MEDPAC'S ANNUAL MARCH REPORT TO CONGRESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

MARCH 15, 2011

Serial No. 112–HL1

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

70–875 WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MEDPAC'S ANNUAL MARCH REPORT TO CONGRESS

TUESDAY, MARCH 15, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 1:07 p.m., in Room 1100, Longworth House Office Building, Hon. Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 8, 2011
HL–1

CONTACT: (202) 225–1721

Chairman Herger Announces a Hearing on MedPAC's Annual March Report to Congress

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) annual March Report to the Congress which details the Commission's recommendations for updating Medicare payment policies. The Subcommittee will hear from MedPAC's Chairman, Glenn Hackbarth. **The hearing will take place on Tuesday, March 15, 2011, in 1100 Longworth House Office Building, beginning at 1:00 p.m.**

In view of the limited time available to hear the witness, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

MedPAC advises Congress on Medicare payment policy. The Commission is required by law to submit its annual advice and recommendations on Medicare payment policy by March 15. In its March report to the Congress, MedPAC is required to review and make recommendations on payment policies for specific provider groups, including hospitals, skilled nursing facilities, physicians, Medicare Advantage plans, and other providers.

In announcing the hearing, Chairman Herger stated, **"MedPAC provides valuable technical advice and counsel to Congress on the Medicare program, ranging from recommendations on payment adequacy to ways in which we can improve the delivery and quality of care for seniors and people with disabilities. This hearing will offer the Subcommittee an opportunity for an indepth exploration of MedPAC's recent recommendations and their impact on the Medicare program and its beneficiaries. As we confront the issues surrounding implementation of the health care overhaul law passed last year and the continued need to reform entitlement programs, the information we receive from MedPAC will be more important than ever."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March 2011 Report to the Congress on Medicare payment policies.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, March 29, 2011.** Finally, please note that due to the change in House mail

policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman HERGER. The Subcommittee will come to order. I want to welcome everyone to the first hearing in the Subcommittee on Health for the 112th Congress. Today we will be hearing from the Medicare Payment Advisory Commission, MedPAC, on the recommendations from their March 2011 report on Medicare payment policies.

During this Congress, we must come together to address a fiscal crisis of monumental proportions. Every program, no matter how important, must be scrutinized to ensure that scarce taxpayer dollars are being used appropriately and efficiently.

Therefore, I find it fitting that in our inaugural meeting we would hear from MedPAC. The insight and guidance we receive from MedPAC will be very important as we seek ways to reform the Medicare program and improve the accuracy of provider payments while also ensuring that Medicare beneficiaries have access to high-quality care.

Congress relies on MedPAC's Medicare provider payment recommendations because they are based on sound policy and strong data analysis. Traditionally Medicare spending has outpaced growth in the economy at large and is a major driver of our long-term debt. The Congressional Budget Office projects that Medicare spending will nearly double as a share of the U.S. economy over the next 25 years.

By 2050 the Big Three Federal entitlement programs—Medicare, Medicaid and Social Security—are expected to exceed total tax revenue, with Medicare being the largest of the three. We cannot bring about a fiscally sustainable future if these trends continue.

MedPAC's analysis is invaluable in helping us better understand when growth in Medicare spending is appropriate and when Medicare payments need to be adjusted.

Last year Congress passed a massive health care overhaul law that permanently reduces Medicare payments to a number of providers. Less than 3 percent of the more than one-half trillion dollars in cuts from Medicare came from actual delivery reforms.

We must do better than that, which is why we also rely on MedPAC's June report to Congress to guide us toward proposals that offer real reform instead of just turning payment dials up or down. This will help ensure that Medicare savings yield better outcomes for Medicare's beneficiaries.

I think I speak for all of us up here, Republicans and Democrats alike, that we are still looking for the silver bullet that will permanently reform the physician payment system in a fiscally responsible manner, and look forward to working with MedPAC to find such a solution.

I want to offer a warm welcome to our invited witness, MedPAC's Chairman Glenn Hackbarth. Thank you for joining us today and I look forward to hearing your testimony.

I would also like to extend a special word of thanks to MedPAC's executive director, Mark Miller, and the entire MedPAC staff for their hard work on this report.

Before I recognize Ranking Member Stark for the purpose of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

Without objection, so ordered.

I now recognize Ranking Member Stark for his opening statement.

Mr. STARK. Thank you, Mr. Chairman. I would like to join you in welcoming Glenn and MedPAC. It is the efforts of MedPAC and their staff that have helped us in the past. Many of the recommendations in the current law's provisions are MedPAC's work, and they have formed a number of the reforms that are in the law that modernize the delivery of health care that Federal rewards value over volume and encourages better coordination.

They have helped us with ideas to lower their rate of preventable readmissions, the testing of bundled payments, medical homes, and hospital value-based purchasing.

We have made difficult decisions in order to rein in rising health care costs, and it would not have been possible without the advice of MedPAC.

The end result: A program with improved benefits that lower costs for beneficiaries, create taxpayer savings, and innovations that we hope will improve patient care and strengthen finances for the Medicare solvency for an additional number of years. This, we think, is better than the program that favors vouchers or shifting of costs to the very beneficiaries who Medicare was created to serve.

While my Republican colleagues and I have many areas where we disagree, there are several areas where we work together, including Medicare's broken physician payment system. The House Democrats passed comprehensive reform for the physician payment system in the last Congress, and I hope getting a long-term solution is at the top of our to-do list.

As this year progresses, I look forward to getting continued input and advice from Mr. Hackbarth and the MedPAC staff, and will continue to rely on your expertise and advice as we undertake our Medicare and oversight responsibilities.

Thank you, Mr. Chairman.

Chairman HERGER. Mr. Hackbarth, I would like you to go ahead and proceed with your testimony. We do have two votes going on now, so I would like to have you give your testimony, and then we will recess until following those two votes, and then we will come back. If you would proceed with your testimony, please.

STATEMENT OF GLENN M. HACKBARTH,
CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you, Mr. Chairman and Mr. Stark. I especially appreciate the warm welcome and the acknowledgment of the work of the MedPAC staff. We have a terrific staff and without them we couldn't do our work.

As you know, MedPAC is a nonpartisan congressional advisory body, so our goal, our mission, our sole mission is to help you with the difficult decisions that you must make each year. Each year we produce two reports, a March report which usually focuses primarily on payment updates, and then a June report that ranges more broadly across Medicare issues.

We have 17 commissioners, as you know. Six of them have clinical training as either physicians or RNs. Six of our commissioners have high-level executive experience with health care delivery organizations; four high-level government experience; and then six academics who publish frequently in peer-reviewed journals. And some of us have more than one of these credentials.

I mention the credentials to emphasize that we are people who have experience in different facets of the Medicare program, and our goal is to bring that experience to bear for the benefit of the program, the beneficiaries it serves, and the taxpayers who finance it.

Because we have a lot of experience, it doesn't necessarily mean that we are always right. We can be right or wrong, like everybody else, but you can be assured that our agenda as a Commission is the same as yours: High-quality care for Medicare beneficiaries at the lowest possible cost for taxpayers.

Despite the diversity of the MedPAC commissioners, we typically have a high degree of consensus on our recommendations. This March report is no exception. There are 12 recommendations in our March report that represents a total of 187 "yes" votes, versus only two "no" votes, and three abstentions.

The March report, as I say, here is the summary of the major recommendations in the March report. There are recommendations on payment updates for each of the payment systems that Medicare uses. For physicians, hospital inpatient and outpatient dialysis

services and hospice services, we are recommending a 1-percent increase in the Medicare rates. For ambulatory surgery centers, one-half of 1-percent increase in the rates, and then zero update for skilled nursing facilities, home health agencies, inpatient rehab facilities, and long-term care hospitals.

In the case of home health services, we are recommending a rebasing of the rates as we have in the previous year, as well as some changes in the case mix system and a per-episode copay for Medicare beneficiaries.

And then, as we do each year in our March report, we also do a status report on the Part C Medicare Advantage Program and Part D, the prescription drug program.

I want to pick up, Chairman Herger, on one of the points that you made in your introduction. This report is principally about how much the unit prices should change for Medicare services. But we can't get to where we want to go in terms of an efficient Medicare program, providing high-quality care to Medicare beneficiaries at a reasonable cost for taxpayers, if we focus only on the unit prices.

In addition to that, we must look at the relative values that we pay for different types of services. We must also look at the payment methods that we use and try new, innovative payment methods that create better incentives for high-value care. And then, finally, we must also look at the incentives for Medicare beneficiaries.

So, Mr. Chairman, those are my summary of comments and I look forward to the opportunity to talk further about our report.

Chairman HERGER. Thank you very much.

[The statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Report to the Congress: Medicare Payment Policy

March 15, 2011

Statement of

Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

601 New Jersey Avenue, NW • Suite 9000 • Washington, DC 20001 • 202-220-3700 • Fax: 202-220-3759 • www.medpac.gov

Chairman Herger, Ranking Member Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's March Report to the Congress and our recent recommendations on Medicare payment policy.

The Medicare Payment Advisory Commission is a Congressional agency that provides independent, non-partisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that assures beneficiary access to high-quality care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends tax dollars responsibly. While the Commission is concerned with a wide variety of policy approaches to improving quality and constraining costs, the Congress directs us in our March Report to Congress to look specifically at provider payment rates.

Introduction

The Commission's objective is to obtain good value for the Medicare program's expenditures, which means maintaining beneficiaries' access to high-quality care while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. In our March report we review:

- The traditional Medicare fee-for-service (FFS) program, which funds healthcare for about three-quarters of the over 46 million beneficiaries in Medicare. Specifically, we make recommendations for Medicare FFS payment policy in 2012 for: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation, long-term care hospital, and hospice.
- The Medicare Advantage (MA) program, which enrolls almost a quarter of Medicare beneficiaries and allows them to receive Medicare benefits administered by private plans rather than by the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans

can provide.

- The prescription drug plans in Part D that enroll about 60 percent of Medicare beneficiaries. Beneficiaries can enroll in either stand-alone prescription drug plans or Medicare Advantage prescription drug plans. Most enrollees report high satisfaction with the Part D program and with their plans.

Context

Obtaining good value for the expenditures in the Medicare program is essential not only for Medicare beneficiaries but also for taxpayers and for the health of the Federal budget and the economy as a whole. Medicare's share of total economic output is large and growing. It was 3.5 percent in 2009, and it is projected to rise to 5.5 percent by 2035. Medicare also consumes a significant share, 18 percent, of all income tax revenue (in addition to Medicare's dedicated payroll tax revenues, premiums, and cost sharing). Those tax revenues are then not available to fund other national priorities or to reduce the national debt. Complicating Medicare's long-term outlook is the large non-Medicare federal fiscal burden. In total, CBO estimates that debt held by the public is expected to be about 77 percent of gross domestic product (GDP) within the next decade, a level not seen since World War II. Under alternative assumptions, that figure would be about 97 percent.

In this context, controlling growth in the Medicare program is vital for the nation's fiscal health. However, Medicare's cost growth does not occur in a vacuum—it is linked to other forces that drive growth in health care spending. Overall health care spending has risen faster than GDP for over four decades.

Making recommendations for Medicare's payment systems

In our March report we are directed by the Congress to evaluate Medicare's payment systems and make recommendations to encourage the efficient provision of high-quality services for Medicare beneficiaries, while being mindful of the value of the beneficiaries' and taxpayers' dollars. We make recommendations year-by-year so that we can look at all the indicators of payment

adequacy and other factors using the most recent data available to make sure our recommendations accurately reflect current conditions.

An important element of this report is the Commission's recommendations for annual rate updates under Medicare's various FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed. Our general approach for determining an update has two steps. First, we assess the adequacy of Medicare payments for providers in the current year (2011) by considering beneficiaries' access to care, the supply of providers, service volume, the quality of care, providers' access to capital, and Medicare payments and providers' cost. Second, we assess how those providers' costs are likely to change in the year the update will take effect—2012. As part of the process, we examine payment adequacy for the "efficient" provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

When we consider provider's costs, we recognize that payments and costs are dynamically linked. That is, unlike some who argue that costs are immutable and providers cannot control them, we find that financial pressure from constrained payments can change costs and cost growth. For example, we find that in general, hospitals under greater financial pressure control their cost growth more than those under less pressure. In fact, in 2009 hospitals responded to the financial pressure of the recession and reduced their cost growth to the lowest rate since 2000. Moreover, we can identify a set of efficient hospitals that control their costs and at the same time provide high quality care for beneficiaries. These relatively efficient hospitals have lower mortality and lower readmission rates, as well as lower costs. We also find that some skilled nursing facilities (SNFs) provide high quality care at lower costs than others. Encouraging providers to be efficient in their use of resources while still providing high quality care should be a key aspect of Medicare payment policy.

In addition to changes in updates, we also evaluate the way payments are distributed within a payment system. We evaluate whether there is equity among providers and whether there are any

biases that may make patients with certain conditions financially undesirable or particular procedures unusually profitable. For example, we have made recommendations to change the skilled nursing facility payment system to rebalance payments from therapy services to complex medical services, and to redistribute physician fee schedule payments from procedural services to primary care services. In this report, we recommend changing the home health payment system, which would have the effect of increasing payments for clinically complex patients.

Policies affecting the level and distribution of payments to providers may not always be enough to achieve our objectives. In some cases, recommendations may also be warranted to guard against fraudulent or abusive practices. For example, this year we recommend review of areas with aberrant home health utilization and suspension of enrollment and payment in areas with widespread fraud. In the past, we have recommended steps to curb aberrant patterns of use in the hospice sector. In other cases, engaging beneficiaries to be a more active participants in their care by modifying the design of the benefit may be necessary. For example, this year we recommend adding a cost sharing requirement to the home health benefit. This would make the home health benefit similar to other sectors (most of which have some form of beneficiary cost sharing) and it would serve to help beneficiaries consider the value of the service.

We recognize that managing updates and relative payment rates alone will not solve a fundamental problem with current Medicare FFS payment systems—that providers are generally paid more when they deliver more services without regard to the quality or value of those additional services. To address the problem directly two approaches must be pursued. First, payment reforms which are just beginning—such as penalties for excessive readmission rates and linking some percentage of payment to quality outcomes—need to be widely implemented. Second, delivery system reforms, such as medical homes, bundling, and accountable care organizations, need to be tested and successful models adopted on a broad scale.

In the interim, it is imperative that the current FFS payment systems be managed carefully. Medicare is likely to continue using its current payment systems for some years into the future.

This alone makes Medicare payment rates—their overall level, the relative rates for different services in a sector, and the relative rates for the same services across sectors—an important topic. In addition, if Medicare payment rates were constrained, that could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

In the following sections of this testimony we discuss our recommendations for Medicare FFS payment policy in 2012 for: hospital inpatient, hospital outpatient, physician, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation, long-term care hospital, and hospice. In addition to our work on FFS payment systems, we also review the status of the MA plans beneficiaries can join instead of traditional FFS Medicare and the status of the plans that provide prescription drug coverage.

Hospital inpatient and outpatient services

In 2009, the 3,500 hospitals paid under the hospital inpatient prospective payment system received $148 billion for roughly 10 million Medicare inpatient admissions and 147 million outpatient services. From 2008 to 2009, Medicare payments per FFS beneficiary for hospital inpatient and outpatient services grew by 6 percent.

In our assessment of payment adequacy for these services we find:

- Access measures are positive. The supply of hospitals, range of services offered, and the number of hospital employees all continue to grow. The volume of hospital outpatient services per Medicare FFS beneficiary grew by 4 percent per year from 2005 to 2009 as inpatient admissions per beneficiary declined 1 percent per year. Hospital-based outpatient physician office visits grew by 9 percent from 2008 to 2009, representing a quarter of all outpatient volume growth.

- Quality continues to improve on most measures. Hospitals reduced in-hospital and 30-day mortality rates across 5 prevalent clinical conditions. Patient experience measures

have shown a slight improvement in recent years. However, patient safety indicators and readmission rates have not improved significantly.

- Access to capital has been volatile over the past three years but appears adequate at this time.

- In 2009, Medicare margins improved to -5.2% from -7.0% in 2008. Medicare payment growth outpaced cost growth for two reasons. First, Medicare inpatient payments per discharge grew by 5.3 percent, which was the highest growth in payments in over a decade. The high increase in the average payment rate reflects the update in payment rates and the effect of hospitals' documentation and coding. Second, costs per discharge grew by 3.0 percent, which was the lowest cost growth since 2000. The lower cost growth reflects the hospital industry's response to the financial crisis that occurred in fall 2008, which increased pressure on hospitals to constrain their cost growth in 2009.

- In 2009, the Medicare margin for the median efficient hospital was 3.0 percent. (We define efficient hospitals as those that consistently perform relatively well on cost, mortality, and readmission measures.)

The Commission recommends an update of 1 percent for both the inpatient and outpatient prospective payment systems for 2012. In its update recommendation, the Commission has struck a balance among several competing factors. On the one hand, average total Medicare margins are negative. On the other hand, our other payment adequacy indicators are positive. Furthermore, the negative Medicare margins reflect in part the lack of private financial pressure for cost containment, and the set of hospitals identified as efficient have a positive median Medicare margin. Based on these circumstances the Commission contemplated an update of 2.5 percent.

However, for inpatient services, changes in documentation and coding following the implementation of Medicare severity–diagnosis related groups in 2008 have created overpayments to hospitals. Current law does not allow full recovery of past overpayments and no

action has been taken to stop the ongoing overpayments. The Commission maintains that all overpayments should be recovered and recommends that the Congress require the Secretary of Health and Human Services to make adjustments to payment rates in future years to do so. Stopping the ongoing overpayments is a crucial first step. Therefore, the Commission would reduce the ongoing overpayment by 1.5 percentage points in 2012—that is, the difference between its contemplated update of 2.5 percent and its recommended update of 1 percent. In addition to this 1.5 percentage point adjustment in 2012, a further 2.4 percentage point adjustment downward will be needed in future years to fully prevent further overpayments.

For outpatient hospital services, the Commission is concerned that significant payment disparities among Medicare's ambulatory care settings (hospital outpatient departments, ambulatory surgical centers (ASCs), and physicians' offices) for similar services are fostering undesirable financial incentives. Physician practices and ASCs are being reorganized as hospital outpatient entities in part to receive higher reimbursements. Medicare should seek to pay similar amounts for similar services, taking into account differences in quality of care and in the relative risks of the patient populations. The Commission is concerned by the incentive to reorganize for higher reimbursement and will examine this issue. However, in the interim, the modest update of 1 percent is warranted in the hospital outpatient setting to limit the growing payment rate disparities among ambulatory care settings.

Physician and other health professional services

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In 2009, FFS Medicare spent about $64 billion on physician and other health professional services.

We find that most indicators of Medicare's payment adequacy for fee-schedule services are positive and stable, suggesting that, at current payment levels, most beneficiaries can obtain care on a timely basis.

- Overall, beneficiary access to physician services is good or better than that reported by privately insured patients age 50 to 64. For example, in 2010, 75 percent of beneficiaries reported that they had no problem scheduling timely routine-care physician appointments, compared with 72 percent of privately insured individuals 50 to 64. Similarly, 83 percent of beneficiaries reported they had no problem scheduling timely appointments for care for illness or injury, compared with 80 percent of privately insured individuals.

- Multiple surveys show that most physicians are accepting Medicare patients. For example, the 2008 National Ambulatory Medical Care Survey found that 90 percent of physicians with at least 10 percent of their practice revenue coming from Medicare accepted at least some new Medicare patients.

- Service volume per beneficiary continued to grow in 2009. Overall volume (including both service units and intensity) grew 3.3 percent per beneficiary.

- Most claims-based indicators for ambulatory quality that we examined for the elderly improved slightly or were stable from 2007 to 2009.

- Medicare's payment for physician fee-schedule services in 2009 averaged 80 percent of private insurer payments for preferred provider organizations, a figure unchanged from the preceding year.

In light of these positive indicators and the modest expected growth in physicians' and other health professionals' costs, the Commission recommends an update of 1 percent for physician fee-schedule services in 2012.

We also consider two key issues. The first is beneficiary access to primary care. While our analysis finds that access to physician and other health professional services is good nationally, a small share of the Medicare population continues to report problems finding a new primary care physician—an essential component to a well-functioning delivery system. The Commission has

recommended enhancements to primary care, such as increasing Medicare payments for primary care services provided by primary care practitioners. The Congress's adoption of this policy marks an important step toward ensuring beneficiaries' access to primary care. The Commission will explore other levers to promote primary care including other payment approaches and maximizing the use of health professionals such as advanced nurse practitioners.

The second issue centers on the sustainable growth rate (SGR) system, the budgetary mechanism designed to address growth in Medicare spending for physician and other health professional services. In previous reports, the Commission has discussed the flaws of the SGR system, while recognizing that having an expenditure target can provide some restraint on updates.

A main flaw of the SGR is it neither rewards individual providers who restrain unnecessary volume growth nor penalizes those who contribute most to inappropriate volume increases. Indeed, volume growth has been a major factor in the prescribed SGR payment cuts—cuts expected to be at least 25 percent in 2012.

There is general consensus that fee cuts of that magnitude would be detrimental to beneficiary access to care, and legislative overrides of the SGR have averted payment cuts in recent years. However, these overrides are merely temporary, leading to mounting frustration among physicians, other health professionals, and their patients and to a desire for a longer term remedy. However, the high budgetary cost of eliminating some or all of the scheduled fee cuts in the longer term has prevented such proposals from becoming law. The Commission plans to continue to work on SGR payment policies and consider various approaches for updating the Medicare physician fee schedule.

Ambulatory surgical centers

ASCs furnish outpatient surgical services to patients not requiring hospitalization and for whom an overnight stay is not expected after surgery. In 2009, Medicare combined program and beneficiary spending on ASC services was $3.2 billion ($2.6 billion in program spending), an increase of 5.1 percent per FFS beneficiary over 2008.

We find that most of the available indicators of payment adequacy for ASC services are positive:

- Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC care has generally been adequate. There were 5,260 Medicare-certified ASCs, an increase of 2.1 percent (109 ASCs) over 2008. In 2009, service volume increased by 3.4 percent.

- CMS does not require ASCs to submit data on the quality of care they provide. Consequently, we do not have sufficient data to assess ASCs' quality of care.

- ASCs' access to capital appears to be adequate as the number of ASCs has continued to increase.

- Medicare payments per FFS beneficiary increased by 5.1 percent in 2009. ASCs do not submit data on the cost of care they provide to the Medicare program. Therefore, we cannot calculate a margin as we do in other sectors to assist in assessing payment adequacy.

The Commission recommends an increase of 0.5 percent for ASC payments in 2012, concurrent with a requirement that ASCs submit cost and quality data.

Outpatient dialysis services

Outpatient dialysis services are used to treat individuals with end-stage renal disease (ESRD). In 2009, about 340,000 dialysis beneficiaries were covered under FFS Medicare, and Medicare expenditures for outpatient dialysis services, including separately billable drugs administered during dialysis, were $9.2 billion, an increase of 7 percent from 2008 spending levels.

The payment adequacy indicators for outpatient dialysis services are generally positive:

- Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has generally kept pace with growth in the number of dialysis patients.

- Between 2008 and 2009, the number of FFS dialysis beneficiaries and dialysis treatments grew by 4 percent. Use of dialysis drugs also increased between 2008 and 2009.
- Dialysis quality has improved over time for some measures, such as use of the recommended type of vascular access—the site on the patient's body where blood is removed and returned during dialysis. Other measures suggest that improvements in quality are still needed.
- Access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase.
- In 2009, the Medicare margin for composite rate services and dialysis drugs for freestanding facilities was 3.1 percent.

The Commission recommends an update of 1 percent for outpatient dialysis services in 2012. Consistent with the Commission's long-standing recommendation, a new dialysis prospective payment method began in 2011 that includes dialysis drugs in the payment bundle and requires that CMS implement a quality incentive program beginning in 2012.

Skilled nursing facility services

SNFs furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. Most SNFs are part of nursing homes that furnish long-term care, which Medicare does not cover. In fiscal year 2010, Medicare spent $26.4 billion on SNF care.

Most indicators of payment adequacy for SNFs are positive:

- Access to SNF services remains stable for most beneficiaries, though minorities use SNF services less than other beneficiaries. The number of SNFs has increased gradually since 2001. Available SNF bed days increased 4 percent between 2008 and 2009. However, since 2004, the share of SNFs admitting medically complex patients decreased. As a result, some beneficiaries may have to wait to be placed in a SNF that will take them.

- Days and admissions on a per FFS beneficiary basis decreased slightly between 2008 and 2009. This decline reflects fewer hospital admissions (a prerequisite for Medicare coverage). However, despite these reductions, use rates were higher in 2009 than in 2006.

- SNF quality of care in 2008 was unchanged from the prior year.

- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Access to capital has improved since 2009 but some investors are wary of the impact of states' budget difficulties. Any uncertainties in lending do not center on the adequacy of Medicare payments; from all accounts, Medicare remains a sought-after payer.

- Increases in payments between 2008 and 2009 outpaced increases in provider costs, reflecting the continued concentration of days in the highest payment case-mix groups. In 2009, the average Medicare margin for freestanding SNFs was 18.1 percent.

Financial performance continued to differ substantially across the industry—a function of distortions in the prospective payment system (PPS) and cost differences of providers. Compared to SNFs with relatively low margins, SNFs with the highest margins had higher shares of days in intensive rehabilitation case-mix groups and lower shares of days in the medically complex groups. We also examined relatively efficient SNFs and found that it is possible to have costs well below average, above-average quality, and more than adequate Medicare margins.

In light of these findings, the Commission recommends no update for SNFs in 2012.

In addition, to address flaws in the SNF payment system, the Commission reiterates its previous recommendations to improve payment accuracy and drive improvements in quality in SNFs. In its previous work, the Commission found that the SNF case-mix system overvalued payments for care of rehabilitation patients and undervalued payments for care of medically complex patients. Therefore, the Commission recommended adding a separate nontherapy ancillary component to the payment system (to better capture nursing care needs of patients in SNFs); replacing the

therapy component with one that makes payments based on patient care needs, not on therapy provision; and adopting an outlier policy. Other recommendations include:

- establishing a quality incentive payment policy for SNFs,
- improving quality measurement for SNFs by adding the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge, and
- requiring the reporting of more accurate diagnostic and service-use information.

PPACA requires that we report on Medicaid utilization, spending, and non-Medicare margins for SNFs beginning in 2012. Medicaid finances mostly long-term care services provided in nursing homes but also covers the copayments for dual-eligible beneficiaries who stay 21 or more days in a SNF. Our initial investigation finds the number of Medicaid-certified facilities decreased between 2000 and 2009 but Medicaid-covered days and spending increased during this period. Non-Medicare margins (for all lines of business) were negative between 2000 and 2009, but total margins (for all payers and all lines of business) were positive.

Home health services

Home health agencies provide services to beneficiaries who are homebound and need skilled care (nursing or therapy). In 2009, about 3.3 million Medicare beneficiaries received home health services from about 11,000 home health agencies. Medicare spent $19 billion on home health services in 2009.

The indicators of payment adequacy for home health are positive:

- Access to home health care is generally adequate. Ninety-nine percent of beneficiaries live in a ZIP code where a Medicare home health agency operates and 98 percent live in a ZIP code with two or more agencies.

- The number of agencies continues to increase, with over 650 new agencies in 2010. The total number of agencies exceeds 11,400, surpassing the peak of 10,917 agencies in 1997. Most new agencies have been for profit and concentrated in a few states.

- The volume of services continues to rise. The average number of episodes per user increased by 25 percent from 2002 to 2009 and the share of FFS beneficiaries using home health care increased as well.

- The Home Health Compare quality measures for 2010 are similar to those for previous years, showing improvement in the functional measures and mostly unchanged rates of adverse events. However, the Commission believes that supplemental measures of quality that focus on specific conditions are needed to assess home health quality and has a project under way to develop new measures.

- The major publicly traded for-profit home health companies have sufficient access to capital markets for their credit needs. The significant number of new agencies in 2010 suggests that smaller agencies also have access to capital necessary for start-up.

- In prior years, payments have consistently and substantially exceeded costs in the home health PPS. Medicare margins for freestanding providers in 2009 were 17.7 percent. Two factors have contributed to payments exceeding costs: Fewer services are delivered than is assumed in Medicare's rates, and growth in cost per episode has been lower than what is assumed in the market basket.

In consideration of these findings, the Commission recommends that the Congress eliminate the market basket update for 2012 and direct the Secretary to implement a two-year rebasing of home health rates beginning in 2013. In addition, the Commission finds that the home health benefit has significant vulnerabilities that need to be addressed urgently and recommends policies to strengthen program integrity, improve payment accuracy, and establish beneficiary incentives.

- Recent trends in several parts of the nation suggest that fraud has become a significant concern in the home health benefit. The Commission recommends that the Secretary and the Office of Inspector General review areas with aberrant home health utilization and that the Secretary implement suspensions of enrollment and payment in areas with widespread fraud.

- The Commission finds the current home health payment system is flawed and creates incentives for patient selection. Analysis by the Commission and the Urban Institute suggests that the current case-mix system may, in effect, overvalue therapy services and undervalue nontherapy services. The Commission recommends that the Secretary implement a revised payment system that addresses these flaws.

- The lack of cost sharing in Medicare for home health services is unusual, as most services in Medicare's traditional FFS program include some form of beneficiary cost sharing. The Commission recommends adding a cost-sharing requirement, which would make the benefit similar to other sectors and encourage the beneficiary to consider the value of the services they use.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after an injury, illness, or surgery. In 2009, almost 360,000 Medicare FFS beneficiaries received care in IRFs. Medicare FFS expenditures for IRF services were about $6 billion in 2009.

The indicators of Medicare payment adequacy for IRFs are generally stable or positive:

- Our measures of access to care suggest that beneficiaries have sufficient access to IRF services. The supply of IRFs, occupancy rates, and volume were stable in 2009. In addition, the decline in the number of rehabilitation beds since 2005 tapered off in 2009.

- From 2004 to 2010, IRF patients' functional improvement between admission and discharge increased, suggesting improvements in quality. However, changes over time in patient mix make it difficult to draw definitive conclusions about quality trends.

- Hospital-based units, through their parent institutions, have adequate access to capital. The largest chain of freestanding facilities also appears to have adequate access to capital. We are not able to determine the ability of independent freestanding facilities to raise capital.

- The IRF aggregate Medicare margin for 2009 was 8.4 percent.

The Commission recommends a zero update to payments for IRFs in 2012. We conclude that IRFs will be able to absorb cost increases and continue to provide care to clinically appropriate Medicare cases under this update.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with clinically complex problems—such as multiple acute or chronic conditions—who need hospital-level care for relatively extended periods. Medicare is the predominant payer for LTCH services, accounting for about two-thirds of LTCH discharges. In 2009, Medicare spent $4.9 billion on care furnished by roughly 400 LTCHs nationwide. About 116,000 beneficiaries had almost 131,500 LTCH stays.

Our analysis of payment adequacy indicators finds:

- The number of LTCHs increased 6.6 percent between 2008 and 2009, despite a limited moratorium on new LTCHs and new beds in existing LTCHs from July 2007 until December 28, 2012. New LTCHs were able to enter the Medicare program because they met specific exceptions to the moratorium.

- Beneficiaries' use of services suggests that access has not been a problem. Controlling for the number of FFS beneficiaries, we found that the number of LTCH cases rose 0.9

percent between 2008 and 2009, suggesting that access to care was maintained during this period.

- Unlike most other health care facilities, LTCHs do not submit quality data to CMS. Our claims-based analysis found stable or declining rates of readmission, death in the LTCH, and death within 30 days of discharge for most of the top 20 diagnoses in 2009.

- The moratorium on new beds and facilities reduces opportunities in the near future for expansion and need for capital, although the largest LTCH chains continued with construction of new LTCHs that were already in the pipeline and thus exempt from the moratorium. In addition, these chains, which together own slightly more than half of all LTCHs, continued in 2010 to acquire other LTCHs, as well as other post-acute care providers.

- Payments per case increased 6.4 percent between 2008 and 2009. Cost per case rose less than 2 percent. The 2009 Medicare margin for LTCHs was 5.7 percent.

The Commission recommends a zero update for LTCHs in 2012.

PPACA mandates that CMS implement a pay-for-reporting program for LTCHs by 2014. The quality measures LTCHs report should include process, patient safety, and outcome measures. Pay for reporting is a first step. The next step should be pay for performance. Linking a portion of LTCH payment to quality will create stronger incentives to improve care delivery. We are exploring measures for LTCHs that will contribute to a strong pay-for-performance program.

Hospice

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less who choose to enroll in the benefit. In 2009, nearly 1.1 million Medicare beneficiaries received hospice services from nearly 3,500 providers, and Medicare expenditures totaled $12 billion.

The indicators of payment adequacy for hospices are generally positive:

- Hospice use among Medicare decedents has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2009, hospice use increased across almost all demographic and beneficiary characteristics examined.

- The supply of hospices increased 50 percent from 2000 to 2009—growing on average 5 percent per year from 2000 to 2008 and 3 percent from 2008 to 2009. For-profit providers accounted almost entirely for the increase in the number of hospices.

- Use of Medicare hospice services continues to increase, with growth in both the number of hospice users and average length of stay. In 2009, 42 percent of Medicare decedents used hospice, up from 40 percent in 2008 and 23 percent in 2000. Between 2000 and 2009, average stay grew from 54 days to 86 days, reflecting longer stays among patients with the longest stays.

- At this time, we do not have sufficient data to assess the quality of hospice care provided to Medicare beneficiaries, as information on quality of care is very limited. PPACA mandates that CMS publish quality measures in 2012. Beginning in fiscal year 2014, hospices that do not report quality data will receive a 2 percentage point reduction in their annual payment update.

- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. The continued influx of new providers suggests access to capital is adequate.

- The aggregate Medicare margin was 5.1 percent in 2008. This margin excludes nonreimbursable costs associated with bereavement services and volunteers (at most 1.5 percent and 0.3 percent of total costs, respectively).

The Commission recommends an update of 1 percent for hospices in 2012. The chapter also reiterates previous Commission recommendations to:

- improve the accuracy of the PPS by increasing payments for days at the beginning and end of the episode relative to days in the middle of the episode,
- increase program integrity by having the Office of Inspector General investigate the prevalence of financial relationships between hospices and long-term care facilities, differences in patterns of nursing home referrals to hospice, enrollment practices at hospices with aberrant utilization patterns, and hospice marketing and admissions practices and their relation to length of stay.

Status report on the Medicare Advantage program

The MA program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater potential to innovate and to use care management techniques and, if paid appropriately, would have more incentive to do so.

In 2010, MA enrollment increased to 11.4 million beneficiaries (24 percent of all Medicare beneficiaries). Enrollment in HMOs, the dominant form of MA plan, grew by 7 percent. Preferred provider organizations (PPOs) exhibited rapid enrollment growth, with local PPO enrollment growing about 40 percent and enrollment in regional PPOs more than doubling between 2009 and 2010. Enrollment in private FFS (PFFS) plans declined from about 2.4 million to about 1.6 million enrollees as plans reduced their PFFS service areas in anticipation of new network requirements for PFFS beginning in 2011.

In 2011, virtually all Medicare beneficiaries have access to an MA plan and 99 percent have access to a network-based coordinated care plan (CCP). Ninety percent of beneficiaries have

access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium). Beneficiaries can choose from an average of 12 plans, including 8 CCPs.

We estimate that, on average, 2011 MA benchmarks, bids, and payments will be 113 percent, 100 percent, and 110 percent of FFS spending, respectively—similar to the ratios in 2010. That is, on average, Medicare will spend 10 percent more for beneficiaries enrolled in MA plans than if those beneficiaries were in FFS Medicare. MA plan benchmarks were frozen in 2011 and further PPACA changes to the benchmarks will be fully phased in by 2017. This new method of setting MA payment benchmarks may need some technical adjustments to correct intercounty benchmark inequities.

For 2010, quality measures have been stable with some improvement in clinical process measures over the preceding year. At an aggregate level, vaccination rates and measures of patient experience are comparable to the rates in FFS Medicare, although the comparison is limited by differences in population demographics and geographic location. Measures of patient outcomes in MA are stable and not significantly changed from earlier years. There continues to be wide variation in quality indicators across MA plans.

PPACA introduced a pay-for-performance program that, beginning in 2012, would provide bonus payments to higher quality plans under a five-star rating system. The number of stars is based on measures of clinical quality, patients' care experience, and contract performance. Under the PPACA provisions, plans with the highest ratings (four or more stars) would have been the plans receiving quality bonuses. However, from 2012 through 2014, CMS is replacing the PPACA bonus system with a program-wide demonstration that will incur higher program costs. Under the demonstration, plans with as few as three stars will be eligible for bonus payments. The Commission is concerned that the five-star system grants too much weight to administrative measures and not enough to clinical measures.

Status report on Part D

The Commission provides a status report on Part D that provides information on beneficiaries' access to prescription drugs—including enrollment figures and benefit design—program costs, and the quality of Part D services.

In early 2010, about 60 percent of the 46.5 million Medicare beneficiaries were enrolled in Part D plans, slightly over 30 percent had other sources of drug coverage at least as generous as Part D's defined standard benefit, and 10 percent had no drug coverage or coverage less generous than Part D. Among those in Part D plans, about 10 million (about 36 percent of Part D enrollees) received the low-income subsidy (LIS). Roughly two-thirds of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans (MA–PDs). Most enrollees report high satisfaction with the Part D program and with their plans.

For 2011:

- Sponsors are offering fewer stand-alone PDPs and MA–PDs than in 2010. The reduction in plan offerings is primarily the result of CMS guidance to differentiate between basic and enhanced benefit plans as well as to reduce the number of plans with low enrollment and a decline in PFFS plans. These declines should not decrease access, as beneficiaries on average have from 28 to 38 PDP options to choose from, along with many MA–PDs, and more PDPs are available to LIS enrollees at no premium.

- The structure of drug benefits for both PDPs and MA–PDs held fairly steady—the share of plans with no deductible remains at about 40 percent for PDPs and close to 90 percent for MA–PDs. A larger share of PDPs will provide gap coverage—33 percent compared with 20 percent in 2010—while the share of MA–PDs with gap coverage remains at about 50 percent.

- For the basic portion of the benefit, CMS estimates an actual average monthly premium of $30, which would be an increase by $1 over the average in 2010.

In 2009, Part D spending totaled $52.5 billion, and the Medicare Board of Trustees estimated it will have reached $56 billion in 2010. These expenditures cover the direct monthly subsidy plans receive for their Part D enrollees, reinsurance for very high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their retirees who are Medicare beneficiaries. In 2009, LIS payments continued to be the largest component of Part D spending.

CMS publishes 19 performance metrics aggregated into a five-star rating system. To date, the metrics focus mostly on customer service and enrollee satisfaction. Although the metrics now include some quality measures, additional measures on patient safety and appropriate medication use could provide further information on quality.

Chairman HERGER. Again, as I mentioned earlier, to allow our Members to vote, we have two votes going on, we are going to recess and we will reconvene immediately after the second vote. With that, we stand in recess.

[Recess.]

Chairman HERGER. The Health Subcommittee of the Ways and Means Committee will reconvene.

Mr. Hackbarth, I want to thank you for your testimony. In MedPAC's report, you recommend that Congress should freeze Medicare rates for inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Can you explain what led the Commission to recommend freezing payment rates for these providers?

Mr. HACKBARTH. Mr. Chairman, the analysis that we go through for each of the provider sectors takes into account a variety of different factors, one of which is their financial margin on Medicare business where that data is available, but we also look at access to capital, the quality of services to Medicare beneficiaries, whether facilities are opening or closing.

So it is sort of a multifactorial analysis that we go through, so the specifics for each of those sectors varies a little bit. But in general, what they have in common is that the projected margins are pretty healthy for each of those, and we think that there is ample room for efficient providers of those services to operate within the existing rates, so no increase in the rates is necessary.

Chairman HERGER. Thank you. Currently there is no copayment for home health care. In the March report, MedPAC recommends that most Medicare beneficiaries be required to pay a copayment for each episode of home health care they receive. The commissioners recommended that exceptions be made for low-income beneficiaries and those being discharged from the hospital.

Could you explain why the Commission arrived at this recommendation and the impact it would have on overutilization and fraud?

Mr. HACKBARTH. Yes. Well, this is a challenging issue for MedPAC. This is an issue where we actually did have a dissenting vote and an abstention, which, as I indicated earlier, is fairly unusual for us.

We concluded, the majority of us concluded, the vast majority of us concluded that a $150 per episode copay was an appropriate and necessary step to help curb unnecessary utilization of home health services. As you know, home health is an area where utilization has increased rapidly and, in particular, in some parts of the country. And by its nature, it is a service where there aren't clear, clinical guidelines as to appropriate use of the service. And under those circumstances, we think it is an appropriate thing to do to ask the beneficiaries to pay a modest copay.

To put the $150 per episode copay in context, for a beneficiary with a typical number of visits, home health visits in an episode, it would work out to about $8 per visit, so a smaller amount than that same beneficiary would pay for a physician office visit or an outpatient therapy visit. So it is modest, but we think it is appropriate.

And I would emphasize the point that you picked up on, which is it is targeted to apply only to beneficiaries who are admitted to home health from the community. It doesn't apply to Medicare beneficiaries following a hospital stay or a stay in a skilled nursing facility, and there is also an exemption from the copay for beneficiaries who use four or fewer home health visits.

Chairman HERGER. Thank you for that.

Some have expressed concerns that the addition of a home health copayment would drive seniors to other sites of care such as outpatient facilities. Are seniors currently required to pay a copayment for the care they receive in these outpatient settings?

Mr. HACKBARTH. Yes, that is true. They are required to pay copays. Home health is one of the few services where Medicare beneficiaries are not required to pay a copay.

And as I indicated in what we thought was an appropriate home health copay, we took into account how much beneficiaries paid for some of these alternative services.

Chairman HERGER. So in your opinion, home health copayments would not shift a beneficiary to other sites of service?

Mr. HACKBARTH. That is our expectation, yes. It would not shift them, yes.

Chairman HERGER. I thank you again for your testimony.

Now, the gentleman from California, Mr. Thompson, is recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you, Mr. Hackbarth, for being here.

In your March 10, 2010 report, you state that Medicare is the single largest payer in regard to Medicare, in regard to health care. And you also go on to say that for the next decade that that cost is going to slow vis-à-vis the previous decade. I think it was are you looking at 6-percent growth between now and 2019? It was about almost 10 percent in the past decade. And I am assuming that part of that reason is because of the health care reform legislation that was passed, and the idea was to pass legislation that bends that cost that we have heard so much about that, and at the same time creating better care, better health, and lower costs.

There was a very interesting article in the National Journal, I think it was last Friday, that is entitled, Adapt or Else. And they state that whether it wants to or not, the health care system is being forced to reinvent itself. The health care law is a clearinghouse of sorts for policies that have circulated among health care analysts for years but struggled to gain traction.

Isn't the truth of the matter that much of what was put into the health care reform bill either came from MedPAC advice or proposals that MedPAC itself put forward?

Mr. HACKBARTH. Well, certainly there were many provisions that were linked to past recommendations of MedPAC.

Mr. THOMPSON. So bundling around hospital administrations?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. That was one of your recommendations that was in there.

Mr. HACKBARTH. Yes, that is correct.

Mr. THOMPSON. Reducing hospital readmissions, that was a MedPAC recommendation?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. Value-based purchasing aimed at rewarding quality?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. Primary care investments and expanded primary care reimbursement?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. Payment accuracy including reducing Medicare Advantage overpayments?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. Adoption of comparative effectiveness research?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. And expanded fraud fighting authorities?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. Thank you.

The other question I have is, as you know I think firsthand, I am very concerned about representation for rural areas. And as cochair of the bipartisan Rural Health Care Coalition, we have been very, very active in trying to bring attention to that issue.

And rural health care delivery has a lot of unique challenges, shortages of health care providers, and probably spills over into other underserved areas as well, but geographic remoteness, low-patient volume with disproportionately high Medicare populations, limited access to integrated health care systems, and a lack of electronic networks to efficiently manage health care.

I understand that it is probably a challenge for you too, and I know you don't do it personally, but it is a challenge to get that appropriateness, or proportionateness on the Commission. But in your report, there is not even a mention of the word "rural." And I think it is a concern for those of us who live in rural areas and represent rural areas.

Is there anything that you can tell us that we can look forward to? Are we going to address this issue? Are we going to get proportional representation on that board?

Mr. HACKBARTH. Well, thank you, Mr. Thompson, for raising this. We have talked about this issue before.

We share your concern about ensuring access to quality care for beneficiaries in rural areas and assuring appropriate payment for providers in rural areas. In fact, the very first report that I did, on becoming chairman of MedPAC, is "Medicare in Rural America," a typically thick MedPAC report. And in every report since, in every March report since, there are in fact lots of analyses directed specifically at the issue of fair payment for rural providers.

Let me cite a couple of examples.

Mr. THOMPSON. I said "report," I meant your testimony. I apologize for that.

Mr. HACKBARTH. Okay. Well, in this March report, let me just highlight a couple of examples that are important. We have recommended changes in the payment systems for lots of different Medicare providers, but in this particular report we talk about fairness and payment for skilled nursing facilities and home health agencies, and we have made recommendations in changing the case mix system used to allocate those payments.

Among the benefits from those changes would be increased payments for rural providers of home health services and skilled nursing facility services. So throughout all of our reports, there are issues like that where we are trying to assure accuracy and fairness in payment, which we think is very important.

On the specific issue of representation, we have four commissioners that have significant rural experience out of our 17. We have two physicians and then two people——

Chairman HERGER. The gentleman's time has expired. Thank you.

The gentleman from Texas, Mr. Johnson, is recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Thank you for being here today. I appreciate you saying you are out to get good value for what we spend in Medicare. I am committed to making sure that Medicare has provided high-quality care while at the same time being wise with taxpayer dollars.

Your report mentions the variations between Medicare payments for the same services in different settings. Medicare generally pays more for a service in a hospital than in an ambulatory surgical center.

Does this create an incentive for care to be provided in one setting over another, based on higher reimbursement?

Mr. HACKBARTH. Yes, that is our concern, Mr. Johnson, and it is a growing concern. And we see some shift toward hospital-based services that may be driven, at least in part, by higher payment levels.

Mr. JOHNSON. Are you looking to do something about it?

Mr. HACKBARTH. We are, in fact. It is a tricky issue to deal with for a variety of reasons, but in particular, because the patients are often different. So it can be the exact same service—for example, some type of ambulatory surgery—but the patients that go to the hospital are sicker on average. They have more underlying conditions. They are at higher risk of a bad event. So they are done at the hospital outpatient department so that they are closer to backup in case something goes wrong.

And so if you go to equal payment, you have to make sure that it is properly risk-adjusted for the different types of patients seen in the different settings.

Mr. JOHNSON. Yes, I understand that, but you ought to be able to work that problem I think.

Mr. HACKBARTH. And we are working on that, and I hope we will be making some recommendations.

Mr. JOHNSON. Thank you. So you have got a plan for studying these payment variations?

Mr. HACKBARTH. Yes, sir.

Mr. JOHNSON. I appreciate that. Our health care delivery system needs to focus on the right procedures to the right patient at the right time and place. Does the current payment system make that hard to achieve?

Mr. HACKBARTH. It does. It creates incentives often for more costly services than are absolutely necessary for patients and, as we just discussed a minute ago, sometimes not in the lowest cost, most efficient setting.

Mr. JOHNSON. Okay. We know you are interested in combating waste, fraud and abuse in the Medicare system, and we have heard about the problems across all areas of the country, including reports of alleged fraud in home health services occurring near my district in Dallas. Secretary Sebelius has said that her Agency is setting up new checks to screen providers before they are ever accepted into the system.

Can you comment on what progress has been made in becoming more proactive rather than reactive in preventing fraud?

Mr. HACKBARTH. Well, we are not specifically engaged in the operational side of enforcement, but we have recommended that the Secretary monitor home health use for unusual patterns, very high levels of use, and that the Congress give the Secretary the authority to do things like limit new providers, limit payment when abberant patterns of home health use are found.

And so our contribution to this has been to mostly identify some of these very unusual patterns. So in some areas of the country, you will see home health use that is like seven times the national average, and we think that sort of analysis is a useful screening tool for the Secretary and the Justice Department to use.

Mr. JOHNSON. Do you think she has taken your statistics and done anything with them?

Mr. HACKBARTH. Our understanding is that they are intensifying their focus on Medicare fraud in general, but in particular in the home health area.

Mr. JOHNSON. That is an interesting word you chose, "intensify."

Thank you, Mr. Chairman, I appreciate the time.

Chairman HERGER. Thank you. The gentleman yields back.

The gentleman from New Jersey, Mr. Pascrell, is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman. Mr. Chairman, I think that Glenn Hackbarth brings some unique qualities to our Committee in that the recommendations from MedPAC, many of them were incorporated into the affordable health care bill, which is now the law of the land.

And so when people talk about they made cuts but they didn't get into the entitlements where the real money is, we all know Social Security did not add to the debt; and now they miss the point about the health care legislation, because one-third of it dealt with Medicare and Medicaid, addressing the entitlement but specifically adopting many of your recommendations. That is a fact of life.

We can point out chapter and verse where the recommendations the Commission made are in there. This is entitlement reform.

And what was the purpose of your recommendations? Well, if you read your report, and not just read what somebody else said about it, but if you read your report, you are saying that this is—you didn't use the word "reform," this is changing how we look at Medicare and Medicaid.

So one of the fundamental problems we face in health care deliverance—I mean, no use putting a system together if we don't have the people to deliver it. So we spend quite a bit of time on work force. I know when we are putting the legislation together, quite

a bit of time, doctors and nurses, how to get more doctors and nurses.

We know about the shortages. But you are going to cripple the system, regardless of what the system is and how we want to deliver it to the patient, if you don't have the personnel that is properly trained, updated, et cetera.

You offer two solutions, both of which were involved or implemented, put into the health care reform, which we hope will be implemented: the idea of a payment reform, like paying for quality outcomes and delivery system reforms, such as medical homes and the accountable care organizations. You were very, very specific.

Do you think that these reforms, these two reforms, will help improve the delivery of health care for Medicare beneficiaries and, more importantly, do you think that these are essential changes to Medicare itself?

Mr. HACKBARTH. Well, it is certainly our hope and expectation that those two reforms would both improve quality of care for Medicare beneficiaries and, we hope, also reduced the cost. In each case, medical homes and ACOs, there are a lot of important issues to be worked out. And each idea, I am sure, will evolve over time, but we think that they are promising steps.

Mr. PASCRELL. Mr. Chairman, I want to bring to your attention something. Most of these reforms and changes were never scored, never scored', which means we do not have a true picture of the amount of savings when we move from pay-per-service to proper care and help for the patient.

We don't know really what the results will be. That was never scored by CBO. And I would contend to you, if you look at your recommendations, and you look at very specifically the Health Care Reform Act, that you can find areas where it doesn't take too much to conclude that there must be a savings from moving away from fee-for-service and into those specific things which you just mentioned.

Would you agree with me?

Mr. HACKBARTH. Well, certainly that is why we recommended them is that we think by moving away from straight fee-for-service payment, changing the incentives for providers, helping them focus on value, changing the organization of care delivery, can result in better care at lower cost.

Mr. PASCRELL. So those editorials and those politicians and Congressmen on both sides of the aisle, I am going to ask you the question; let me make the statement, and it is like when did you stop beating your wife this time?

Chairman HERGER. The gentleman's time has expired.

Mr. PASCRELL. Can I finish the question?

Chairman HERGER. Very quickly, please.

Mr. PASCRELL. Then I will try to answer it. The question is, the editorials and those Congressmen on both sides of the aisle who said, very specifically, that we need to get to entitlement in order for us to have true cuts in the budget——

Chairman HERGER. The gentleman's time has expired.

You can ask if we get a second round, or you can submit in writing.

Chairman HERGER. Again, the gentleman's time has expired.

I might also mention several of these issues that you brought up were scored, but they scored so small they weren't listed.

Mr. PASCRELL. Many of them were not, Mr. Chairman. I will go over them one by one with you if you wish.

Chairman HERGER. The gentleman's time has expired.

Mr. PASCRELL. Thank you, Mr. Chairman.

Chairman HERGER. With that, the gentleman from Georgia, Dr. Price, is recognized for 5 minutes.

Mr. PRICE. Thank you, Mr. Chairman.

In your assessment of the handout that we got, you have the volume growth increasing significantly. Can you cite for us the main drivers of that volume briefly?

Mr. HACKBARTH. So, Dr. Price, you are referring to this one?

Mr. PRICE. I think this one.

Mr. HACKBARTH. Right. So the principal drivers are the top line, the red line, is spending per Medicare beneficiary. So a small piece of it is due to the annual updates and payment rates. That is the lowest line, sort of gold update line.

The difference between the red line and the yellow line is due to changes in the volume and intensity of service. So more visits, more procedures, more imaging tests, things of nature.

Mr. PRICE. What would you say would be the—are there incentivizations in the program itself that drive that volume?

Mr. HACKBARTH. Well, the amount that we pay for a service can influence volume, and one of the issues that we——

Mr. PRICE. Anything else?

Mr. HACKBARTH. Differences in, you know, burden of illness from year to year can affect volume. Changes in technology as new technology develops; concerns about malpractice can be a factor in volume growth.

Mr. PRICE. Would you say that there are folks out there in the community, in the medical arena, that are working to decrease those costs as well on their own?

Mr. HACKBARTH. Sure. Absolutely.

Mr. PRICE. And when we as a government or as a society identify those, shouldn't we use some of those as best practices?

Mr. HACKBARTH. Absolutely. As somebody who ran a large physician practice, that was one of the things that we tried to do most often was learn from colleagues and practices.

Mr. PRICE. Exactly. That is kind of the hallmark of health care, isn't it, to find what works best and use it.

Mr. HACKBARTH. It is best.

Mr. PRICE. Then I would like you to address, please, the issue of physician-owned facilities, hospitals, ambulatory surgery centers. All of the reports that I have seen and read and all of my personal experience leads me to believe that they are one—oftentimes drive the highest quality of care at the greatest efficiency and the lowest possible cost per patient. Yet we as a society disincent and, in fact, punish them for doing what they are doing.

How would you address that?

Mr. HACKBARTH. Well, it is a tricky issue, Dr. Price. On the one hand, I ran a large multispecialty practice where we brought all kinds of services in-house; and so we were self-referring through our colleagues, and we thought that was good for patients.

On the other hand, there are instances where that sort of self-referral can cause problems.

Mr. PRICE. Then shouldn't we be addressing, then, the self-referral, as opposed to saying you can't have any of those things anymore?

Mr. HACKBARTH. Yes.

Mr. PRICE. Do you disagree with the fact that physician-owned entities out there oftentimes have the highest quality at the lowest cost per patient?

Mr. HACKBARTH. No, I don't disagree with that. I think that can often be the case.

Mr. PRICE. Do you agree or disagree with the statement that we as a Congress and as a government have put in place policies that will actually diminish the ability of those kinds of services to be in existence?

Mr. HACKBARTH. Yes, there are some policies. But here is the tricky part about it. The problem isn't physician ownership per se or self-referral per se; it is the combination of self-referral with fee-for-service payment that rewards more volume and intensity, and often missed pricing of services that creates real substantial profit opportunities.

Mr. PRICE. So I hear you say, then, that if we had a level playing field and allowed physician-owned entities to compete with other entities, level playing field, same pricing mechanism and the like, the same reimbursement mechanism, that you would be supportive of that opportunity; is that right?

Mr. HACKBARTH. The first step is to try to get the prices right so there aren't undue profit opportunities.

The second step is to try to move to new payment systems that don't reward volume intensity, but reward better care.

Mr. PRICE. Mr. Chairman, let me just say if I may, because my time is very, very brief, I think we are missing a huge opportunity by not rewarding those individuals that actually provide the highest quality of care at the lowest possible cost; and, in fact, we are punishing those individuals for doing what they are doing. And I look forward to my second round.

Chairman HERGER. I thank the gentleman. The gentleman's time has expired.

The gentleman from Washington, Mr. Reichert, is recognized for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman. Welcome, thanks for being here today.

There is a movement among employers toward what people have called a value-based benefit design where preventive primary and chronic disease care is cheaper for employees and things like high-end imaging and unnecessary emergency room visits, which we sort of touched on a little bit already, or high-cost drugs, those things that have been identified as not having I guess any, proven value, are more expensive.

These coverage programs are combined with wellness programs and incentives for things like improved physical activity and nutrition. There are some great examples from Washington State, including Group Health, Costco, Boeing, which all use different ap-

proaches to providing very structured, purposeful health care to their employees.

Medicare, by comparison, seems to be behind the curve a little bit. Some have said maybe even in the dark ages. But Medicare Advantage offers promise, though, for coordinated care. Would you agree with that?

Mr. HACKBARTH. Yes, I would.

Mr. REICHERT. And MedPAC has encouraged Congress and CMS to add pay-for-quality components to the fee-for-service payment system in Medicare, but this is just one step. Could Medicare actually change its benefit structure to be more innovative and value-based?

Mr. HACKBARTH. Yes.

Mr. REICHERT. It even sort of goes to the doctor's question of best practices.

Mr. HACKBARTH. Yes. In fact, it is an issue that is currently on the MedPAC agenda, and we will have a chapter on the subject in our June report this coming June, and we are looking hopefully to moving toward some recommendations on redesign of the Medicare benefit package.

Mr. REICHERT. Would it be possible for you to share some of those ideas that you are looking at today?

Mr. HACKBARTH. Well, we are not to the point of concrete recommendations. We are drawn to the idea of value-based insurance design. In fact, one of the MedPAC commissioners, Mike Chernew, is one of the leading academic thinkers behind the value-based insurance design movement.

Mr. REICHERT. So your discussion and your recommendations, how long has that discussion been ongoing?

Mr. HACKBARTH. Well, on this particular issue, I think we had one session last year, and then we had a session in February, and then our upcoming meeting in a couple of weeks.

Mr. REICHERT. So your awareness of this issue and discussion was started last year. You have had another meeting since, so we are sort of behind the curve here on this issue. So we have gone a year; what is the expectation on your recommendations being presented, published?

Mr. HACKBARTH. Well, you know, I don't want to get in front of my colleagues and presume a final conclusion.

As I say, I think we will have a chapter in our June report. It could—it won't include recommendations, bold-faced recommendations, but it could have some clear directional signals. And then if we have agreement in June, we would come back next year and potentially consider——

Mr. REICHERT. It could be a while before we see a value-based system, then, in Medicare?

Mr. HACKBARTH. It will. And, of course, it would require legislation to change.

Mr. REICHERT. All right. What could Congress do to help you speed the process up or probably, more likely, slow it down?

Mr. HACKBARTH. Well, we are well aware of the interest in Congress in the issue, and there is a lot of interest among MedPAC commissioners. So it isn't for a lack of interest or effort, but it is a complex issue to change the Medicare benefit package.

Mr. REICHERT. So are we looking at 2 years, 3 years, 4 years?

Mr. HACKBARTH. Well, I would hope, if we are going to make recommendations, that it would be in our next cycle. We operate upon a September-to-June cycle so we would take them up in the fall.

Mr. REICHERT. When is your next meeting?

Mr. HACKBARTH. In 2 weeks.

Mr. REICHERT. Is it a public meeting?

Mr. HACKBARTH. All of our meetings are public.

Mr. REICHERT. Could you provide me with the date and time of the meeting, please?

Mr. HACKBARTH. Oh, absolutely.

Mr. REICHERT. Thank you. I yield back, Mr. Chairman.

Chairman HERGER. The gentleman yields back. The gentleman from California, the Ranking Member, Mr. Stark, is recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman. Glenn, thank you again for all the good work that MedPAC does.

I know Mr. Herger has been concerned about copayment for certain beneficiaries that use home health services. It is my understanding that home health users are older, poorer, more frail, more likely to be female, than the overall Medicare population, and I am concerned about putting further cost-sharing on this population. I gather some MedPAC commissioners were as well, given that the Commission, as I understand it, was not unanimous on this proposal.

What were the concerns of those who didn't support the idea?

Mr. HACKBARTH. Mr. Stark, they are much like what you just described; that the copay would fall disproportionately on a vulnerable portion of the Medicare population, which was an issue that all of us, including those of us who voted "yes" on the recommendation, took very seriously. And so what we tried to do was tailor our recommendation in ways that would minimize although not eliminate that impact.

And it is also important to keep in mind, as you well know, that using copays is not new in Medicare; it is the norm in Medicare. And they inevitably fall on users of services who tend to be sicker and the like.

So it is always a challenging balancing act. We think by having a modest copay, $150 targeted on admissions from the community, that we have tailored in a way that minimizes the adverse impact.

Mr. STARK. Okay. And I know that you have a long history, MedPAC does, of recommending parity in payments between Medicare Advantage and the fee-for-service side. And your recent report summarizes your earlier recommendations about Medicare Advantage and the estimates that Medicare Advantage plans are paid, on average, 113 percent of the traditional fee-for-service.

Didn't private managed care plans originally come into Medicare saying they could do more for less; in other words, for 20 years they were paid 95 percent of our fee-for-service rate, I believe, or thereabouts, and over time we have actually moved from demanding they do better and trying to demand that they break even.

You have long recommended that there be a financial neutrality between Medicare Advantage and fee-for-service. I think that is correct.

Mr. HACKBARTH. That is correct.

Mr. STARK. And the Affordable Care Act takes steps to begin to bring financial neutrality between those two programs. Can you tell us what MedPAC is seeing in the 2011 landscape in terms of Medicare Advantage availability, enrollment, and premiums?

Mr. HACKBARTH. Yeah. Well, enrollment is up. The number of plans is down somewhat, and the reduction is primarily due to the reduction in private fee-for-service plans.

Mr. STARK. Okay.

Mr. HACKBARTH. Because of the requirement enacted, not in PPACA, but several years ago in MIPPA, that fee-for-service plans could not operate if there were coordinated care, coordinated network plans available. So some of the private fee-for-service plans have left the program, and that is the single biggest factor in reduction in the number of available plans.

Membership is, as I say, up in the most recent numbers.

Mr. STARK. Again, thank you very much for your advice to this Committee. We appreciate it, appreciate the work you do. Thank you, Mr. Chairman.

Chairman HERGER. I thank the gentleman who yields back.

I now recognize for 5 minutes the gentleman from Pennsylvania, Mr. Gerlach, to inquire.

Mr. GERLACH. Thank you, Mr. Chairman. I have a question with regard to your recommendations relative to radiologic and other imaging services. Can you briefly give me a summary of what your recommendations there are?

Mr. HACKBARTH. Well, on the specific issue of the imaging in this report, I don't think we made any specific recommendations in this report. In the past, in previous reports, we have made a number of recommendations related to how the price for imaging services is set. In some instances we think those prices have been too high, and we have recommended specific changes to reduce price.

Mr. GERLACH. I understand that there is a professional component and a technical component to the reimbursement structure.

Mr. HACKBARTH. That is correct.

Mr. GERLACH. That there has already been an adjustment downward for the technical component. Is there also a recommendation that you want to implement to also reduce the professional component of that reimbursement for radiological services?

Mr. HACKBARTH. We have looked at recommendations for reducing the professional component as well.

Mr. GERLACH. What is that based on?

Mr. HACKBARTH. For duplication of work would be an example. When two tests are done on the same patient at the same time, the amount of work is reduced because you don't have to do some things twice. It is the same patient at the same time, and that may justify reduction in the professional component.

Mr. GERLACH. Okay. So you are obviously concerned about utilization overall, and therefore by reducing the professional component aspect of that, you can reduce utilization?

Mr. HACKBARTH. Well, certainly there are indications that when the price is too high, you get more utilization. People go to areas that are more profitable, they invest in equipment if there is significant profit in that area. So it is very important to keep the prices right, as close to the cost of delivery as possible.

Mr. GERLACH. Is there an understanding in your review process of how the services come about to begin with? For example, if a radiologist—I am thinking of one in one of my hospitals who does a service based upon a referral from another physician—if there is a reduction in the professional component of that radiologist's service but the radiologist didn't initiate the service, the radiologist just took a referral, how would a referral-based system, cutting the professional component for service based on a referral from somebody from the outside, how would that affect utilization?

Mr. HACKBARTH. So what you are suggesting, I just want to make sure I understand the situation. So this is a radiologist who has received a referral for imaging service. And you are saying if their professional component is reduced?

Mr. GERLACH. Yeah. As I understand, what you are talking about is reducing the professional component for that service.

Mr. HACKBARTH. Again what we have talked about are making adjustments in very specific instances; for example, when you are doing multiple images on the same visit.

Mr. GERLACH. Okay.

Mr. HACKBARTH. Then we think there are some economies in doing it that way, and it is appropriate to reduce the professional component in instances like that.

We have not just said across the board, oh, let's reduce imaging services because we think we want to try to suppress utilization. We take a much more targeted approach than that.

Mr. GERLACH. Is it only in cases of multiple services or imaging work being done with one patient at one time that you are suggesting that change?

Mr. HACKBARTH. Specifically on the work component, I think it is multiple services. There have been, in the physician fee schedule also, changes in the practice expense for physician services that have changed the payment levels for different types of service.

Mr. GERLACH. Okay. And in coming up with this recommendation, who did you talk to within the profession to get a sense of how patients come to undertake those imaging—have those imaging services undertaken, both referral and, in some instances, the physician is able to do imaging on his own or her own, based upon how they are set up as a practice. Who did you talk to in essence to come up with the conclusion that there ought to be a change in the professional component of those services of being reimbursed?

Mr. HACKBARTH. Well, one of the things that I am most proud of in that MedPAC is that we do reach out to all of the relevant professional associations. As you well know, in this particular area there are also some coalitions of people in the imaging field, professional physicians and imaging equipment manufacturers. And we hear, believe me, often from those people and exchange ideas. All of our recommendations, when we make them we have open public discussion. Draft recommendation is discussed in a public meeting.

We solicit input from affected parties on those recommendations before we finally act. We have a very open process.

Chairman HERGER. The gentleman's time has expired.

Mr. GERLACH. Thank you. I yield back.

Chairman HERGER. The gentleman from California, Mr. Nunes is recognized for 5 minutes.

Mr. NUNES. Thank you, Mr. Chairman. I would like to yield 5 minutes to the gentleman from Georgia, Mr. Price.

Mr. PRICE. I thank my friend from California for yielding, and I appreciate the continued response that you give me.

I want to follow up on the comments that Mr. Gerlach was just making, or the line of questioning on the multiple tests. For example, if a patient is coming for a certain MRI procedure, one procedure, the costs of that procedure that are borne by the facility and by the physician involved in interpreting that are pretty much fixed, correct?

Mr. HACKBARTH. On the interpretation side or the technical component related to the equipment?

Mr. PRICE. Both.

Mr. HACKBARTH. Well, the cost of operating the equipment is influenced by the volume of service provided. So you make a capital expenditure. The more you use that equipment, the lower your unit cost for the capital expense, you spread it over more units.

Mr. PRICE. The machine doesn't know whether it is one patient or two patients who are getting the two different procedures, right? The volume is the number of procedures itself; it is not how many patients there are.

Mr. HACKBARTH. That is right. It doesn't matter whether they are distinct patients or not.

Mr. PRICE. All right. You have a patient coming in for an MRI of a cervical spine and a patient coming in for an MRI of a lumbar spine. Those two procedures are separate, distinct, and require the use of the machine itself, the technical side; and the interpretive side physician is using his or her best knowledge and information and expertise to interpret that. You wouldn't say that that had a volume component, would you?

Mr. HACKBARTH. In terms of interpreting——

Mr. PRICE. Yeah.

Mr. HACKBARTH. No.

Mr. PRICE. Okay. So the physician side ought to be fixed you just said, right?

Mr. HACKBARTH. Professional.

Mr. PRICE. We ought not decrease physician reimbursement based on whether or not it is one patient or two patients.

Mr. HACKBARTH. Well, based on whether it is one versus two, no. But as new technology, imaging being one example, becomes more widely used, more frequently used, I do think it is reasonable for the cost per unit of service, as the experience level goes up, to go down.

Mr. PRICE. That——

Mr. HACKBARTH. That happens in almost every market for every service in the economy.

Mr. PRICE. I might be able, if it was two C-spine MRIs on the same patient, at the same time; but we are talking about two dif-

ferent procedures on the same patient, requiring the same use of the machine, and the different brain power of the physician involved to interpret it. And so it is astounding to us—unless your goal is to simply decrease the cost, not worry about the quality and the access—if your goal is simply to decrease the cost, then that might make sense. But if you are interested in maintaining access to care and maintaining quality to care, then many of us believe that you are cutting right at the core of it.

Mr. HACKBARTH. A couple points are key here, Dr. Price. First of all, the method for setting the relative values. As you know, MedPAC does not do that, CMS does not do that. An AMA-sponsored RUC does that. So it is people from the professional societies sit down together and determine the relative values for the work element.

Mr. PRICE. If a specialty society says no, that is not the appropriate reimbursement for this procedure, do they have any ultimate authority in that?

Mr. HACKBARTH. There is a very elaborate process.

Mr. PRICE. Who makes the final decision?

Mr. HACKBARTH. The ultimate decision on the fee schedule is in CMS.

Mr. PRICE. There you go.

Mr. HACKBARTH. But in the vast majority of cases, they adopt the recommendations from the AMA-sponsored RUC.

Mr. PRICE. Can you name a single procedure? Because the cost that the government reimburses physicians, pays physicians for the care, allows for the access to care, right?

Mr. HACKBARTH. That is true.

Mr. PRICE. Okay. So can you name a single procedure for which physicians are being reimbursed in real dollars more today than when they were 15 years ago?

Mr. HACKBARTH. Not off the top of my head.

Mr. PRICE. Yeah. And I would love to have you get back, because I don't think there is one. I say that in all sincerity and honesty. What we are doing is drastically limiting the access, availability, of patients—your mom, your folks, seniors across this country—to access to care because of how we are dealing with reimbursement issues. That is where we ought to be looking for——

Mr. HACKBARTH. What I would like do is, if we could put this slide up. Medicare payments to physicians have been going up quite rapidly in fact.

Mr. PRICE. If I may, Mr. Chairman, the payment per—for a procedure for physicians, for visitation, the cost of a patient to come to an office for a visit is drastically reduced from where it was 15 years ago.

Mr. HACKBARTH. Yeah.

Mr. PRICE. Right?

Mr. HACKBARTH. I am not trying to be argumentative.

Mr. PRICE. Nor am I.

Mr. HACKBARTH. But there is an important point here, Mr. Chairman. The unit prices you and I would agree—the increase in unit prices, the price per office visit, the price per procedure, has gone up relatively slowly. That is that bottom line on this graph.

But the amount of income that physicians get from Medicare has gone up rapidly, the red line.

Mr. PRICE. In real dollars, the inflation-adjusted dollars, that line goes below the access, as you well now.

Mr. HACKBARTH. The red line represents a 5½-percent increase, average increase per year per beneficiary, since the year 2000.

Chairman HERGER. The gentleman's time has expired.

Mr. PRICE. Thank you.

Chairman HERGER. If time permits, we may try to go for a second round of questioning.

Now the gentleman from Oregon, Mr. Blumenauer, is recognized for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman. Welcome, Doctor, a Northwesterner here.

Before I get to my questions, though, I want to just allow you to finish your thought that you had with my good friend from Georgia, because we watch a certain amount of different impulses. There are some who suggest that the solution to exploding Medicare costs is to basically voucher this and index it at a level that is dramatically below the cost of inflation, medical inflation, something that would be the curve going down, down. And if there are problems associated—and you folks try and split the difference. I mean, you are cognizant of the problems, you deal with practice patterns, you recommend year after year, after year, after year, to Congress and the Administration things that could help bend that cost curve. There is quite a bit of bipartisan pushback over the years. I mean, that is not political, that is just—because people get pinched and they don't want to reduce that cost.

My impression is that, as we constructed the Affordable Care Act, that we actually included most of the recommendations over the—they don't maybe have the teeth that some would like, they don't implement them instantly. There are too many, maybe pilot projects and test this, but they are there.

I am curious if you want to just finish answering the question, because if the spending per beneficiary is going up compounded over 5 percent per year, it suggests that there are a whole lot of procedures and a whole lot of more expensive somethings that are going on there. And I just want to make sure you are able to complete your thought.

Mr. HACKBARTH. All right. So I guess I would summarize our view on this with a few points.

One is, overall, it is our sense that there is enough money in the physician fee schedule; Medicare pays enough for physician services overall to assure adequate access for Medicare beneficiaries. However, we are concerned about how the money is distributed.

We think we pay too much for some types of services and too little for other types of services. Primary care would be an example where we are worried that the payments are too low. So we think some redistribution of the payments is appropriate.

And then finally we think it ought to be a high-priority goal for Medicare to move to new payment systems that don't just reward more volume and intensity, but reward higher value care for both Medicare beneficiaries and the program.

I would agree that just holding down the unit price increase, the way the yellow line has, is not the best way to get good care for Medicare beneficiaries.

Mr. BLUMENAUER. And that, of course, is why we attempted to have a comprehensive approach that incorporated these elements in, and hopefully they can be implemented sooner rather than later, after they are tested, to be able to make a system that does reward health care value over volume.

Mr. HACKBARTH. Right.

Mr. BLUMENAUER. I find it a little bit ironic that some of my Republican friends talk about massive cuts in, for example, Medicare Advantage, when in fact it is a move to try and deal with the quality of the system. And they propose to replace it with something that would be far more draconian than any modest adjustment in Medicare Advantage.

Mr. HACKBARTH. Mr. Blumenauer, if I may, could I just pick up on——

Mr. BLUMENAUER. Well, I only have 30 seconds left, and I gave 3 minutes to you.

Mr. HACKBARTH. You were generous, I am sorry, go ahead.

Mr. BLUMENAUER. But there is just one area that I wanted to leave for your review, because we are watching palliative care and hospice kind of merge, and there is an opportunity for us to be able to give higher quality care for our people. We used to talk about in the last 6 months of life, but we are finding because of palliative care, because of changes in treatment patterns, sometimes people in "hospice" live longer than people who are given intensive treatments, ICUs and chemo, expensive and really painful chemotherapies.

I am wondering if there is a way going forward that we can work with you to think a little bit about the recalibration of what hospice care means, ways that better meet the needs of patients and families, actually might end up being less expensive but certainly better care.

Chairman HERGER. The gentleman's time has expired.

Mr. BLUMENAUER. Thank you.

Chairman HERGER. The gentlelady from Tennessee, Ms. Black, is recognized for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman.

Mr. Hackbarth, I want to go to the issue of outpatient settings. And your report verifies something that I have heard within the district, in that there is a significant variation in the amount of Medicare payments for similar services that are provided in outpatient settings, with Medicare generally paying more for services that are furnished in a hospital outpatient department than in an ambulatory surgical center or in a physician's office. And this variation of course results in an undesirable financial incentive, such as those ambulatory surgical centers being organized as more a hospital outpatient department, at least in part, to receive the higher payments.

Does the Commission have a plan for studying this? And if so, do you have a sense for where those policy options will be that may result from this review?

Mr. HACKBARTH. Yes. It is an issue that we are actively looking at. We are concerned that the disparities in payment for the same service, based on the location where it is provided, can cause problems. And there is some evidence that, in fact, it is causing problems. As you indicate, people are converting to hospital status simply to get the benefit of the higher payment, and clearly that is a problem.

As I indicated earlier in response to Mr. Johnson's question, it is a little bit tricky in the sense that, although the service might be the same—for example, a given ambulatory surgical procedure—the patients receiving it could be different between the ASC and the hospital outpatient department. I know this from experience, having run a large group. We did surgery in both ASCs and hospital outpatient departments. And we would send, quite consciously, the more difficult patients to the hospital outpatient department; same surgery, but the riskier patients, because of comorbidities and the like. And we wanted them to be at the hospital in case something went wrong and we needed backup.

Because they were sicker patients, we paid the hospital more for the same surgical procedure that we paid the ASC. It was an adjustment in effect for the higher risk of the patient.

So what we need to do is move toward equal rates for the same service on a risk-adjusted basis. And that last part is the tricky part in this that we are looking at.

Mrs. BLACK. Thank you. And that certainly makes sense. But at the current time where you look at apples to apples, it doesn't appear to be that way. So I think that certainly is a wise thing to take a look at.

Additional question. In your latest report the Commission notes that beneficiaries who receive the Part D low-income subsidy, they account for nearly 22 percent of all enrollees, and yet more than half—of them reach the doughnut hole. Further, these low-income subsidy enrollees account for about 2 million of the 2.4 million enrollees who reached that Part D catastrophic spending cap in 2008.

Your report also notes that average per-capita spending for the low-income subsidy enrollees were double that of the non low-income subsidy enrollees. And I know that these low-income enrollees are probably for the most part sicker, and they require more medication, but this disparity really is very alarming.

Do you have any recommendations on how we might be able to better control the cost for this population?

Mr. HACKBARTH. We have not looked specifically at that. We have done some research that suggests that there may be differences in risk that aren't fully captured by the existing risk-adjustment systems, and that may be a reason for the higher utilization. Because you are talking about a low-income population, the tool of using copays to try to limit access utilization is not one that is really available to serve people that don't have much income and appropriately need to be protected from excessive copays. If we don't do that, then there is the risk that they won't get needed drugs, and we will have higher costs.

Mrs. BLACK. I don't discount that, but I think what I have seen in my experience as an emergency room nurse is that when people have an opportunity to have a smorgasbord, or more services avail-

able for them, they tend to overutilize those services just because they are available. And I am not casting any stones there. Because if we all go into a buffet, we eat a whole lot more food at the buffet than we would if we ordered an individual plate.

And so trying to get at how do you do a better job while making sure that the services that are being required are actually services that are really needed and not just being utilized because they are there.

Chairman HERGER. The gentlelady's time has expired. The gentleman from Wisconsin, Mr. Kind, is recognized for 5 minutes.

The Ranking Member is recognized.

Mr. STARK. Mr. Chairman, I ask unanimous consent to put in this National Journal article from Mr. Thompson.

Chairman HERGER. Without objection.

[The information follows:]

NationalJournalMember

HEALTH

Adapt or Else

Whether it wants to or not, the health care system is being forced to reinvent itself.

by **Matthew DoBias**

Thursday, March 10, 2011 | 4:00 p.m.

JOHN MOORE/GETTY IMAGES

Say aaaah: The health care law makes primary-care physicians the fulcrum of a new delivery system.

In April 2010, one month after President Obama signed the law overhauling nearly every aspect of the U.S. health care system, physicians at Summit Medical Group in Knoxville, Tenn., spent the day plotting a reform course of their own.

Summit's chief executive, Tim Young, and the board members who govern the medical group had tracked the law's legislative twists and turns from the start. They understood the contours of the package even when political jockeying in Washington clouded the eventual outcome. As best they could, they focused on the policy, not the politics.

What Young and the 200-plus doctors at Summit came to realize was that the law's key goals hewed closely to their own. The dozens of provisions geared toward improving and streamlining patient care were similar to many of the initiatives the medical group either had in place or planned to implement.

In fact, nearly a year earlier, Summit's physicians had begun discussing how best to integrate care—not only in their own practices but also in the Knoxville medical community as a whole. They decided to take the unusual step of forging alliances with two competing hospitals to form what is somewhat nebulously described as an accountable care organization.

"It wasn't the first time [our doctors had] heard about an integration strategy," Young said of health care reform. "It wasn't news to them." In a vote last November, 90 percent of Summit's

practicing physicians backed the ACO option, a stunningly high number when you consider the fierce independent streak common among physicians. Last week, Summit received letters of agreement with the hospitals to form one of the largest accountable care organizations in Tennessee.

At more than 2,700 pages, the health reform law may be dense, abstruse, and complex, but it's not necessarily new. Holding the promise of reshaping the country's entire health care system, the act is a clearinghouse, of sorts, for policies that have circulated among health care analysts for years but struggled to gain traction.

The law has changed that dynamic and, with it, the tone and tenor of the way health care providers communicate with each other and their patients. Just a year in, it has reshaped the conversation in fundamental ways. In the past, quality-improvement and patient-safety initiatives either took root or they didn't. Now, facing an explicit directive, providers know they must improve care—or else. For members of the medical community, there's no going back.

And even if they could go back, why would they? That way lies a jumbled mess of paperwork, repeated and misused tests, and sometimes-misguided care. You only have to experience it as a patient once to fully understand the shortcomings of the system that has no clear lines of communication among patients, physicians, and other caregivers.

The good news is that peppered throughout the reform package are measures aimed at changing the system in tangible ways. Taken as a whole, these provisions are designed to break old habits, not just among providers but also throughout a society that has become increasingly sedentary and bloated. In many respects, that's a fairly accurate description of the American population—and of its health care system, too.

The law hoists change upon an industry that has been reluctant at best, fiercely opposed at worst, to try new things. It reshuffles hospital payments and puts a premium on the quality, rather than the amount, of care delivered. It punishes providers for lax patient care and rewards those that boost quality. It redefines primary-care physicians as the fulcrum of a new, improved delivery system.

To be sure, you'd be hard-pressed to find anyone who doesn't think the system is in need of a shake-up. The medical industry developed in silo-like fragments, each of which set up its own payment and reimbursement practices. As a result, federal and private insurers' reimbursement patterns have grown increasingly out of whack, rewarding volume and, in some instances, mistakes.

The system's breaking point has occurred at a time when care has become more complex. Physicians are ill-advised to try to go it alone these days. Instead, the law demands that someone should be coordinating care across many specialties and levels. It's not enough for a physician to simply treat a patient in the examining room. Now, he or she must also treat patients in the bedroom, in the kitchen, in the hospital, and at all points in between.

"TECTONIC SHIFTS"

Long before he took the reins at the Centers for Medicare and Medicaid Services, Donald Berwick, a pediatrician by training, preached the gospel of improved patient care. For many patients, the health care experience had become frustrating and cumbersome. The actual care itself was only middling. Berwick winced at the volume of medical errors that made headlines and cringed because he knew that many more went unnoticed.

In a speech last week to the Federation of American Hospitals, Berwick described what he calls "tectonic shifts" in health care brought on by the globalization of medicine. "Health care is nothing like it used to be," he said. "It brings entirely new challenges to us."

Predictably, these changes cause anxiety within the medical community. Yet Berwick is adamant that reform is the only option. Ever the optimist, he told the crowd of hospital executives to "notice the opportunities."

"All of us wonder about the future," he acknowledged. "It can make us nostalgic for a remembered past that seemed simpler, perhaps."

This is the context for the health care reform. The law is as much a toolbox as it is a compass. If providers follow its compass and use its tools creatively, Berwick said, the nation's health care system will emerge stronger, better, leaner. "Your old business plans are not going to work anymore," he warned. "Change is possible as never before. [Providers] will begin by accepting the realities and then, I hope, by diving in to the challenges to achieve the successes we want."

"Hospitals are racing to re-create themselves." —John Chessare, president, Greater Baltimore Medical Center

Berwick should be heartened to know that the future has indeed begun. Like no time before, physicians, hospitals, and insurers are immersed in a dialog about how to improve care and make payment sustainable. The discussion is difficult. It involves a subtle shift in power, away from costly hospitals toward primary care, where patients encounter more comprehensive treatment. One testimonial to just how dysfunctional the old system has become is that so many providers have championed this vision of reform, even if it comes at a cost.

John Chessare, president and chief executive officer of the Greater Baltimore Medical Center, says he witnessed an "aha" moment when he met with his hospital's board in October to discuss some of the changes he saw coming. Before the meeting, he asked each member to read Atul Gawande's June 2009 *New Yorker* article, "The Cost Conundrum," detailing the misaligned incentives in today's health care system.

"We were trying to educate the board on the need for reform," Chessare said.

He describes a moment when several of the primary-care physicians at the meeting described gaps in the continuum of care "and how it was so hard to actually get the kind of care for an individual [that] you would want for your own loved one." The doctors ticked off a list of problems: scarce services, inaccessible providers, not enough money flowing to primary care.

"It was at that point the board really started to get it," Chessare said. A blueprint emerged. With the board's approval, the medical center would work to achieve what CMS's Berwick coined as the "triple aim" of reform: better care, better health, and lower costs.

What came next was a series of strategies emblematic of what other health care systems have done in the year since the reform law took hold. The medical center organized its phalanx of primary -care physicians, forming the Greater Baltimore Health Alliance, which functions as a de facto ACO. Providers' ticket for entry, Chessare said, is dedication to improving care through quality measurement and reporting. Physicians must adhere to Berwick's triple aim, no matter how humbling
the results.

A FOCUS ON PATIENTS

The health reform law does more than just nudge executives to improve clinical outcomes and control costs. It gives them the framework to create an accountable care organization under the Medicare payment structure. To streamline and deliver high-value care, the federal government wants health care organizations to be anchored by hospitals, physicians, nurses, and other key providers. If coordinating care saves money, ACO members all get a share.

The program's roots are embedded in Medicare's five-year Physician Group Practice Demonstration, which created financial incentives for doctors to more closely follow the care their Medicare patients were receiving. Ten physician groups participated in the project, and although not all of them earned the potential bonus payment, each improved the quality of patient care.

Outside of Medicare, private insurers pioneered versions of ACOs, often contracting directly with hospitals or physician groups. Beginning in the 1980s and '90s, physicians formed partnerships with each other and
with private insurers to form health maintenance organizations to provide total care to participants. Often, the care was reimbursed at a flat rate.

As a result of the coordination, the physician groups effectively began to make decisions more typical of insurers. They decided what services were covered and who would deliver them. The idea was to deliver patient care on a budget. It worked to an extent. Costs grew at a much slower clip, although criticism grew that physicians were holding back care to keep costs down.

Physicians want accountable care organizations to mirror the good parts of the HMO experience and mitigate the rest. The law

Chairman HERGER. The gentleman from Wisconsin for 5 minutes.

Mr. KIND. Thank you. Thank you, Mr. Chairman, and thank you, Mr. Hackbarth and your staff, for the update that you are giving us today. And I think this is a very important hearing, just hearing the recommendations that you are making. We appreciate all the work that you put into this and the effort to provide us guidance and where we are going to go with the Medicare program.

Now, I notice in your January 2011 report, you reported on various geographic variations in the health care system, utilization variation. And you found in that report that one area that was high, one are of utilization tended to be high in all areas of utilization. In fact, you specifically noted that the area with the greatest service use, Miami, is nearly twice the level of utilization than the least use area, which is my hometown of La Crosse, Wisconsin. And yet in the report then and today, you are not making any recommendations on how to deal with this geographic payment variation or utilization variation around the country.

I am wondering why you are not being a little more explicit in the recommendations, and will you in the future provide greater guidance in this area?

Mr. HACKBARTH. We think, Mr. Kind, that the best way to reward high-value health care delivery, whether it is in La Crosse or perhaps a provider in Miami, is through changing the payment system, moving away from fee-for-service payment to new payment methods.

Mr. KIND. I agree. But are you going to come up with specific proposals on how do that?

Mr. HACKBARTH. We have made many proposals, medical home, ACOs, bundling around hospital admissions, many of them picked up in PPACA. And so we think payment reform is the best way to move to value.

Mr. KIND. Most of that is already in the Affordable Care Act.

Mr. HACKBARTH. That is correct.

Mr. KIND. Again, relying on your recommendations in the past. But what about systematic reform——

Mr. HACKBARTH. There is a lot of discussion in recent years about geographic variation. And one of the points that I think has been missed in that we can talk about regions of the country, and Florida is more expensive than Wisconsin, but there is variation within Wisconsin, there is variation within Florida. And so if you apply a geographic approach and say we want to reward Wisconsin and penalize Florida, there is going to be a lot of collateral damage.

Mr. KIND. I agree, and that is the point. And that is the point that many of us have been trying to make for the last 2 or 3 years is this geographic variation is occurring within congressional districts, within communities themselves. So it is less Wisconsin versus Florida as it is from individual providers, no matter where you find them.

And that is the point on payment reform. And you even recognize on page 4 of your March report—you are right—we recognize that managing updates and relative payment rates alone will not solve a fundamental problem with the current Medicare fee-for-service payment system; that providers are generally paid more when they

deliver more services, without regard to the quality or value of those additional services.

I think that is going to be the key and the ultimate verdict on health care reform. If we can move to a different reimbursement or payment system, outcome and value, and that I think will solve a lot of the problems.

As far as the cost curve that we were just talking about, but also the quality of care that we are striving for out there, and I was hoping MedPAC throughout the years would have been a little more affirmative in the recommendations in how we can get there other than through pilots and ACOs and medical homes and bundling, which is all necessary and good, but something more dramatic in proposal.

Mr. HACKBARTH. Well, the challenge that we have—you know, everybody says that fee-for-service is bad because there are rewards of volume and intensity of service. And for sure, that is true. But from my perspective the worst legacy of fee-for-service is that we have a fragmented delivery system.

Mr. KIND. Right.

Mr. HACKBARTH. Where people don't work together to improve care for patients. In too many instances they operate separately, they don't communicate well, they don't coordinate well. And the difficult thing about payment reform is that you can change payment methods, but there has to be somebody at the other end to receive it.

Mr. KIND. Right.

Mr. HACKBARTH. There has to be a reorganization.

Mr. KIND. I agree. And you are probably aware that, again, under the Affordable Care Act, two things are going to happen, both through the Institute of Medicine. They are going to have an update for the first time in the Medicare reimbursement formula, using real data, realtime instead of the proxy data, which I think is long overdue.

But second and most importantly, they have embarked on a 2-year study now to come up with an actionable plan to change fee-for-service to a fee-for-value reimbursement system. That then can go to the Administration, and the IPAT Commission for implementation, which again I think is going to be key. That is already moving forward under health care reform, which again I think is going to be the key to sustaining the system that we have in a much more affordable basis but getting better outcomes, too.

The thing with the accountable care organizations, medical homes bundling, that is fine for pilots, but it is basically saying you need to structure yourself in this fashion to be rewarded, instead of saying you will be rewarded for value and outcome of care; you figure it out as far as what is the best approach to achieve it. Because, obviously, smaller groups are going to have a little more difficulty than the larger providers to form in ACOs or some type of medical home model, wouldn't you agree?

Mr. HACKBARTH. Yeah. In fact one of the challenges with small providers, for example, physicians in solo practice, is it is difficult to assess their performance because of small——

Chairman HERGER. The gentleman's time has expired.

Mr. KIND. That is right. Thank you.

Chairman HERGER. We have—everyone has asked a question, maybe there are a couple of Members who would like to ask a second question, so we will begin to move to that. The gentleman from Georgia, Dr. Price, for 5 minutes.

Mr. PRICE. Thank you, Mr. Chairman. I look forward—there are so many questions. I look forward to being able to provide some for you and respond in writing.

The part A, primarily hospital services, part B, primarily physician services, is described. What percent of part B is physician reimbursement?

Mr. HACKBARTH. Actually to M.D.s as opposed to other health professionals?

Mr. PRICE. Yes.

Mr. HACKBARTH. It is about 12 or 13 percent of total spending for physicians. Is that the number you are looking for?

Mr. PRICE. Yes.

Mr. HACKBARTH. Or what share of part B is physicians?

Mr. PRICE. Well, both. But 12 or 13 percent is fine, because I think there is this sense by many that if you just whack away, and whack away, and whack away at the docs, that you will be able to control the cost. And in fact if we continue as a society to whack away at what the physicians are able to gain for their services, for their caring, compassionate, and knowledgeable services, we will truly harm the access to quality care in this country, because physicians are saying, "I can't do that anymore, I can't do that anymore."

And that is what I hear from my colleagues, former medical colleagues at home and across the country, who say—what I was trying to get to with the previous line of questioning, on not having any—any significant increase in reimbursement. And all insurance pegs itself to Medicare now, basically, in terms of reimbursement. So the Federal Government controls the payments to physicians for virtually every single procedure in this country.

I want to talk about a couple other items in the short time that I have available. You mentioned about the RUC, having the availability to have significant input into the cost—payment for physician services; also agreed that it was CMS that had the final say.

Mr. HACKBARTH. Right.

Mr. PRICE. The RUC itself, as I understand it, has significant responsibility from the 90 percent of the costs—the payment for the services that are provided. That number may or may not be right. About half of Medicare visits are through primary care, yet the number of primary care physicians on the RUC is in the teens, and maybe even lower, maybe even single digits in terms of a percent. How do you reconcile that?

Mr. HACKBARTH. Well, certainly that has been a sore point among primary care physicians, that they felt they have been underrepresented and that the process is skewed against them in various ways.

Mr. PRICE. Isn't that part of the problem, though, of setting up the kind of apparatus that we currently have, is that you rarely if ever can get to the right answer, because you rarely have the right people in the room.

Mr. HACKBARTH. Yeah. Medicare has very complicated payment systems, as you know. Better than most people, I am aware of not only the complexity but also some of the weaknesses. The problem, however, is that it is not like we can say, Oh, it is these Medicare-administered prices or prices set by the competitive market. As you just indicated, private insurers tend to say, Oh, Medicare's way is better than what we were using, so we are going to adopt Medicare's fee schedule.

Mr. PRICE. So what we have is essentially price-fixing from the Federal Government.

Mr. HACKBARTH. It is a difficult system, but there aren't clear, better alternatives. One point on the——

Mr. PRICE. If there are clear, better alternatives, then I look forward to that discussion.

Mr. HACKBARTH. Well, I would look forward to that as well. But let me just make one point how private insurers use the Medicare system. Typically what they use is the relative values, but they set their own conversion factor.

Mr. PRICE. Let me talk about——

Mr. HACKBARTH. But the price is not the same.

Mr. PRICE. That is true. It is 90 percent or 110 percent or 130.

Let me talk about one of those relative values and that is the E&M codes, evaluation and management; the doc visit codes, if you will. My understanding—what evidence or what science went into the setting of those codes? Are you aware of the initiation of the——

Mr. HACKBARTH. Well, the original system back in the early nineties was based on an extensive research project done by Bill Showell at Harvard to set initial relative values. And then the RUC process was established for purposes of maintaining the system.

Mr. PRICE. And "maintaining" is the right word. Because there hasn't been, as I understand it, a critical evaluation of the E&M codes and what we are incenting in terms of office visits and——

Mr. HACKBARTH. Well, actually by law there is a 5-year review. Each 5 years they do a comprehensive review of the work values. That doesn't mean every single code, but it is a far-reaching review of the work.

Mr. PRICE. And it compares to what has been—I would suggest it compares to what has been the occurrence as opposed to looking at whether or not we are getting the desired——

Mr. HACKBARTH. In fact, a critical question in the whole system is do we want to base the prices for different services on estimates of the cost of producing them, or do we want to take into account the value of the service to patients?

Mr. PRICE. Which brings me to a value question. All of the values comments seem to imply that every single patient can have an ideal outcome regardless of the diagnosis and regardless of the clinical status. How do you pay for value in a patient who has a terminal disease, is at the end of life, and needs caring, compassionate care for that? It will have a lousy outcome.

Mr. HACKBARTH. Well, when I talk about pay for value, I am talking about, number one, looking at populations served and not individual cases, as I think you are pointing out. Individual cases,

sometimes there are unavoidable bad results. That is not a sign of poor care. So you look across broader populations, you risk-adjust for the underlying conditions, and you use measures that take into account things like patient satisfaction; it is not just outcomes. You know, a terminal patient could receive good care, and acknowledge it is high-quality, humane care, even though it is a bad outcome.

Mr. PRICE. Thank you.

Chairman HERGER. The gentleman's time has expired.

The gentleman from Washington, Mr. McDermott, is recognized for 5 minutes.

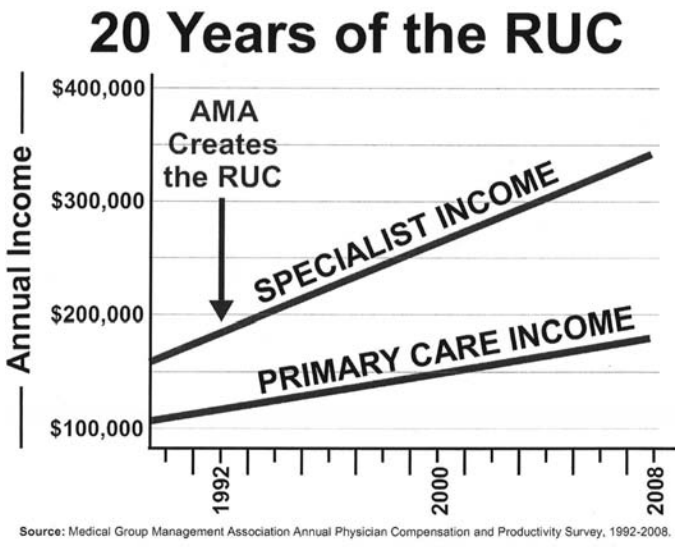
Mr. MCDERMOTT. Thank you very much, Mr. Chairman. I was sitting down in my office watching this on the television, and I decided I better come up here and ask a question.

Mr. HACKBARTH. Okay.

Mr. MCDERMOTT. Because I think the least known Committee in the medical industrial complex in the United States is the RUC and the impact that they have.

And I would like to submit for the record a graph from the Medical Group Management Association, Annual Physician Compensation Productive Survey. It is 1992 to 2008.

[The information follows:]



Mr. MCDERMOTT. And you can see when the RUC started, and the top line is the specialist's income and the bottom line is primary care.

And so I started looking at the RUC and figuring out who is on the RUC and how do they do this, and they clearly submit their recommendations to CMS. And nine times out of ten, or more than that, maybe 95 times out of 100, the CMS accepts their recommendation; is that correct?

Mr. HACKBARTH. That is correct, yes.

Mr. MCDERMOTT. So it is not being set by CMS, but is being set by a private committee controlled by the American Medical Association; is that correct?

Mr. HACKBARTH. That is correct. I would point out that what we have recommended—and this was 2 or 3 years ago now—is that CMS take a more assertive role and not just be a passive receiver of recommendations, but be more directive in what they need to look at, and change the dynamic that otherwise exists within the RUC. And they have taken some steps in that direction. That was the answer.

Mr. MCDERMOTT. I would like to submit another article for the record, which is from the New England Journal of Medicine, dated 22 March 2007, which says that in 2006 the RUC recommendations—well, MedPAC went up on 227 services and down on 26.

[The information follows:]

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Revising Medicare's Physician Fee Schedule — Much Activity, Little Change

Paul B. Ginsburg, Ph.D., and Robert A. Berenson, M.D.

N Engl J Med 2007; 356:1201-1203 | March 22, 2007

Article

What garners attention when it comes to Medicare's payment rates for physicians is the annual drama over possible 11th-hour congressional intervention to prevent cuts under the sustainable growth rate formula. But behind the scenes, Medicare policymakers have been focusing on another aspect of the periodic adjustments: the updating of the relative values in the physician fee schedule and the accuracy of the data on which it relies. Since 1992, Medicare has paid physicians through a fee schedule according to a resource-based relative-value scale (RBRVS). This approach was intended to address distortions produced by basing payments on prevailing charges, which had resulted in relatively low payment rates for evaluation and management services, as compared with procedures and technical services, as well as in large geographic variations not explainable by cost variation. The distortions were thought to discourage physicians from practicing in primary care specialties and in rural areas and to encourage a procedurally oriented style of care.

To develop its fee schedule, Medicare sets payments for services on the basis of relative costs, as determined by estimates of physician work (time and intensity), practice expenses, and malpractice insurance expenses, with geographic adjustments to reflect cost variation. A conversion factor is used to translate this structure into dollar amounts for each service. Private insurers and Medicaid programs often base their payment rates on Medicare's relative values (using different conversion factors), so changes in Medicare's relative values can profoundly affect physicians' revenues.

Keeping the relative values current requires an effective process that reflects changes in medical practice and trends in physician productivity. But during the 15 years since this system was implemented, relative values have defied gravity — going up or staying the same but rarely coming down. For example, in 2006, the Centers for Medicare and Medicaid Services (CMS) raised physician-work values for 227 services and lowered them for only 26. As we and the Medicare Payment Advisory Commission (MedPAC) have pointed out, in a budget-constrained environment, the absence of relative-value reductions for services in which physicians' productivity has increased condemns services with unchanging physician productivity, such as evaluation and management services, to eroding payment rates.[1-3]

Moreover, problems with accurate estimation of relative values for practice expenses have worsened as physicians in some specialties have been billing for more ancillary services associated with high equipment expenses. CMS has long used unrealistically low assumptions about rates of use of equipment (20 hours per week) and unrealistically high assumptions about the interest rates for financing its purchase (11%). Furthermore, even if estimates of average costs for these services were accurate, the payment of average

specialties having more resources for studies and lobbying, as well as well-heeled industry allies.

Effect of Changes in Work and Practice-Expense Relative Values on Physician Payment Rates, According to Specialty.

The agenda for improving Medicare's methods of paying physicians needs to be broader than the development of more accurate relative values. An increasing proportion of these services is devoted to treating chronic disease, and the absence of payment for activities such as coordinating care and educating patients means that these services are likely to be underprovided. The increasing role of major equipment in medical practice argues for payment schedules that vary with service volume, with sharp increases in volume indicating a need for payment based on episodes of care or capitation. However, such ambitious approaches are probably years away. In the meantime, the RBRVS-based fee schedule, which has been on automatic pilot, needs much greater attention to ensure that its objectives are again achieved.

Dr. Ginsburg is the president of the Center for Studying Health System Change, Washington, DC, where Dr. Berenson is a senior consulting researcher. Dr. Berenson is also a senior fellow at the Urban Institute, Washington, DC.

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Citing Articles (7)

Mr. MCDERMOTT. So there has never been any bending of the curve on the basis of the RUC; is that correct?

Mr. HACKBARTH. And that is precisely our concern. The dynamics of the RUC are that there are lots of incentives to identify a service for higher payment. There is very little incentive to collect data to document Oh, my service ought to go down.

And so what we have said is that CMS needs to redress that imbalance in incentives within the RUC by directing them to look at particular services that are likely to be overvalued.

Mr. MCDERMOTT. Do you think it might be better just to collect your own data and never mind the RUC? I mean, why should the medical association be setting their own fees? How are you ever going to get control of costs if you let the fox decide what the keys to the hen house are going to be used for?

Mr. HACKBARTH. Well, what we have recommended is a hybrid approach where CMS does not turn over the keys to the fox, is much more assertive in the process, but then takes advantage of the expertise of the relevant specialties to provide input to that process. So it is a rebalancing of the system, we think mirroring professional expertise with data analysis done by CMS.

Mr. MCDERMOTT. How about a rebalancing of the components inside the RUC? My looking at the list, depending how you look at people and what you can figure out is that mostly it is special—or it is a balance heavily weighted toward specialists, not toward primary care physicians.

Mr. HACKBARTH. And that, too, is a concern of ours and certainly it is a concern of many of the primary care physicians in the relevant professional societies.

Mr. MCDERMOTT. It seems to me that the biggest problem that those of us who are supporting of the President's plan still have about what is going on, is that controlling costs is still not very well done. We have done well at access, in including more people through the exchanges and that sort of thing, but the question is ultimately going to be how come we are spending 16 percent of GDP, or 17 percent of GDP, and the Swiss are spending 11 percent, and the French are spending 12 and whatever?

Where is that 5 percent coming from is what I have been looking at trying to figure out. And I keep coming back to the fact that Medicare allowed usual and customary fees in the original legislation, and we are continuing it with RUC is simply an extension of that as I see it. Am I misreading the facts?

Mr. HACKBARTH. No. We believe how Medicare pays for services is an important contributor to the level of expenditure and the rate of growth. If we ever want to reduce the rate of growth, let alone reduce the level of expenditure, if we ever want to improve the value we get for our Medicare expenditures, we need to change the payment methods.

Chairman HERGER. The gentleman's time has expired.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman HERGER. The gentleman from New Jersey, Mr. Pascrell, is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Chairman, I looked over the report from the Centers for Medicare and Medicaid Services, the CMS report of April 22nd of

2010, that also is an interesting document. And I just wanted to clarify something we started to get into before on the previous question.

Clearly the CBO and the CMS scored all the legislative language. I misspoke, but I am trying to get to the point, I didn't finish my point. It did score all of the words in the 970 pages or so of that health care reform bill in that bill, in the Act. They did not give as much credit, though, the point I am trying to make, to delivery system reforms that we believe, those of us who support the legislation, support the Act, will lead to better care at lower costs.

Mr. HACKBARTH. Right.

Mr. PASCRELL. We had the—Mr. Chairman, we had the CMS actuary here, if you remember, in this room last month.

Mr. HACKBARTH. Right.

Mr. PASCRELL. I asked him why these provisions weren't worth—weren't credited with more savings. If you look at the chart, they go—each one of the provisions, and you see a lot of zeros, of course, and you see a lot of low numbers and some other things, but things we were talking about before the pilot testing for pay for performance.

The technical corrections to hospital value-based purchasing, support the patient-centered medical homes, which is only a small part of this. There is the whole list in the report which we were provided. It is very, very clear.

The question, what we are saying, those of us who support the legislation in the Act, why we think these things will lead to better care and lower costs? Plus, why the hell did we put the bill together in the first place? We had the actuary here and I asked why those provisions weren't credited with more savings than the charts would indicate. So you can score it and not give credit for the savings. I don't think that is a score that—you know, we probably wait for the results because we didn't get any results. They said, We don't have enough information.

Mr. HACKBARTH. Right.

Mr. PASCRELL. Is that correct?

Mr. HACKBARTH. That is my understanding of what they did.

Mr. PASCRELL. Now, he answered this; he answered that he believed in their potential to save Medicare money, he stated for the record, but that he didn't have enough data to estimate the amount of savings they would be given. How am I doing so far?

Mr. HACKBARTH. I think you have accurately described the situation. The concepts can be sound. The concepts have to be turned into operational payment systems and then you have to get providers to convert to those new payment systems. There are certain connections there——

Mr. PASCRELL. Not unlike the changes we made to Medicare since its beginning in the sixties. We made dramatic changes to the Medicare program. Made dramatic changes when we prognosticate, when we went out from the point that we were at. So this is not unusual, this is not something that we say, Well, is it going to be in 2022? I mean the charts here go up to 2019. I think they are very optimistic, but I hope that all of us recognize these provisions.

These provisions, the breadth and the width of Medicare and Medicaid entitlement changes, we are changing business in the Health Care Act, aren't we, Mr. Hackbarth?

Mr. HACKBARTH. That is certainly the goal. That is why we recommended various provisions that we did that were included in the law. We think they have the potential to change.

Mr. PASCRELL. Okay. So if these ideas in health care reform which would move us toward paying for the quality of care rather than the quantity of care, something my friend from Wisconsin keeps talking about, I would assume everybody understands, I know there will be pushbacks from the medical profession.

Chairman HERGER. The gentleman's time has expired.

Mr. PASCRELL. And you have heard them. Cannot be identified as entitlement reform, then what the heck can be? Thank you, Mr. Chairman.

Chairman HERGER. The gentleman's time has expired.

Mr. Hackbarth, the Commission intends to consider different approaches to updating physician payments in an attempt to provide options aimed at fixing the SGR problem. Can you preview the timing and the substance of the Commission's work on this pressing issue?

Mr. HACKBARTH. Yeah. Our hope is that we will have recommendations in the fall, draft recommendations in September, final recommendations for vote within the Commission in October. That is a hope.

We have got to obviously do a lot of work between now and then and forge a consensus on what to do. The work we think is urgent. It is motivated by a growing concern among MedPAC commissioners that the SGR is a growing threat to access to services for Medicare beneficiaries.

I want to be clear; we don't see wide-scale evidence of that right now, but our concern is that the repeated difficult process of trying to avert large-scale cuts in physician payments, doing that over and over, sometimes multiple times in the same year, the cumulative effect of that exercise is undermining both physician and beneficiary confidence in the Medicare program.

So for a long time I have been able to sit before the Subcommittee and say, yeah, SGR is a problem that we don't see an imminent threat to access. We think we are getting closer to that tipping point. And so we are looking at options for potentially addressing that.

Just if I may, Mr. Chairman, just one last point. I don't want to create the false expectation that we may come up with a new payment system that is not going to have a budget score attached to it; that the big SGR budget problem is going to go away. I don't think that there is a rational policy option that will make that number go away.

I think the question for the Congress is not whether we are going to spend more than the SGR baseline says. I think everybody in this room, the CMS actuary, the Medicare trustees, everybody, knows we are going to spend more than the SGR says we will. The only question now is whether we are going spend more by making last-minute adjustments, plowing more money into the existing

payment system, or whether we are going to spend more strategically to achieve important goals for the Medicare program.

We think that the latter course is the wise course, and so my hope is that we can develop a package that will have a cost, a budget cost to it, but will achieve some important goals for Medicare reform going forward. That is our goal.

Now whether I can, you know, get the consensus within MedPAC, I won't know until we are further into the process, but that is the mindset that I have.

Chairman HERGER. All right. I thank you for your comments. And I am sure you know this is a bipartisan major concern that, as Members of the Committee each of us deal with as we talk with our physicians. It is one that we need to place; and it is important for to you know, as I am sure you do, that this is a high priority of us, of this Committee, and certainly of this Subcommittee.

And, again, I want to thank our witness for your testimony today.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. Mr. Hackbarth, if any questions are submitted, I ask that you respond in a timely manner. With that, the Subcommittee is adjourned.

[Whereupon, at 2:57 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

Statement of the
American College of Radiology
To the
House Ways and Means Health Subcommittee's
Hearing on MedPAC's Annual March Report to Congress

Tuesday, March 15, 2011

The American College of Radiology (ACR), a professional organization representing more than 34,000 radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, is pleased to submit testimony for the record regarding the Ways and Means Health Subcommittee's "Hearing on the Medicare Payment Advisory Commission's (MedPAC) Annual March Report to Congress." Although the hearing was primarily focused on MedPAC's March 2011 Report, ACR is taking this opportunity to comment on a specific issue raised at the Commission's February 23, 2010 session: "Improving Payment Accuracy and Appropriate use of Ancillary Services". ACR's specific concern lies with a particular MedPAC-suggested resolution to the problem of physician self-referral that may become part of its June 2011 report.

The ACR initially applauded the June 2010 MedPAC report which noted that any recommendations to control growth in imaging should include critical review of the current services exempted under the in-office ancillary exception (IOASE) with recommendations to severely limit and/or regulate the practice of self-referral. In the months leading up to the February 2011 MedPAC meeting, the ACR had been encouraged by the amount of time and analysis devoted to this issue by MedPAC staff and the Commission and fully anticipated a workable solution would be offered. Unfortunately, MedPAC offered draft recommendations that are nothing more than a continued commentary on the misperception that imaging services are overpriced and that somehow this drives self-referral. The College views MedPAC's continued misperception as ignoring the role that physician ownership plays in skewing clinical decision making and increasing utilization of imaging services.

Specifically, ACR is concerned with MedPAC's proposal to curb the practice of self-referral through an imaging reimbursement policy that would apply a multiple procedure payment reduction (MPPR) to the professional component (PC) of multiple imaging procedures performed on a single patient in one day. MedPAC appears to have lifted this policy from a 2009 Government Accountability Office (GAO) report that proposed expanding the MPPR to the PC. The 2009 GAO report mischaracterized potential MPPR savings based on duplication of pre-service and post-service work. GAO also equated less intense pre-service and post-service work with intra-service work, which dramatically overstates the potential savings. This flaw in GAO's

understanding of the valuation of physician work in the Medicare Physician Fee Schedule (MPFS) made ACR question the validity of the entire GAO report. The ACR vehemently disagreed with GAO's proposal to apply the MPPR to the PC and expressed this sentiment formally as part of an American Medical Association (AMA) response to this report.

Now MedPAC, apparently without verifying the original GAO data and without gathering any further data of its own, has resurrected this ill-conceived proposal (**MedPAC Draft Recommendation 2: Congress should direct the Secretary to apply Multiple Procedure Payment Reductions (MPPR) to the physician work component (of the Physician Fee Schedule) in addition to the technical component)**. As in 2009, ACR still maintains that while there may be some efficiencies gained under the technical component portion (TC) of the fee schedule for performing contiguous body part imaging services, it is not entirely clear how MedPAC or GAO envisions gaining similar efficiencies from the PC portion.

The Subcommittee, as well as the rest of Congress, must understand the PC for imaging services primarily represents the interpreting physician's time and effort (i.e., physician work). In the case of multiple imaging studies during the same session, whether they involve contiguous or non-contiguous body areas, the same modality or different modalities, or a single session or multiple sessions during the same day, the number of images required to be interpreted is additive, with few, if any, measureable economies of scale. Each imaging study produces its own unique set of images that must be interpreted in their entirety, separately dictated and written in separate reports to the referring physician. Thus, the interpreting physician must expend the same amount of time and effort (work) to interpret each individual imaging study. Therefore, based on the current dynamic as it pertains to the interpretation of imaging services, and that neither the GAO nor MedPAC seems to be able to justify their proposal, the ACR believes there is no reasonable or rational reason that CMS or Congress should apply the MPPR to the physician work component (PC) for multiple imaging services.

In conclusion, the specialty of radiology, and specifically payments for the advanced imaging modalities, has been the focus of payment reductions both legislatively and through the regulatory process for several years now. These payment reductions are making it increasingly difficult, even impossible, for many radiologists to keep their offices and freestanding imaging centers open while actual practice costs continue to increase, therefore reducing patients' access to timely, non-emergent imaging services. Additional cuts, such as the MedPAC-suggested MPPR for the PC of imaging services, are not only unjustified and reflect a total lack of understanding of the medical image interpretive process, but also would continue to severely erode the ability of radiologists to offer their patients the choice to seek a non-hospital setting for their imaging services.

As always, the American College of Radiology appreciates the opportunity to share its views on this matter and is committed to working with the Health Subcommittee members and staff to maintain timely access by Medicare beneficiaries to these services.

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Title of Hearing: House Ways and Means Health Subcommittee's Hearing on MedPAC's Annual March Report to Congress

Statement of

The American Health Care Association

for the

U.S. House Ways & Means Health Subcommittee

Hearing on

MedPAC's March 2011 *Report to the Congress* on Medicare Payment Policy

March 15, 2011

The American Health Care Association (AHCA) appreciates Chairman Wally Herger (R-CA), Ranking Member Pete Stark (D-CA) and the Members of this committee for the opportunity to offer this statement for your consideration as you review the recommendations included in the Medicare Payment Advisory Commission's (MedPAC's) *2011 Report to the Congress*.

The nation's leading long term care organization, AHCA and our membership of more than 11,000 non-profit and proprietary facilities are committed to the delivery of professional, compassionate care for America's seniors and people with disabilities. AHCA agrees with MedPAC's stated goal of achieving "a Medicare program that assures beneficiary access to high-quality care, pays health care providers and health plans fairly, and spends tax dollars responsibly." Even so, we take exception with several of its recommendations, including that Congress provide no market basket update for skilled nursing care for fiscal year (FY) 2012.

Providing Measureable Improvements in Quality

Millions of America's seniors rely on Medicare to pay for their health care needs across care settings, which often includes an average month-long stay in a skilled nursing facility after being hospitalized after a heart attack or stroke, or for hip or knee replacement surgery. Beneficiaries' access to care is one of the key components that MedPAC reviewed in its assessment of existing payment rates for each of ten different

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Medicare fee-for-service payment systems, including: hospital inpatient; hospital outpatient; physician and other health professionals; ambulatory surgical center; outpatient dialysis; skilled nursing; home health; inpatient rehabilitation; long term care hospital; and hospice. The other key components MedPAC identified as critical to determining the adequacy of current payment rates in its *2011 Report to the Congress* are a sector's capacity for delivering care, care costs, Medicare payments, and care quality.

AHCA appreciates MedPAC's consideration of those key components – especially care quality – in assessing the adequacy of Medicare payment rates. Ironically, it is precisely because of the relative stability that Medicare payments have brought to the long term and post-acute care sector that there has been measureable improvement in 16 of 26 quality indicators monitored by the Centers for Medicare & Medicaid Services (CMS) between 2000 and 2009. Moreover, as noted in our *2010 Annual Quality Report,* providers' focus on quality also has contributed to an annual increase in the percentage of Medicare beneficiaries discharged to the community within 100 days since 2003.

Ensuring adequate, stable Medicare funding for FY 2012 is especially critical given the recession – indeed fiscal instability – of state Medicaid budgets. With approximately 70 percent of facility costs related to labor and the inextricable link between quality and stable funding, we are concerned that MedPAC's advice to provide no cost-of-living adjustment for skilled nursing care in FY 2012 will have a direct, negative effect on patients, caregivers and facility operations overall.

Medicare-Medicaid Cross Subsidization

AHCA appreciates that Section 2801 of the *Patient Protection & Affordable Care Act (PPACA)* has expanded MedPAC's duties in recognition of the real and growing inter-dependence between Medicare and Medicaid by allowing the Commission to consult on certain Medicaid-related issues that impact federal payment policy. Such consideration is critical when considering that 65 percent of skilled nursing facility patients rely on Medicaid to fund part, or all, of their skilled nursing care; the number of dually eligible beneficiaries who need long term care and services; and the Medicaid program's chronic underfunding of that care.

The chart below reflects the most recent data as prepared for AHCA by nationally-recognized Medicaid experts at Eljay, LLC in *A Report on Shortfalls in Medicaid Funding for Nursing Home Care,* which was released in December 2010. The data shows how significant this underfunding is – estimated to be $5.6 billion in 2010 alone.

Figure VIII*

Estimated Combined Medicare/Medicaid Shortfall for 2010

Payer	*2010 Average Rate*	*Days in Millions*	*Revenue in Billions*	*Margin (Shortfall) As % of Revenue*	*Net Margin (Shortfall) in Billions*
Medicare	$ 422.07	72.5	$ 30.60	10.3%	$ 3.15
Medicaid	$ 172.16	325.2	$ 55.99	(10.1%)	$ (5.65)
			$ 86.59		$ (2.50)

Net Medicare/Medicaid Shortfall as a Percentage of Revenue (2.9%)

Sources: Medicare Rates & Days based upon AHCA Reimbursement & Research Department SNF PPS Simulation Model using 2008 SNF claims data. Medicare 2010 projected margin percentage derived from Medicare Payment Advisory Commission (MedPAC) Report to Congress, March 2010. *Medicaid rates, days & margins derived from this report.*

**Figure VIII reproduced from page 15 of Eljay, LLC December 2010 report. To view the entire report, go to* A Report on Shortfalls in Medicaid Funding for Nursing Home Care.

Advancing Quality

In addition to Medicaid underfunding, both federal regulatory and budgetary actions over the past two years call for nearly $30 billion in Medicare cuts over the next decade. AHCA asks that the Members of this Health Subcommittee, along with the Members of the full Ways and Means Committee, keep these facts in mind during your deliberations about federal funding of long term care. We also ask that you encourage CMS to work with stakeholders in developing a more integrated approach to federal funding that may help to resolve chronic Medicaid underfunding of long term care.

Despite the complex issues and recommendations detailed in MedPAC's *2011 Report to the Congress*, the matter at hand is relatively simple. When Medicare funding for skilled nursing care remains stable, quality of care and services improve. This fundamental connection is the reason Medicare funding for FY 2012 represents such a critical calculation for Congress, for long term care, and for those who rely on the care AHCA's membership provides each day.

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