend for several years now, and it is fueled in part by movement of surgery from the inpatient to the outpatient setting. In contrast, service volume in the outpatient setting has been increasing rapidly. For Medicare fee-for-service, the increase has been 33 percent over the last 7 years.

While it varies by market, overall there appears to be excess inpatient capacity in the country. Hospital occupancy rates are around 60 percent and have been declining. And in rural areas the occupancy rates are around 40 percent. This is an issue that will drive change in the near term. Regardless of whether a

hospital is urban or rural, the focus of hospital care is changing from the inpatient setting to the outpatient setting.

Another fact of life is that the hospital industry has been consolidating for several decades now. Again, it varies by market, but many hospitals have very strong bargaining positions relative to private insurers. And, consequently, private insurers pay hospitals well above their cost, and much more than Medicare pays. On average, hospitals are paid 150 percent above their cost by private insurers. Our analysis has shown that these higher payment rates in turn results in higher costs. In other words, if a hospital is paid more by private insurers, all things considered, there are higher costs per admissions in that hospital.

One other trend that I believe all of you are aware of is that there has been a lot of activity by hospitals in purchasing physician practices [sic]. Some argue that this is to integrate and coordinate care. Other argues that -- others argue that this is to capture market share and increase revenue by obtaining higher outpatient hospital payment rates for office services.

Perhaps the most concerning version of this is where a hospital purchases a physician practice in the community, and then shifts the billing for those services from an office fee schedule to a hospital fee schedule. This means that insurers, private and Medicare, pay more, although very little has changed. And, of course, of most concern, the beneficiary has a higher copayment, as a result of this.

Turning to some of the Commission's recommendations, the Commission has recommended increasing Medicare's hospital payment rate, but coupled that with site-neutral payment reductions to remove some of the market distortions I just mentioned. To improve coordination, the Congress adopted the Commission's recommendation for a penalty on hospitals with excessive readmission rates. Readmission rates have fallen, but there is a further adjustment needed for hospitals that serve substantial numbers of the poor.

The Commission recommended retargeting the excess indirect medical education add-on payment to hospitals and other entities that administer reform graduate medical education programs that focus on care coordination, and provide training in alternative sites of care. The Institute of Medicine recently made a similar recommendation.

Most recently, the Commission has made a series of recommendations regarding the recovery audit contractors, to strike a balance between program integrity and administrative burden on hospitals. At the same time, the Commission made a set of recommendations to improve the protections for beneficiaries who are treated in observation status in the hospital.

With respect to rural care, the Commission has made a number of recommendations that have resulted in higher payments for rural hospitals over the years. And, as a result, the 900 rural PPS hospitals have higher margins than those for urban hospitals. And, as you know, the remaining 1,300 rural critical access hospitals are paid on a cost basis.

The Commission undertook a comprehensive review of access, quality, and payment between urban and rural areas in 2012. In general, the Commission found that urban and rural Medicare beneficiaries have similar levels of health care use, satisfaction, and quality, although there are some important differences that should be discussed, if we get into that.

More importantly, the Commission strongly believes that there is a need for supports in rural areas, but that these supports are often not well targeted or designed. One principle for reform that I will mention here is that supports should be targeted to providers who have low patient volume, and are thus unable to cover their fixed cost, but serve as a vital source of access, meaning that they are distant from other providers. To put it simply, in short, targets should support low-volume, isolated providers.

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

*Chairman Brady. Doctor, thank you very much. Clearly, our goal is to save Medicare for the long term. And to do that we have got to get the incentives right, both for providing high-quality care to patients, affordability for our seniors, and to make sure this important program is around for a long time in the future.

I found it striking that MedPAC concluded that Medicare paid roughly \$4,240 more, on average, for an inpatient stay than for a comparable outpatient surgery. This sounds like a good place for Congress to start establishing site-neutral payment. I hope you agree with that.

*Mr. Miller. It is certainly an area that should be looked at. It is one that we have begun to look at.

*Chairman Brady. You know, focusing on just the 10 surgical DRGs, or the procedures, like MedPAC did, how difficult would it be for Congress to craft a policy -- and, obviously, what we are looking for is providing appropriate care at the appropriate setting for the appropriate price, and not creating incentives for people to get moved into higher costs, procedures, or areas, when we could do it in a neutral approach.

*Mr. Miller. I think that there is probably two ways to -- or two ways to think about responding to that. One is whether there is the ability to kind of crosswalk between sets of services in the settings, so that you could create relatively comparable classifications of services, and actually focus on this is the service and set payments around that. And that, while it has a complexity to it, is probably something that could be done. And we could talk more about that. What I think --

*Chairman Brady. And a crosswalk is what, exactly?

*Mr. Miller. So it was what you were saying in your opening statement. You were talking about the notion that there were different systems and different codes, and that is why I was trying to bring it back to that. There are different systems and different codes, but you can probably work, you know, a crosswalk across that to begin to look at comparable, you know, groupings of services, or overlapping services. And the number that you are referring to in our report is a pass through, you know, the top 10 medical and the top 10 surgical services, where we try to do that.

But what I do also want to say, just by way of, you know, of caution, is what is more difficult to comment on is the actual structure of the policy. So if you try and say, "I am going to set up a site-neutral policy, where you have some services paid outpatient, some inpatient, and then some paid site-neutral," that is certainly a goal that you can move towards. But what will be key is how services get in and out of those three systems, and how, in a sense, you police the borders, if you will, when a service gets into one setting versus another.

And so, that would be the kind of issues that you would have to think through, and not inadvertently create other incentives that drive services in one direction or another.

*Chairman Brady. Just sort of proven out, the crosswalk, we think, is very important. We have gotten some pushback that that is difficult to do. I think -- how difficult do you think it would be for CMS if we focused on these 10, you know, where you have identified them?

*Mr. Miller. Yes, and I don't want to toss this off as simple, but I -- you know, I decidedly think it is doable. These things -- there are, you know, proprietary products that exist in nature. They do somewhat different things, so reasonable people can kind of end up with somewhat different categorizations.

And so, there is some issues there that need to be smoothed through. And probably what you want, you know, if you were to ask CMS to do this, you would want, after they develop the crosswalk, you would want a clinical scrub, to make sure that you have some coherency in the categories that you created from a clinician's point of view -- does this make sense to a physician?

*Chairman Brady. Sure.

*Mr. Miller. Nurse practitioner, that type of thing. And then, you know, you put it out for notice and comment.

But, you know, my sense is that the intellectual technology to do the crosswalking exists.

*Chairman Brady. Yes. One of the areas of reforms, obviously, inpatient/outpatient, are tremendously complicated. They are, in some sense, a demolition derby of reimbursements and incentives. The June Report, again, looking at these surgical procedures, June Report mentioned, really, two approaches: one, the site-neutral payment for these surgeries could be carved out of the inpatient/outpatient system and moved into a separate one; secondly, surgeries calling for site-neutral could be subsumed under the inpatient payment system.

These are two approaches we ought to be looking at. We included one of them in our draft last November on hospital reforms. Can you lay out sort of for the subcommittee what you see, the pros and cons of that? A separate system for those, or moving them under an inpatient?

*Mr. Miller. Okay. So -- and I want to just do one thing quickly before I answer your question. You know, the way the Commission went at this was we were responding to kind of the two-midnight rule and a lot of the reaction to that, and a lot of concern on the part of the committees, and so forth, of what to do there. And the Commission ended up making recommendations on RACs and beneficiary protections, and talked about the payment stuff, but have not made recommendations on that yet. So I want to be real clear.

*Chairman Brady. Got it.

*Mr. Miller. We are talking about, you know, ideas, not policies, and not recommendations.

I think one thing to think through is the reason that you want to do these types of things is that your need for oversight, RAC types of overview, becomes less. To the extent that you make payments more comparable, there is less incentives to push a patient in one direction or another. So, to the extent that you are setting out and saying, "I want to set up payments so that this incentive is not so clear," that is one of the benefits of it. You are making decisions for clinical reasons, as opposed to financial reasons, and you may not have to have so much oversight.

The risk -- and I already said it, so I will try and be very abbreviated -- is how you set those boundaries and what services, whether the services are well-defined or bluntly subject to gaming, depends on, you know -- that is the risk you run when you try and set something up like this.

If you do it inside one of the existing systems -- because your other question was what if I did some site-neutral stuff inside inpatient, or I did some site-neutral stuff in kind of a stand-alone system -- my sense is, particularly if you are talking about a small set of services or conditions, or whatever we are talking about here, is you probably have less churning and change if you put it inside at one of the existing systems.

But I got to tell you, I am talking right off the top of my head, here. I would have to -- want to think about this a lot more. Just saying that part --

*Chairman Brady. Yes, good. Finish with this question. We talked about a bit, both in the opening statement and yours, there is a gradual migration services from inpatient to outpatient. We need to recognize that. So we are concerned that this means, for our policies and payments associated with that, such as indirect medical education and DSH, it has an impact.

So, our goal is to preserve and protect these funds. I am concerned that they are not protected when they are so dependent on just one area, inpatient admission. One strategy I think Congress can pursue is reimburse indirect medical education and DSH in a lump-sum payment, rather than as a per-discharge add-on. So what do you think of this approach, how it might preserve and protect IME and DSH goals?

*Mr. Miller. I want to be really clear. This precise idea, or this precise notion, is not something that the Commission has talked about. And at the end of my answer I am going to tell you one thing the Commission has talked about.

But to try and answer your question first, I think I understand your instinct. I think your instinct is what you are saying is -- if you are tied to inpatient, and inpatient is going down, how do you preserve that, I think, if that is what you are saying. And, to the extent you were to capture that, and assign that dollar to a hospital, in theory, movements in volume up or down or in or out would make that a more stable -- regardless of movement, it would make that a more stable payment, all things considered.

I would also think if you were to say that is the direction you would go, I am sure the Commission would also say, "You want to think about, like, maintenance of effort types of things." If you get the block of dollars, you don't just back out of the teaching function, and that type of thing. But I assume, you know, if you are thinking about these kinds of things, you would be thinking about that.

Now, the one thing I do have to say is the Commission went in a different direction on this, and said there is \$3.5 billion in direct medical education payments that are not well accounted for, and the Commission said, "Take that as a lump sum," but it was payable to hospitals or other entities that created these new programs. So, in a sense, we went in a somewhat different direction here from your idea.

*Chairman Brady. Well, I am not so sure we aren't going in that direction --

*Mr. Miller. Well --

*Chairman Brady. -- as well, to be honest.

*Mr. Miller. Well, that is --

*Chairman Brady. Because I think we need a better -- one thing, this is a bipartisan issue. How do we make sure we have the right training, the -- for more doctors and future doctors? And we are intent on getting a much better insight into how all this is funded, and the results of that funding, going forward. So, Doctor, thank you very much.

Dr. McDermott?

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

I read your report, and over half of it is drug policy. About 100 pages are --

*Mr. Miller. June Report, yes.

*Mr. McDermott. And it is interesting we are focusing on hospitals, because I think drugs -- we recently passed a bill out of here called -- the 21st Century Cures Act was passed out of the House. It didn't

come through this commission -- this Committee. But it had a provision in there that gave incentives to hospitals for the overuse of newer antibiotics.

And my question was did they come to you and talk to you about that? Did the Energy and Commerce Committee come to you?

*Mr. Miller. Not specifically, that I remember.

*Mr. McDermott. It seems like it is going to --

*Mr. Miller. I am not sure I have got the provision well squared away in my head, just to be --

*Mr. McDermott. Well, they are saying, "Use these new antibiotics, as opposed to the traditional antibiotics," there would be an incentive if you used the new antibiotics. Obviously, more expensive and better for the pharmaceutical industry, but I am not sure it doesn't drive up costs in hospitals.

*Mr. Miller. And I am just not wired enough on the specific --

*Mr. McDermott. Okay, all right.

*Mr. Miller. -- provision to help you.

*Mr. McDermott. That is fair enough. The issue that got you here -- that is, the two-night, or the midnight, two-night -- midnight business and all that -- do you think you can find a site-neutral payment system that will not disadvantage the patients?

*Mr. Miller. And just to kind of try and pick up the thread here in my own mind, you know, the Commission approached the two-midnight issue, and ended up with a set of recommendations on RAC and beneficiaries, and ultimately didn't make recommendations on payment, and didn't feel that there was a necessity at that moment to deal with a -- you know, the RAC, and the backlog issues through a payment change.

Your question is a little bit different, perhaps. But can you create a site-neutral payment that is fair to the beneficiary? I think it is all in the design of the policy, so I would say it is possible. Not this site-neutral conversation, but the Commission has made recommendations in -- on other site-neutral policies between the physician setting and the outpatient setting. We actually think that helps the beneficiary, because it keeps their copayments down. In fact, it was one of the motivations for it.

Now, here, in this -- pushing together inpatient and outpatient, it would probably depend on what services and how you defined the actual thing, as to what the effect on the beneficiary's out-of-pocket would be. It would be very hard for me to comment, without knowing "the thing."

*Mr. McDermott. We are talking theoretically here. Do you think you then could design a policy that a doctor and a hospital wouldn't look at and say, "Hey, let's do this, because that will qualify for this," which is a higher payment than that which is not a higher payment?

*Mr. Miller. And what I have tried to say and respond to a couple of questions that have occurred so far is that is the trick, is, you know -- right now there is an incentive between the inpatient and outpatient settings that look like this. And if I can get into the inpatient, and I can keep the inpatient for one day -- or keep the patient for one day, that is a very, you know, profitable transaction. I think you --

*Mr. McDermott. Let me stop you right there.

*Mr. Miller. All right.

*Mr. McDermott. Okay, it is transaction good for the hospitals.

*Mr. Miller. Yes.

*Mr. McDermott. What about the beneficiary?

*Mr. Miller. So it depends on whether the beneficiary -- so, generally, the beneficiary's out of pocket is less in outpatient than it is in inpatient. If you jump the inpatient wall, you pay \$1,000, \$1,200 deductible. If you are staying in the outpatient, in general, the beneficiary's liability is less.

However, if it is surgery, it is actually not as much difference. So it really kind of depends on -- and this is why I am saying which services and what you do with them. And I think part of the reason the Commission said, "If you started thinking about surgery" -- I mean thinking about site-neutral here, you might start with thinking about surgery, because the event is pretty definable, it is harder to game. And the differences in the copayments may not be as much.

*Mr. McDermott. You are talking, therefore, about a patient who comes in with what looks like appendicitis, and they put him in observation, and they ultimately wind up becoming an operation for removal of the appendix. That is one kind. But the other kind of case would be somebody who has a pain in their chest, and they put him in for observation, and they never graduate to full-fledged ICU or cardiac surgery, or whatever.

*Mr. Miller. And just to take that point and just put it a little bit differently --

*Chairman Brady. Dr. Miller, could you do me a favor? Pull that microphone just a little closer to you.

*Mr. Miller. I am really sorry about that. So nobody has heard anything I said up to this point?

[Laughter.]

*Mr. McDermott. I have bene listening.

*Mr. Miller. Okay. All right. So now I have no idea what is going on.

[Laughter.]

*Mr. Miller. So, just to pick up on the thread of your question -- I apologize, I didn't realize that was going on -- the -- one of the things that the Commission did think about was whether we were talking about this kind of idea for medical or for surgical.

For -- and I am not a physician, so I apologize for everything that is about to happen. For a medical condition, it is more complex to kind of follow what is going to -- it can be more complex -- on what is going to happen with the patient. You know, your point. Chest pain, I have chest pain, I have a heart attack, you know, these types of things can be relatively fluid, as opposed to surgery, where the event and the procedure and the thing that is going to happen to the patient is more well-defined, and most of the cost is very present in that event. And I think that is why the Commission thought, if you start something, start looking there.

Does that answer your question, or am I -- now you are sorry I moved this close to me, right?

[Laughter.]

*Mr. McDermott. Well, I -- my feeling, then, is what happens to the patient at that point? Does he or she wind up more out of pocket?

*Mr. Miller. And I think that really depends on the service. But in a surgical situation -- and I don't want to speak too globally on this, because the Commission really sort of looked at this, but didn't dive as, you know, deep on it. Generally between, you know -- for over -- surgeries that tend to overlap settings, the beneficiary's liability is more comparable between the inpatient and outpatient setting than the liabilities for a medical procedure.

*Mr. McDermott. Can I have just a second to ask unanimous consent to drop in a letter from the American Hospital Association dated July 22nd?

[No response.]

*Mr. McDermott. It is their --

*Chairman Brady. Without objection.

*Mr. McDermott. -- this Committee.

[The information follows: [The Honorable Jim McDermott Submission](#)]

*Chairman Brady. Thank you, Dr. McDermott.

Mr. Johnson, you are recognized.

*Mr. Johnson. Thank you, Mr. Chairman.

Mr. Miller, let me start by thanking you for testifying today. As you know, our nation has an incredibly complex hospital payment system, with different coding classification systems and reimbursement systems, and where the procedure is performed.

MedPAC concluded in its June Report that, because Medicare generally pays more for patients who receive similar services in inpatient settings compared with outpatient settings, hospitals have a financial incentive to admit patients. To address the problem, MedPAC drafted a crosswalk to link 10 comparable inpatient and outpatient surgical codes. Such a crosswalk allowed MedPAC to compare these similar codes, which you then found resulted in inpatient surgical costs, roughly 4,000-plus higher than for similar outpatient surgeries.

I think it is an important step to ensure greater transparency in Medicare spending, so we can ensure hospitals are not admitting patients solely for financial profit, but because it is medically necessary. So I would like to take these moments to ask a couple specifics.

First, how important is it to have a crosswalk between similar surgical codes for inpatient and outpatient payment systems?

*Mr. Miller. I think, if the committee wants to pursue the idea that it seems to be asking questions about, site-neutral, that type of thing, you have to have something like that.

*Mr. Johnson. Okay. How difficult was it for MedPAC to establish a crosswalk for these 10 surgical codes?

*Mr. Miller. It was not simple. And I will just say, again, I think reasonable people could come to different places in crosswalking individual codes from one location to the other. But I think there is probably a manageable process that people could go through to come to a crosswalk that would generally be viewed as acceptable.

You would want a clinical, as I said, overlay after you did those crosswalks, to make sure you were doing things in a clinically rationale way. I would say that.

*Mr. Johnson. Well, thanks. And finally, in your opinion, is this something CMS could pursue in the future?

*Mr. Miller. I do. I think -- I am sure they would prefer to speak for themselves, but, you know, my sense is that they could engage through a contracting process with, you know, firms that exist that do this, bring something in that would be used for public use. They would have to work with it, both mechanically and clinically, as I said, because I don't think these things are just off-the-shelf, everything is perfect, you know. They would have -- and they would want to put it out for notice and comment, get people -- the hospitals, physicians, beneficiaries, everybody -- to comment on it. But I do think it is a process that they could pursue.

*Mr. Johnson. Everything is off the shelf, just like this hearing.

*Mr. Miller. Yes, right.

*Mr. Johnson. Thank you, sir. I appreciate your opinion, and I appreciate your help on that issue. Thank you.

*Mr. Price. [Presiding] The gentleman yields back. Mr. Kind from Wisconsin is recognized for five minutes.

*Mr. Kind. Thank you, Mr. Chairman.

Dr. Miller, thank you for being here. I usually ask you a quick question about rural hospital reimbursements. In your 2013 -- your recent report, you indicated in 2013 the overall margin rate for rural hospitals was about 22 percent. But also in the report you acknowledged that a large part of that margin was based on the HIT incentive programs that have been going to rural hospitals. That now is being phased out.

So, are you -- is MedPAC taking into consideration the phase-out of the HIT incentive program, and what that is going to do to margins for rurals? Because 40 percent of them are operating in negative margin territory, already.

*Mr. Miller. I think the answer to that is yes. The Commission -- and one thing, and it went by really fast in my opening statement, so I will just say it again. We have made, for the last few years, positive Medicare payment increases for hospitals. We recognize that rural hospitals are about at 0.2, but let's just call it zero. Overall margins are negative for hospitals in Medicare. And, consequently, the Commission has -- among other reasons, the Commission has made recommendations for payment updates for rural and urban hospitals. So --

*Mr. Kind. Okay.

*Mr. Miller. And, in thinking through those issues, we take into account things like your -- exactly what you are asking. What is going to happen to this? What is going to happen to that. And we look forward to all of that --

*Mr. Kind. Okay, very good. Let me shift gears. Obviously, CMS has been pushing the metal a little bit hard now on changing the payment system, going to a more value and outcome-based payment model. You, undoubtedly -- and MedPAC, undoubtedly -- has been watching this very closely. I want to get your impressions on how that is going, and whether there are some additional areas of acceleration when it comes to value-based payment models, especially in the post-acute care area, where I think there is some substantial savings that can be had, while also increasing the quality of care.

*Mr. Miller. So we are not talking about hospitals or rural, necessarily --

*Mr. Kind. Now, we have --

*Mr. Miller. We are talking bigger --

*Mr. Kind. -- moved on to a totally different payment question here.

*Mr. Miller. Okay. I am going to start. But if I don't have the right question here, you know, just redirect.

So, if you are talking about kind of large, you know, payment delivery reform types of things, like accountable care organizations --

*Mr. Kind. Right.

*Mr. Miller. -- and that type of thing, so what I would say is, you know, coming out of the health reform legislation -- so there were things like the re-admissions penalty, which I know is not particularly popular, but has actually had the effect of reducing re-admissions. And just by the way, the Commission has some ideas to address hospitals that deal with disproportionate shares of the poor that we could talk about if anybody wants.

Moving on from that, ACOs, I think the analysis we have done there suggests that ACOs are producing small savings, onesie and twosie percent types, and it is in parts of the country where fee-for-service tends to be high, which, if you think about it for 30 seconds, kind of makes sense.

On the bundling and post-acute care, there hasn't -- you know, there is that demonstration -- I don't want to make a global statement, and I don't think this is a Commission statement, but there hasn't been a lot to show there yet, that I have seen. And I think there is some concern on the part of the Commission that, you know, lots of people wanted the data, a lot fewer people wanted to take risk. And to the extent they wanted to take risk, they wanted to do it for only a few services.

And so, getting a lot of traction in the post-acute care, say through a bundling strategy, I don't see a lot of it yet, and I am worried that what is out there isn't going to necessarily --

*Mr. Kind. Well, Mr. Brady and I have been working on some proposals, and undoubtedly would like to follow up with you and others at MedPAC for some advice or guidance, as we get ready to move forward on that.

*Mr. Miller. Okay.

*Mr. Kind. Great, thank you.

*Mr. Price. The gentleman yields back. I was next in line, so -- maybe I will let the Chair take over here, and then I will assume my rightful position.

[Laughter.]

*Chairman Brady. [Presiding] So Dr. Price declined to recognize Dr. Price?

[Laughter.]

*Chairman Brady. Is that the case? Thank you for letting me step out for a minute.

Dr. Price, you are recognized.

*Mr. Price. It was this perspective that I -- welcome back.

*Mr. Miller. It is good to see you.

*Mr. Price. Thanks for coming. And I appreciate your qualification on -- as a surgeon -- on your definition or your description of the difference between a medical observation and a surgical observation, and we will have a conversation about that offline.

*Mr. Miller. Okay.

*Mr. Price. The -- I have a number of questions I want to raise. The first is on meaningful use and electronic health records. In a 2012 MedPAC report you commented -- MedPAC commented on -- talking about the decreased uptake of utilization by physicians of EHRs. And I have been surprised that in the last three reports, or last three years, MedPAC hasn't addressed the issue of meaningful use and EHRs. Is there a reason for that? Do you plan on addressing this issue that is so incredibly important for the --

*Mr. Miller. We can certainly dive back into it. You know, we are a small operation. We kind of -- we can't cover the waterfront every year, all day. And so we tend to focus on things and then move to other issues. But if there is an interest in it, we can certainly try and look back into it.

*Mr. Price. Let me just share with you. I spent a couple hours this past Monday night in Atlanta with a group of, oh, 80 to 100 physicians on the specific issue of meaningful use, and the incredible challenges that they are having in their practice, caring for their patients: decreasing productivity, increasing costs, decreasing access to care from the patient standpoint. And so I would urge MedPAC to take another look at it, especially in view of the fact that it appears that CMS is forging forward with stage three without regard to any information or statistics, real metrics that demonstrate that stage two has actually been a success.

Let me shift to site-neutral payments. And I appreciate MedPAC's perspective on this, and the push that you all have made. I think it is an incredibly important issue. And I am curious as to whether or not you believe that CMS could go ahead and do site-neutral payments right now, without Congress acting.

*Mr. Miller. Without Congress acting? I don't know the answer to your question, off the top of my head, not in any real, significant way, at least that we have been thinking about it. The recommendations we have made, and I think some of the discussion here -- although I would really have to think about it -- would require more changes in law. But I am not 100 percent --

*Mr. Price. Sure.

*Mr. Miller. It would depend on what you meant by "site neutral," I suppose.

*Mr. Price. Well, especially outpatient surgical procedures and what I think are significantly-increased costs to the system, yes, but also, as Dr. McDermott has pointed out, to the patient, as well, in terms of copays and deductibles on things as insignificant as minor procedures, but as significant as major procedures like joint replacements, which are now being done in an outpatient setting in many, many instances, so I would --

*Mr. Miller. And I want to say I want to think about the answer to your question, because, depending on if it is done inside an existing system, I wonder what flexibility the Secretary would have. So I want to withdraw a little bit, and --

*Mr. Price. Great.

*Mr. Miller. -- think about it.

*Mr. Price. I would love to --

*Mr. Miller. Yes, I don't know the answer to your question.

*Mr. Price. In-office ancillary services exception, GAO reported in multiple studies for between 2004 and 2010 that they didn't uncover any evidence at all that suggested that it would be appropriate to repeal the in-office ancillary exception. Milliman did a study that showed that costs in the hospital were greater than costs in the office. JAMA has done a recent report that demonstrated the same.

Can you opine as to -- or can you share with us what information you have provided to CMS as it relates to this, or opine as to whether -- why you believe HHS or the Administration seems to be incentivizing a move towards hospitalization, as opposed to -- and utilizing services in hospitals, as opposed to the office for these kinds of procedures and examinations?

*Mr. Miller. Yes, and I am just going to -- and you tell me if I am off base. I am not -- I don't feel so much that people are actively trying to incent the move from office to hospital, although you may be aware of something I am not.

More -- the way I think about the issue is, historically, private and Medicare created payment systems to pay for hospital care and physician care. Hospitals is no mystery. Hospitals are more expensive.

*Mr. Price. Yes.

*Mr. Miller. And a big argument is why and what people should pay for, and all of that. And so you end up with payment systems for comparable services that look like this. And then, hospitals have started to purchase physician practices, and then just shift the billings from one setting to the other.

More what I see is that motivation, is that there is a financial signal out there, and people have begun to pick up on it, and are moving in that direction. And our recommendations on site-neutral -- and I think what was included in the President's budget, although I don't have that wired in my head -- were to try and do a bit more of leveling that out --

*Mr. Price. Correct.

*Mr. Miller. -- so that that incentive didn't exist as strongly.

*Mr. Price. Correct. Did that mean my time is up, or that I have got a minute?

*Chairman Brady. Thank you both very much.

*Mr. Price. I look forward to getting back with you, Dr. Miller.

*Mr. Miller. Yes. Sorry for going on.

*Chairman Brady. Mr. Pascrell, you are recognized.

*Mr. Pascrell. Thank you, Mr. Chairman, and thank you, Dr. Miller, for your service.

I would like to discuss with you graduate medical education. In my home state of New Jersey, there is 42 hospitals maintaining residency programs. That number is increasing. I am proud that our hospitals are at the forefront of training the next generation of physicians. I know you are very interested in that.

*Mr. Miller. The Commission is, yes.

*Mr. Pascrell. Despite the fact that our teaching hospitals turn out many highly-trained physicians every year, New Jersey faces a physician shortage. My state's challenge retaining physicians in New Jersey after they complete their residencies is a big problem. But many of the states that my colleagues here today actually benefit from this problem. States like Pennsylvania and Delaware, with lower costs of living, benefit from residency programs that New Jersey hospitals undertake. When physicians complete their residencies, they move out of the state.

A few months back I met with a family physician who completed his residency in New Jersey, and then moved to Texas to practice where the cost of living is much lower. Given the shortage in the physician workforce pipeline, impending physician retirements, the aging of the Baby Boomer population and a number of other issues, we need to be growing the number of Medicare-supported residency positions, not reducing them.

The landscape of how we deliver health care is changing. The Affordable Care Act laid the foundation for moving away from a fee-for-service model towards quality-based payment systems. Congress could take one step further by repealing the sustainable growth rate earlier this year. That is what we did.

One of the issues MedPAC has highlighted in the past is the role that GME funds and teaching hospitals can play in preparing new physicians to practice in a quality-based health system. One fact -- one of our hospitals in New Jersey, the Hackensack Medical Center, has an extremely successful accountable care organization. They have adopted their GME program to promote this integrated tier model.

Dr. Miller, can you talk a little bit about how teaching hospitals can leverage their position training the next generation of physicians to underscore the importance of quality-driven health care, care coordination, and a team-based approach to health care, which we talk about all the time? But this is going on in places throughout the United States. Would you respond to that?

*Mr. Miller. I think so. So the Commission did some work back several years now, and, as I mentioned quickly in my opening statement, I think the IOM -- read more recently -- said some very similar things. And what the Commission said is we took a look at curriculums. And we are concerned that in the residency trainings there was not focus on team-based care, using evidence-based metrics to guide care, you know, using the HR -- you know, the stuff that you think about in a reformed delivery system.

And what we said was there should be a set of criteria -- and, given time, I won't drive you through it -- there should be a process that includes many stakeholders -- which I won't drive you through, it is all

written down in the report -- to come to this more comprehensive look at graduate training, to drive towards delivery reform, to have physicians and other health professionals who are versed in these skill sets, as well as training in alternative settings.

Physicians see a lot of patients in nursing homes, offices, clinics, you know, urban and rural. And to drive in that direction, and then attach the GME dollar to the programs that meet that criteria. They could be hospitals. And, to the extent that your -- the hospital example you said is driving in that direction, at least in the Commission's point of view, that is what we would be looking for.

*Mr. Pascrell. Well, let me ask this final question, Dr. Miller. If you say -- and I believe you believe in what you said -- wouldn't it be -- an incremental increase in those residency positions help states like New Jersey?

*Mr. Miller. Well, we were so close, but the Commission does not agree with that, and --

*Mr. Pascrell. Why not?

*Mr. Miller. I will tell you. The Commission's view was simply expanding the number of slots is going to produce more of what we have, and it is not necessarily going to keep residents in your states. They can still leave.

*Mr. Pascrell. Right.

*Mr. Miller. And so I think there was some concern that, without a much more rigorous look at, you know, changing the graduate medical education strategy, and what is needed, we shouldn't just simply increase the number of slots.

*Mr. Pascrell. Well, Mr. Chairman, I have a great deal of respect for Dr. Miller, as you know.

*Mr. Miller. But you disagree.

*Mr. Pascrell. But, through the Chair, I would like to get a more definitive answer to the question. We don't have the time right now. With your help, I think we can.

*Chairman Brady. I would be glad to.

*Mr. Pascrell. Thanks.

*Chairman Brady. And, just so you know, we are going to be holding a hearing dealing with GME, and sort of get deeper into this subject, because it is a bipartisan --

*Mr. Pascrell. In the fall?

*Chairman Brady. -- issue, going forward. Yes.

*Mr. Pascrell. Okay, thank you.

*Mr. Miller. And I want you to know that if you would like us to come to your office and -- you or your staff -- and just take you through all of it, we are --

*Mr. Pascrell. Yes, I think that would be a good idea, too.

*Mr. Miller. More than happy to do that.

*Mr. Pascrell. Thank you, appreciate it.

*Chairman Brady. Mr. Smith -- Dr. Smith, you are recognized for five minutes.

*Mr. Smith of Nebraska. I thought physicians were leaving rural America for urban America, but I hear otherwise. So obviously, I represent a rural constituency, and there are many challenges. And I talk to providers, and especially in rural areas, where, you know, support staff is probably not what it is in urban areas. I am not complaining about that, but the recovery audit contractor issue has had a significant impact, and it just has frustrated a lot of providers. So I had a bill last Congress which would have reformed the RACs, and I am continuing to work on this issue.

But I was wondering. Now, the Commission made several recommendations for the RAC program. Can you touch on those recommendations, perhaps, and maybe give a brief rationale for each one? I don't want to put you on the spot, but if you do have those handy --

*Mr. Miller. No, I do have them handy. This was in our most recent report. I figured it would come up at some point.

So, with respect -- just focusing on the RACs -- and we also made recommendations on beneficiary protections, but just on the RACs, we basically said three things, that, instead of the RAC review being very comprehensive and hitting all kinds of hospitals, focus the RAC efforts on hospitals that have apparent patterns of one-day stays. And so, in a sense, it is just -- it is targeting.

Number two, RACs are a contingency fee-type of operation, and we want the RACs to bring the most credible and defensible cases, not just sort of, you know, take as -- take their chances, and do as much as possible, and then see what happens. And so, we would say the contingency fee should, in part, be adjusted if they have poor overturn rates. They bring lots of cases, they get overturned, then their contingency fee should be brought down. Make it a financial incentive to bring good, strong cases.

The third thing was to adjust the look-back period for the RAC. So RACs were able to go back several years on hospitals and say, "I am challenging this particular admission." And, you know, two or three years, a lot of administrative costs trying to dig that out, electronic record. And it may be past the point that, if the claim was denied, that the hospital couldn't bill for the -- a set of outpatient services that they did provide.

So you might say, "Well, this inpatient was unnecessary, but they did provide some outpatient services coming in the door," if you will. And so we said, "That should be better aligned, so that the hospital has the ability to make this calculus: 'I can defend this case, and so I am going to appeal,' or, 'Actually, I am not so sure I can defend it, so I am not going to appeal it, I am going to actually just take the lower outpatient reimbursement, and walk away,'" and that is the dynamic, rather than appealing everything or appealing nothing, that we are trying to get set up in there.

*Mr. Smith of Nebraska. Okay.

*Mr. Miller. So those were the three RAC things.

*Mr. Smith of Nebraska. Sure. I appreciate that. Shifting gears here just a bit, I represent a number of critical access hospitals. Some are -- well, they are all rural. Some of those are actually remote. And I know that you have previously said that the closing of rural hospitals is proportionate to the closure of urban hospitals. Is that an accurate description?

I would say that the impact to the community, or -- and perhaps to the patients themselves is disproportionate. Does the Commission take that into consideration at all?

*Mr. Miller. Yes. And by saying it is proportionate, I don't think anybody was trying to say -- and this drives right to a point that I would like to make; you may agree or not, but it does -- the Commission, in writing that down on paper and reporting what is happening, we aren't trying to say, "and therefore, there is no issue here." I -- you know, obviously, if you are in a urban area and a hospital closes, and there is two other hospitals right nearby, the significance of that closure is very different than if you are the only hospital within 50 miles.

And the thing that we are trying to say is rural -- and this comes from our rural commissioners. First of all, think of rural this way. There is rural, as in 50 miles from any other provider on a hilltop, and there is rural adjacent to an MSA. You are right across the border from, you know, a metropolitan statistical area.

The access implications of closure in those two settings are very different.

*Mr. Smith of Nebraska. Right.

*Mr. Miller. You know? You might have to travel somewhat further into the MSA, but you are -- still have access to something.

And so, the point that I think the Commission has been driving at for several years is think about the supports that go out to rural areas. And what you want is to really support that isolated, low-volume provider, because they can't ever be expected to cover their costs. They are too small, there is not enough admissions that roll through, or outpatient visits to cover their costs, and there is no other alternative.

But all over the place we are -- I think I am done.

[Laughter.]

*Chairman Brady. You know, by the way, no other witness ever stops when I do that, so I appreciate that very much.

[Laughter.]

*Mr. Miller. But I am going to finish. It is very short. A lot of our current supports for rural areas kind of make it critical to the community to hang on to their hospital, even if that hospital is close to another hospital, and they both have low volume, and, bluntly, they are more likely to have low quality. Whereas, if there was a consolidation, they might be economically more viable, and might even improve quality there. Sorry about that.

*Chairman Brady. Thank you, Doctor, and thank you, Mr. Smith.

Mr. Davis, you are recognized.

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

Thank you, Mr. Miller. Illinois's 7th congressional district, which I represent, contains the most hospital beds of any congressional district in the nation. In addition to that, we are home to four major academic medical centers. According to the new workforce projections, the nation faces a shortage of between 46,000 and 90,000 physicians by 2025, with shortages most acute in surgical specialties, the result of a growing aging population, and the newly insured, which tend to need more specialized care, especially the elderly, who are living longer. Medical schools have increased enrollment, and teaching hospitals are

expanding training to address physician shortage. Medical schools and teaching hospitals are also working hard to ensure that new doctors coming into the system are trained to serve in new delivery models that focus on care coordination and quality improvement.

I am concerned that reductions to Medicare graduate medical education would harm teaching hospitals' ability to effectively train the number of physicians we need in the future, and would adversely impact access to care for both the elderly and the newly insured.

My question is, while Congress seeks to reform Medicare payments to graduate medical education, shouldn't we also be making sure -- or trying to make sure -- that we are able to meet the projected need, as we continue towards 2025?

*Mr. Miller. I think the answer to that is yes. I think a couple things that I would say. With absolute respect -- and I don't know the source of your numbers -- but I would say, depending on who is doing the projecting, you can get very different kinds of numbers of what shortage and what is in shortage.

There are also people in the academic community who have less of a stake in this, and have looked at this, and have argued that it is not so much aggregate supply as distribution problems, and have suggested also changes about which, you know, level of physician versus a nurse practitioner versus a PA that could -- for example, to, you know, fill some of the needs.

What I would say directly to your points are one question is, given the dollars that go to support slots, the Commission could think about which of those specialties are likely to either be in short supply or -- and/or are less lucrative for the hospital to support, and shift the given dollar to support those kinds of training programs. So, some interns and residents are very valuable to the hospital, and they will support them even without a subsidy. Others are less valuable to the hospital, and they are less likely to support them. So you could think of, given a dollar, how you distribute that dollar.

A second thing I want to say is the Commission did not ultimately reduce indirect medical education. It did redirect how it was -- you know, it went to the various programs, and that is what I was saying in response to the question before you.

*Mr. Davis. Let me ask you a little bit about site-neutral payment policies. Do you see this adversely affecting teaching hospitals and disproportionate share hospitals, perhaps more than others, because of the clientele --

*Mr. Miller. I definitely --

*Mr. Davis. -- that they --

*Mr. Miller. I definitely see where you are going, and the Commission contemplated this. And so I am just going to blow past this part. It depends on what kind of site-neutral you are talking about; it will affect different hospitals differently.

But let's just say, for the purposes of your question, some site-neutral policy has an effect on a hospital that serves a disproportionate number of poor folks. The Commission said you could mitigate that, the effect of the policy, by looking at the amount of, you know, poor people, say, that hospital serves. They actually directly contemplated policy designs that would try and address that problem.

*Mr. Davis. Thank you very much. I know that time is a factor, but I would like to discuss these issues with you further, if we have an opportunity to do so.

*Mr. Miller. As always, we are happy to brief you and your -- or your staff, whichever way you would like to go.

*Mr. Davis. Thank you very much.

Thank you, Mr. Chairman.

*Chairman Brady. Thank you.

Mr. Marchant, you are recognized.

*Mr. Marchant. Thank you, Mr. Chairman. I would love to pick up where Chairman Brady was talking at the very beginning. The Affordable Care Act splits the DHS funds into two pots: 75 percent of the dollars go into a pot that is being reduced every year; and the other 25 percent, which is sometimes referred to as the empirically justified pot, is not being reduced.

It is my understanding that MedPAC came up with this notion of empirically justified. Can you explain how MedPAC got to that classification, and their reasoning behind it?

*Mr. Miller. I can, and I just -- I think you are clear in your mind, I just want to be clear in everyone else's mind. We didn't come up with this system that you are referring to, the two parts, but we did come up with the empirically justified notion.

So, this is work -- and this is way back, now, but this is work when we were thinking about the indirect medical education add-on payment, and the disproportionate share add-on payment. And here is a way to understand it. It is a little bit technical, but I can do it, I think, very simply.

Here is a hospital's cost per case. And, thinking about what drives that cost per case, it might be more complex patients in one hospital or another, or differences in wages from one area to another, or something like that. And so you could see that cost go up and down, based on what is happening in a given hospital.

There are add-ons for IME and, to your question, disproportionate share. And the rationale for it has changed over time and who you are talking to. But at any -- one way to think about it was it was supposed to help hospitals that served disproportionate shares of the poor. And the thought was serving poor folks increased the cost for the hospital.

And so, if you run that analysis -- which I can take you through in detail, but for this conversation, if you run that analysis -- it says that is true, but it is this much more, and the adjustment is this much more. So, the adjustment over-achieved, if you will, and gave the hospitals more than their cost increase.

We just went through the analysis and said the adjustment actually, you know, should be smaller than it is. And we actually didn't even make a recommendation, we just analytically went through it and said this adjustor is set too high.

*Mr. Marchant. Is it your opinion that the DHS money is going to the hospitals with the greatest need?

*Mr. Miller. All right. I know you think this is a yes or no question.

[Laughter.]

*Mr. Miller. But let me tell you -- let me say it this way. If you think it is about poor Medicare patients, the answer is no, because the DSH adjustor contemplates poor Medicare patients and Medicaid. If you

think it is about supporting poor Medicare and hospitals that get lots of Medicaid patients, it is probably tracking that. If you think it is about uncompensated care, it is not tracking that, so it depends on what you --

*Mr. Marchant. The next question --

*Mr. Miller. -- what you think -- sorry.

*Mr. Marchant. The next question may help you with that.

*Mr. Miller. All right.

*Mr. Marchant. I am particularly interested in the hospitals in the State of Texas. As you may be aware, we are not a Medicaid expansion state. So it is my understanding that The DHS formula is based, in part, on Medicaid days for hospital.

*Mr. Miller. It is.

*Mr. Marchant. Is it possible that the -- that in addition to losing money on the Medicaid DHS side, Texas hospitals are also losing money on the Medicare DHS side because of how the formula is calculated?

*Mr. Miller. It is correct that if you have more Medicaid patients moving through your hospital, your DSH will be higher.

*Mr. Marchant. So, in a state that didn't expand, it is arguable that your volume is not what it would be in a neighboring state that has a similar situation that had expanded?

*Mr. Miller. I think, factually, that is a true statement.

*Mr. Marchant. So I have one, two, three, four -- six hospitals that have contacted me that I believe they feel like that their funding has been affected by the fact that Texas is not an expansion state, based on the formula.

*Mr. Miller. I don't think the fact set is wrong. Without making a judgement about what people want to do, I think the fact set is correct. If you have more Medicaid patients moving through your hospital, your DSH payments will be higher.

*Mr. Marchant. So we are preparing some legislation that we will present to the committee to try to rectify this. Thank you.

*Chairman Brady. Thank you. Mr. Roskam, you are recognized for five minutes.

*Mr. Roskam. Thank you, Mr. Chairman.

Dr. Miller, thanks for your time. My question has to do with some of the work that The Oversight Subcommittee has done at Ways and Means, particularly in the -- looking at fraud and improper payments.

So, a few months ago we had the individual who is in charge of anti-fraud efforts at CMS before the subcommittee, and we posed a simple question to them. And the question was, "What is your fraud and improper payments rate?" And they said it was 12.7 percent, which is a number that is so big it just takes your breath away.

Now, just for the sake of creating a sense of wonder, we had the person who is in charge of anti-fraud efforts at Visa, the credit card people, asked them the same question. His answer was, on \$10 trillion worth of global transactions, their fraud rate is .06 percent. So this cavernous difference just really does take your breath away.

There is a lot of discussion about how it is that we are going to make sure that the trust fund isn't depleted and so forth. One of the things -- there is a general discussion about improper payments as one of the goals that you have, mitigating against improper payments.

So, the reason for my inquiry about improper payments is this. Congress basically -- you know, if you look out over these different things that we have done over the past few months, we have got a highway trust fund that is going broke, we have got this, that, and the other thing, we have the SGR, you know, Congress is basically grubbing around in the forest, looking for truffles, and trying to come up with a bushel of money to pay for these things.

And yet, the amount of money that is going out the door in improper payments just literally, at our hearing, it just took our breath away. You do a back-of-the-napkin calculation on this, and it is -- you know, it is a billion dollars a week. And the cumulative nature of this is just incredible.

What insight would you have for us on the improper payment side, in particular? Because the interesting thing is there is obviously nobody that is defending the status quo. It is not a partisan issue, it is not a philosophical issue, it is not a geographic issue. It is just a common-sense thing, where we should all agree that payments should be proper. And, if they are proper, we are going to save a fortune.

What insight would you have for the committee, as we venture out into this, particularly in the improper payment arena?

*Mr. Miller. Right. And I just want to preface I am probably not the -- you know, the fraud guy that you want to answer this question. The Commission tends to think of payment policy, looks at distortions, tries to stop, you know, bad practices. But detecting fraud is kind of a different option.

So, the first thing I would say about the size of the number -- and in no way am I trying to defend anybody or anything -- is, you know, when I have gotten close to this issue a couple times in my life -- and not close enough, and not really versed in it -- there is this difference between fraud and catching fraud, and documentation of a service. So a service was provided, it is a legitimate provider, but someone takes it apart and says, "You didn't provide the right piece of information." And I don't know if that 12 percent versus whatever you said --

*Mr. Roskam. I take your point. And just parenthetically, here is part of the problem with CMS. They can't tell you the difference.

*Mr. Miller. And that is why, every time I get close to this, my head pretty much explodes. And so I am probably not the right person to do this.

But the thing that I would say -- so there are -- you know, there is this distinction between outright fraud -- and fraud is complicated, because people are actively trying to avoid detection, and I think that makes it hard. There is a cost of detecting it, and a cost of payment ratio. Those are generally pretty positive. And I have seen numbers like that.

The other thing, which is just an off-comment I will say out loud, I think some of these data releases, where you begin to just kind of look at, you know -- look at what the raw data says, has driven CMS and some of the other program integrity folks in directions that they probably wouldn't have otherwise seen, you know, individual sets of providers who come out at the top of the heap, and are just pulling

reimbursements that are just unbelievable. I think those kinds of things, those public releases of data, can also help, almost from a crowd sourcing point of view, to get other eyes on the problem.

*Mr. Roskam. So a sunshine policy. I mean that is sort of --

*Mr. Miller. Yeah --

*Mr. Roskam. -- disinfectant theory.

*Mr. Miller. My sense is that those things have driven people into identifying providers that had huge drug spends, you know, huge Part B spends, that type of thing.

*Mr. Roskam. Okay.

*Mr. Miller. But I don't know this issue real deep. I understand what you are trying to ask, but --

*Mr. Roskam. Okay, thank you. Yield back.

*Chairman Brady. Thank you.

Mrs. Black, you are recognized.

*Mrs. Black. Thank you, Mr. Chairman. And thank you for being here, Dr. Miller. A very interesting discussion today.

I want to ask you about the Medicare hospital area wage index, which is supposed to ensure that Medicare hospital payments reflect the geographic differences in wages. I have concerns that many have raised over the years that the area wage index is neither accurate nor fair. The fact is that around one-third of all hospitals who receive exceptions to the area wage index shows that the system is not working.

I am even more concerned about the adverse impact that the current system is having on hospitals in Tennessee, in particular, and in the South, across the South, which have seen their area wage index levels rapidly decreasing over the years, while the area wage index levels in other states have been increasing.

So, Tennessee hospitals are being penalized, because they have experienced an increase in cost, including wages over the years, but these increases have not been quite as high as the hospitals in other states, where -- with the wage index levels. It is simply unfair. I mean they have done a good job in keeping costs down, but they are being actually punished for that.

So, back in 2007 MedPAC actually recommended that Congress repeal the area wage index. And is this still MedPAC's recommendation, that Congress would repeal this wage index?

*Mr. Miller. I got to tell you, I have been tearing up through this whole thing, because people have kind of forgotten that idea. And the Commission did make a set of recommendations. We do understand what you are saying, and the issues that are being raised there. And we made that recommendation several years ago, and the fundamental -- there is a number of things that are going on in it.

But to get to the heart of your question, what is going on is we would move the wage index system off of a hospital-reported wage, and base it more on area wages in -- or wages in the area for the labor that hospitals, offices, post-acute-care providers are drawing. And that may sound like a big, technical thing, but what it actually does is, if a hospital decides that it happens to be flush, and it raises its wages, all other things being equal, the wage index relative to other hospitals goes down, because it is down across

hospitals. Whereas, we think it would be a lot fairer to hospitals and other providers to base it on the wages in the area, which are much more -- less sensitive to an individual hospital's behaviors. And we think that that would bring some greater equity and address some of the issues that you are raising.

There is a whole set of other things which I won't make you crazy with that we also recommended at the same time. But, yes, that is our policy. We did recommend that change. We think it addresses at least some of the things that you are raising.

*Mrs. Black. I know that that was your recommendation back in 2007. Is MedPAC doing anything now to update that recommendation?

*Mr. Miller. We can go through and update the analysis again. But the principles still stand. And, I mean, bluntly, this requires the Congress to take action.

*Mrs. Black. Okay.

*Mr. Miller. And you know the dynamics here. I mean this means some --

*Mrs. Black. That is right.

*Mr. Miller. Right. And that is the issue.

*Mrs. Black. There will always be winners and losers. But when we look at what is happening in Tennessee, it really is an unfair system.

*Mr. Miller. And --

*Mrs. Black. For our reimbursements. Thank you, Mr. Chairman, I yield back.

*Chairman Brady. Thank you.

Ms. Jenkins, you are recognized.

*Ms. Jenkins. Thank you, Mr. Chairman, for holding the hearing.

Thank you, Mr. Miller, for joining us. I want to return to a discussion Congressman Smith started with you, and discussed the issue of rural hospitals, and some closures.

MedPAC's March 2015 report addresses the rural hospital closure crisis, and finds that rural hospitals represented 44 percent of all closures. The report finds that the closed hospitals are an average of 21 miles to the next nearest hospital. Yet the report does not specifically address the issue of access to care in rural America.

My congressional district has a number of these rural hospitals, and the State of Kansas has 83 critical access hospitals, more than any other. These hospitals provide excellent care to my constituents. And, without them, my constituents would lose local access to care. When a patient has a heart attack, 21 additional miles of travel makes a difference.

So, my question is, has MedPAC considered the impact of access to care for rural Americans if and when these necessary safety net providers close?

*Mr. Miller. So, I mean, my answer would be yes. Each year we assess access, quality, capital markets, cost, and payments, and a number of factors in setting an update payment for the hospitals. And I can't remember if you were here when I was talking to Mr. Kind. The Commission, for the last couple years, has made positive payment updates for hospitals the last couple of years. Over 10 years -- or longer, even -- the Commission has made recommendations with respect to rural payment that have increased payments to rural hospitals, trying to address some of the issues that you raise.

Now, all that said, I also want to say something else, which is in 2012 the Commission did -- and this was an exchange I believe I had with Mr. Smith, which was when you think about the supports, think about, you know, how -- and particularly the Congress is always working with a limited dollar. Think about where that dollar is going to make the greatest difference. If you just say all -- increases to all rural, you are increasing payments for a hospital that sits right next door to, you know, an urban area, and a hospital that is 50, you know, miles out on a hilltop. And so, there are other ways to think about how the support is provided.

And the other thing I think is just a fact of life -- and it is for urban and rural hospitals, but to Mr. Smith's point, and to your point, it can mean a lot more in a rural area -- is if admissions continue to fall, these hospitals are -- urban and rural -- are going to have to rethink their mission. And an idea that seems to be floating around some of the urban -- or rural areas, sorry, that I have talked to people about is the notion of whether -- is it a full inpatient hospital that you need at that point, or do you need something more like an emergency room/urgent care type of thing.

Because, you know, your point is a heart attack, to go 21 miles or more miles, I get your point. But what about a routine, you know, inpatient hospital service, if, in fact, the admissions are declining? It is going to be struggle for hospitals, and particularly for rural areas, to support hospitals if admissions continue to decline.

*Ms. Jenkins. Okay, I agree. Another study I saw from the National Rural Health Association, it reports that 283 additional rural hospitals are on the brink of closure, just shutting their doors. And this means, you know, for these communities, they are not going to have the comprehensive local care that they need to survive. And, of course, I think you understand when rural hospitals close there is a domino effect, and employers are affected, communities, families, and the like.

Just quickly, where are folks that call rural America home receive needed health care -- where are they supposed to receive the needed health care, if we see these rural hospitals closing?

*Mr. Miller. And I think it goes back to a point that I was making a minute ago, which is, again, how many fully comprehensive hospitals do you need for any given set of miles? I absolutely agree that you need some set of comprehensive care. But if the -- we are supporting hospitals that are in rural areas that are very close to one another.

And a question for the Congress, particularly with a limited dollar, is if there was a consolidation there, one hospital, it might be more financially viable. It might have higher quality. And it could be that we need to have these conversations about a different community saying, okay, they will have an emergency facility, and this -- you will have some consolidation for the hospital, and then an emergency facility to serve where you don't have a full hospital. Sorry.

*Chairman Brady. Thank you, Ms. Jenkins.

Mrs. Noem, you are recognized.

*Mrs. Noem. Thank you, Mr. Chairman, and thank you for allowing me to be a part of this Committee hearing today. I appreciate the ability to sit at the dais.

Mr. Miller, I am from South Dakota, so home of where the deer and antelope play, and it is a long ways to drive anywhere. We have had many consolidations already, but yet it is still a struggle for our people to get access. So I wanted to visit with you a little bit about the unique challenges that some of our rural providers face. And in your testimony you stated that the last time MedPAC looked at rural Medicare beneficiaries' access to care, you found that the mix of -- for rural providers was incoherent, and that it lacks a common framework.

So, in South Dakota, the providers that I meet with, they would agree with you. They tell me that they are forced to chase after dollars many times, using a bizarre mix of adjusters and add-ons, which only adds to their administrative burdens. And, to make matters worse, CMS often carves real providers out of payment reforms, leaving them behind.

So, as the committee considers payment reform, can you suggest how we can improve the situation for rural providers?

*Mr. Miller. Okay. I mean we are having a, you know, theoretical or principle conversation.

*Mrs. Noem. Absolutely.

*Mr. Miller. Again, focus your dollar, first and foremost, on isolated, low volume, okay? Because isolated means there is no other alternative, low volume means I can't support my costs. And so, you know, if there is a dollar the Congress has, that first dollar should go to those types of facilities. I hate to keep harping on this. One that is right next door to an urban area, maybe the need is not as great.

And I have to tell you my rural commissioners, when we went through this -- and I don't want you to think we don't look at rural every year. We just did a comprehensive thing in 2012. I mean the rural commissioners were saying, "Rural isn't rural isn't rural." It differs, depending on how far and how frontier you get.

A second principle that the Commission talked about was the notion that you can provide supports, but you can either do it open-ended or in a fixed way. If you provide an open-ended support, you are probably giving them -- and there is evidence of this, that costs go up. And so then your supports have to chase that cost over time. If you give a fixed support, the provider continues to have some pressure to contain their cost. So we would say think about that.

It gets into individual measures. The empirical basis for some of the adjustments is questionable, and gets into a little bit more technical conversation. But there are things where, you know, the analysis would say, "This is how much support you should give," and there is this much, and you get kind of funny distortions, or people chasing what you said.

*Mrs. Noem. Yes.

*Mr. Miller. Because I have talked to rural people, and they say the same thing that you are saying.

On the quality front, there is a dilemma. And I think that is what you meant by leaving them out of reform --

*Mrs. Noem. Payment reforms.

*Mr. Miller. -- or at least part of it is, you know, they can't play as much in the quality. And this is a dilemma, in the sense that if you have a small -- it is hard to get an accurate measure. You get real noisy quality results.

I mean the Commission has talked about accumulating multiple years of data. If rural providers are willing to be treated as a group, you can consolidate them and say, "Judge us on our net performance" is the way to try and jump those kinds of fences.

*Mrs. Noem. Have you come to a conclusion on that? Do you think that would be accurate? Or have you floated that idea to rural providers to see if they would consider --

*Mr. Miller. We have certainly discussed that in principle in our reports. I mean, obviously, when somebody comes to you and says, "Okay," it is the two of us, it is hard, you know, for us to say that one is noisy, that one isn't noisy. We would have to see the thing to know.

And, actually, there is also some people who are trying to organize networks of rural providers and ACOs, as well.

*Mrs. Noem. Okay.

*Mr. Miller. You know, again, kind of accumulating a number of rural providers.

*Mrs. Noem. Okay, thank you.

I yield back, Mr. Chairman.

*Chairman Brady. Thank you, Mrs. Noem.

Mr. Crowley, you are recognized.

*Mr. Crowley. Thank you, Mr. Chairman, and thank you for allowing me to sit on your committee hearing today.

I know this Subcommittee is looking primarily at hospital policy issues, and so I am glad to have the opportunity to participate in the discussion.

Mr. Miller, as you know, I resent -- represent part of New York City, home to a number of world-class medical institutions, from teaching hospitals to cancer centers to medical schools. So I have had many discussions with health care systems on how much they rely on Medicare payments, just to be able to provide care to their populations.

Today I want to focus on the issue of graduate medical education, or GME. At the start there is a point that I want to make clear. Training our nation's doctors has long been a shared responsibility between individual teaching hospitals and the Federal Government. And that is because it is a shared benefit. The teaching hospitals may be the one receiving the payment to offset a portion of their cost, but it is the whole country that benefits from more well-trained doctors.

Ensuring that our academic medical centers receive adequate funding through GME is not just an issue for that hospital. It is an issue for our entire nation. The doctors who are trained in New York, for example, going to practice all over the country. And they practice in every specialty, too, from primary care and family medicine to the most targeted specialties. So, I really do think that the discussion of how we pay for graduate medical education can't just start and stop with dollars and cents at a single hospital. It has to consider the investment that we make in caring for our senior citizens, and in our nation's entire health workforce.

Part of that investment is also in the highly complex and costly patient care missions that teaching hospitals undertake. They run advanced trauma centers and burn units, and they see more complex patient

cases. They treat patients with rare and difficult diseases like Ebola. And that helps train future doctors in all those areas. Graduate medical education payments designed -- were designed by Congress to reflect all these undertakings, beyond just the explicit costs you may see on paper. And teaching hospitals will continue to take on new challenges.

Mr. Miller, in your testimony you say that to provide our health care delivery system, we need to "ensure that our residency programs produce the providers and skills necessary to integrate care across settings, improve quality, and use resources efficiently." Well, from what I have seen, our teaching hospitals are tackling that challenge head on.

One of the things we have strived to do with the Affordable Care Act are -- the permanent doc fix and other initiatives, is to highlight the importance of coordinated care, preventative care, and other quality measures. We all recognize that care does not just happen within the four walls of a hospital, and it shouldn't. Teaching hospitals are doing more to train residents in community care settings, and to focus on giving residents the skills they need to provide exactly the kind of care that MedPAC and others have called for. And they have to use resources efficiently, because they are getting hit with cuts from all sides.

I would argue that a sufficient investment in GME, not cutting and redirecting funding away, is what enables hospitals to do all these things. Do you disagree? Why can't we accomplish these goals without cutting funding?

*Mr. Miller. The Commission has a policy on GME, or a recommendation on GME, that I can take you through. The Commission's policy took a block of the current IME dollars and allocated them in a different way. It didn't reduce them.

But I also would say, in response to at least some of the points that you are making, as it stands -- we are talking about \$3.5 billion -- the accountability for that dollar doesn't exist. The notion that it is being devoted to teaching and, you know, training for, you know, a reformed delivery system, or whatever the case may be, currently we have no accountability for it. It is just a dollar that flows into the hospital. It can be used for anything.

So I think we would agree, in the sense of saying you take the dollars that exist, you allocate them differently -- which I can take you through -- and you target them to hospitals -- and this is the part where you may disagree, but just to be clear -- and other providers who are running graduate medical education programs that are more comprehensive in team-based care, evidence-based medicine, and also alternative sites of care, where they are trained, in addition to the hospital. But we didn't talk about eliminating the dollar.

*Mr. Crowley. I appreciate that. I can appreciate accountability, as well. And I think you appreciate the complexity, in terms of the teaching of a modern doctor today.

As a New Yorker, we can chew and walk gum [sic] at the same time, and I think we can do more and do it better. I agree with you on that.

I believe we need strong investment in graduate medical education, like raising the outdated cap on the number of residents that Medicare supports. And I am just finishing, Mr. Chairman. I have a bill to do just that with my good friend and my colleague, Dr. Boustany, in a bipartisan way, and a large bipartisan support for that, Mr. Miller, as well.

Mr. Chairman, I know you have talked about putting together legislation to help support our nation's hospitals, and I hope you will consider this issue as a priority to include. I also hope you will recognize the hurtful impact of cuts to GME program, not only in the hospitals that rely on this federal contribution, but on the doctors that train there, on the patients who they will see throughout their careers.

I look forward to working with you and the committee to ensure that we continue to provide needed funding to our nation's teaching hospitals. And, with that, I yield back.

*Chairman Brady. Thank you, Mr. Crowley.

Mr. Renacci, you are recognized.

*Mr. Renacci. Thank you, Mr. Chairman. And thank you, as well, for allowing me to be part of this Committee hearing this morning.

Dr. Miller, your testimony and the June MedPAC Report raised some critical issues, especially as they relate to improving hospital payment policy. The ACA included a new program, which is addressed in the report, aimed at reducing unnecessarily hospital readmissions. The program is known as the Hospital Readmission Reduction Program. The goal of this program is one that I and many of my colleagues support. In fact, it is estimated that nearly 18 billion per year is wasted on avoidable readmissions that -- 18 billion per year is wasted on avoidable admissions of Medicare patients alone. Reducing these preventable readmissions would reduce costs and improve outcomes.

However, the implementation of this program has been problematic, especially for those hospitals serving low-income patients. Dr. Miller, can you explain the correlation between hospitals serving low-income patients and readmission penalties? Is there a direct correlation, in your opinion? And do you have some concerns?

*Mr. Miller. Yes, and we have some fixes, as well. So there is a relationship. Depending on what you mean by direct, it -- this is more a subtlety. There seems to be a critical mass. So, you know, you get more poor people, you don't see a lot of change in readmission rates. Then you hit a certain level of having poor people as a percentage of your hospital, and then you start to see higher readmission rates. There is a relationship. It is not directly one to one, but there is a relationship, and we have laid this out in the report, and we, you know, fundamentally agree with the statement that you are making.

The Commission ended up saying this. And what we ideally want -- we have made some other recommendations to refine the measure -- what we really want is we don't want the penalty dollar. We want the hospital to avoid the readmission. It is better for the patient. You know, the program saves money by avoiding the readmission. You know, the penalty is really just a motivation. And, actually, a very small amount of dollars are actually driving relative change. And so I am hoping that this is headed in a positive direction.

With respect to the proportion of poor people, this is what we would do. We would not adjust the measure. So if a hospital has a good or a bad readmission rate, that remains on paper, because we think hospitals need to be focused on that, the public needs to be aware of it. Whether you are rich or poor, you should know what your readmission rate is in a given hospital that you are about to walk in the door.

However, mitigate to some extent the effect of the penalty. And the way you do that is you say that the penalty will be mitigated based on how many proportions of poor people, and we would put hospitals in a category and say lots of poor people, the penalty is not as heavy, few poor people, the penalty is heavier.

And then, within any category, you have to outperform your colleagues. So if I am a hospital with lots of poor people and I do well on readmissions, you know, I am spurring other hospitals to improve their performance. So we would mitigate the effect, but we would do it through the penalty, not adjust the measure.

*Mr. Renacci. But you do agree, then, that hospitals that have these lower-income patients inevitably are going to have these readmissions more than other hospitals.

*Mr. Miller. Yes, but we also believe that there are hospitals out there with lots of poor people who have relatively low readmission rates, and change can occur. And we would mitigate the penalty to help them along. But yes, we agree with the statement you made.

*Mr. Renacci. All right. Well, I share your concerns that many of the hospitals -- especially in my district -- that serve the most needy are being unfairly penalized under the Hospital Readmission Reduction Program.

I have introduced H.R. 1343, the Establishing Beneficiary Equity in the Hospital Readmission Program, which would require risk adjustment for socio-economic factors when calculating hospital penalties, ensuring these critical hospitals can continue to take care of the least among us without being penalized for doing so, and I thank you for your word MedPAC has done on this issue.

And I yield the remainder of my time.

*Chairman Brady. Thank you, Mr. Renacci. You know, going -- as you have noticed, we have a hearing on competition next week, focusing on rural disparities. We are going to be discussing GME and hospital payment reform, in the hopes of bringing -- through the fall, in the hopes of bringing some legislation to the floor and to the committee there. Today's hearing was very helpful and insightful, as we go forward with that.

So, Dr. Miller, thank you for your testimony. Appreciate your continued assistance. We will need it, getting answers to the questions that were asked by those on the committee.

And as a reminder, any Member wishing to submit a question for the record will have 14 days to do so. And if any Member does, Doctor, I ask that you respond in writing in a timely manner, which I know you will.

Again, thank you. With that, the committee is adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

[Public Submission For The Record](#)