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 THIRTEENTH CONGRESS

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MEDPAC'S ANNUAL MARCH REPORT TO CONGRESS

FRIDAY, MARCH 15, 2013

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

The Subcommittee met, pursuant to call, at 9:32 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [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
Friday, March 15, 2013
HL–02

CONTACT: (202) 225–1721

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

House Ways and Means Health Subcommittee Chairman Kevin Brady (R–TX) 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 Friday, March 15, 2013, in 1100 Longworth House Office Building, beginning at 9:30 a.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 recommendations on Medicare payment policy by March 15. In its March Report to Congress, MedPAC is required to review and make recommendations on payment policies for specific provider groups, including hospitals, skilled nursing facilities, physicians, and Medicare Advantage plans.

In announcing the hearing, Chairman Brady stated, **"MedPAC provides critical information to policymakers about the adequacy of provider payments in the Medicare program. With its Hospital Insurance Trust Fund set to go bankrupt as early as 2023, it is clear that Medicare is facing significant financial challenges. This hearing will afford Members the opportunity to understand where Medicare payments can be adjusted in a way that is fair to providers and taxpayers, while protecting seniors' access to care."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March 2013 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 Friday, March 29, 2013**. 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 BRADY. Good morning everyone. I want to welcome everyone to the second hearing of the Subcommittee on Health for the 113th Congress.

Today we will be hearing from the Medicare Payment Advisory Commission, MedPAC, on the recommendations in their March 2013 report on Medicare payment policies. We heard from MedPAC during our Medicare structural reform hearing 2 weeks ago. It was insightful to hear the Commission's recommendations for improving the design of Medicare in a way that is less confusing for seniors, limits their out-of-pocket costs, and provides financial incentives to seek the most appropriate care in the most appropriate setting. It is my hope that the Committee can work together in a bipartisan way to advance these much-needed structural reforms to save Medicare for the long haul.

Today, however, we are hearing from MedPAC on the topic of Medicare payments to providers. We are pleased to have the Commission here to discuss the recommendations in its report, which was released this morning, for updating payments in a way that ensures Medicare families have access to high-quality care while also being fair to local healthcare providers and the American taxpayers. The insight and guidance we receive from MedPAC is very important as we seek ways to reform the Medicare program—for instance, improving the accuracy of provider payments.

The MedPAC recommendations also focus on payment system changes that encourage accountability by local healthcare providers to deliver high-quality care at the most affordable cost. These are

important discussions as we move toward payments that reward providers for the quality they provide rather than the quantity of what they have done. I really appreciate the point that Ranking Member Jim McDermott made in our first hearing. To paraphrase, he said we need to bring value over volume to the Medicare program. The challenge, of course, is to find common ground as we seek these solutions.

One payment system I want to mention specifically is the physician payment system that is governed by the sustainable growth rate formula, or SGR. Democrat or Republican, the truth is; enough is enough. This year, right now, we have a golden opportunity to eliminate the long, problematic SGR once and for all and reform how Medicare pays physicians. I know that MedPAC has put significant thought into this topic. I look forward to hearing more about those ideas today.

Structural changes to the program and payment systems that are accurate and provide the right incentives are complementary pieces. I applaud the MedPAC Commissioners and staff for the work they have done in this area, but, as I mentioned last hearing, I respectfully ask you to do more.

It is abundantly clear Medicare is on an unsustainable path. In fact, two independent agencies, the Congressional Budget Office and the actuaries at the Department of Health and Human Services, estimate that Medicare's Part A trust fund will be bankrupt by 2023. Additionally, CBO projects that by 2222 Medicare spending will top $1 trillion. That is 90 percent more than we currently spend. If these trends continue, we can't save Medicare for every generation or guarantee a sustainable future. Finding solutions to these problems now is our challenge.

The President's healthcare law didn't actually lower healthcare spending. Congressional Budget Office Director Elmendorf recently testified that it could not attribute any particular factor to explain the recent lower healthcare spending other than, of course, the economy. Additionally, CBO estimates that ObamaCare delivery changes will yield a miniscule $14.7 billion in savings. That barely registers.

But regardless of how we feel about the new healthcare law, the glaring fact remains: Medicare's hospital insurance trust fund will go bankrupt in 10 years. We have to act now; the clock is ticking. And today's hearing will help us address our challenges. 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.

We also look forward to receiving MedPAC's next report to Congress in June, which will highlight additional opportunities for reform beyond just changes in the payment system. We rely on MedPAC's recommendations because they are based on strong data analysis. That is a key element in designing policies that improve the Medicare program and save it over the long term.

So I welcome our invited witness, MedPAC Chairman Glenn Hackbarth. Thank you for joining us today, and I look forward to hearing your testimony.

So before I recognize Ranking Member McDermott for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

Without objection, so ordered.

Chairman BRADY. I now recognize Ranking Member McDermott for his opening statement.

Mr. MCDERMOTT. Where is your St. Paddy's Day tie?

Chairman BRADY. I am in trouble.

Mr. MCDERMOTT. You know it is coming.

Chairman BRADY. In a serious way, I am in trouble.

Mr. MCDERMOTT. Mr. Chairman, I am grateful for your calling this hearing today. It is one of our regular reports from CMS. And it is important that we actually have people come in and make these reports and give us a chance to ask questions.

And I appreciate Mr. Hackbarth coming back. You were here the other week. We won't always agree on the recommendations that MedPAC makes, but it does good work and it takes seriously its charge to ensure appropriate payment and access.

Government oversight keeps people accountable to the interests of the people and to the experts of our field. It is sometimes easy for us, sitting up here, to stand on our respective sides screaming at each other across the aisle, but your agency can help us to find common ground and to cut through the self-serving claims of the special interests. Our offices are filled with them.

Today's discussion will also be useful as we look at the Affordable Care Act's opportunities to explore innovative payment and delivery systems, some of which are based on MedPAC's work. With the freedom to think in new ways about how to pay for services, aligning the needs of providers and patients, and deliver care, I believe we can continue to improve cost and quality for everyone while still protecting benefits.

I appreciate MedPAC's commitments to evidence-based data. I am one of those that believes that you can have whatever opinion you want, but you can't have your own facts. And I like the fact that you are a fact agency. This agency has proved itself to be credible, nonpartisan, and committed to transparent and well-founded methodologies and results. MedPAC's efforts to take a comprehensive look each year at the underlying economics of each sector drive thoughtful recommendations rooted in reality. We share your goals in ensuring that payments are both appropriate and adequate.

Medicare is an entitlement to a defined set of benefits. It is not an entitlement to specific reimbursement for providers or plans. While we need to ensure that hospitals and doctors and others earn enough off of Medicare to preserve access, sometimes people lose sight of the program's purpose, which is to serve the people. We, likewise, have an obligation to taxpayers to ensure that the payments are appropriate and not too high.

That said, given Medicare's size and the health needs of the Medicare population and our reimbursement rates, many in the healthcare sector have made and will continue to make a very pretty penny off the program. I remember when doctors didn't have a certain way to get paid when they saw old people. They had to rely on the children of or the collection agencies or bags of potatoes or whatever.

So when people come in to cry poverty over a proposed regulation or piece of legislation, we would all be well-advised to take such claims with a grain of salt. And then we should pick up the phone to call MedPAC to find out just how pressed the group in question is.

Even so, while data are important, we mustn't let ourselves lose sight of the people behind the numbers. As health economist Uwe Reinhardt noted, you can put a person on a hot stove and another one on a block of ice. On average, sure, they are a comfortable temperature. Individually, they might disagree.

With that in mind, I hope that we will receive the recommendations in the context of our current environment and consider the challenges of the year ahead. In the time since these recommendations were voted on, the sequester has been implemented, with no end in sight. Republicans failed to address this in the budget. Instead of replacing blunt, across-the-board cuts with more justifiable, targeted proposals, they kept the sequester and they added to it.

These recommendations are a healthy and timely reminder that there are still plenty of well-justified potential provider savings that should be pursued before asking patients to pay more.

And I thank you again for joining us, and we look forward to your testimony.

Chairman BRADY. Thank you, Mr. McDermott.

And today Glenn Hackbarth, the Chairman of MedPAC, joins us. Mr. Hackbarth is no stranger to the Subcommittee, having served as MedPAC's Chairman for more than 11 years and having appeared before the Subcommittee numerous times.

We are pleased to have you with us, Mr. Chairman. As you know, we have reserved 5 minutes for your opening statements. Your entire written statement will be made a part of the record. You are recognized.

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

Mr. HACKBARTH. Thank you, Chairman Brady and Ranking Member McDermott. I appreciate your kind words about MedPAC.

Since there are some new Members of this Subcommittee, I thought I would take just a second to introduce MedPAC a little bit further.

We are a nonpartisan advisory body to the Congress. We have 17 Commissioners appointed by the GAO. Six of our current Commissioners have clinical training either as physicians or as nurses; five have experience as hospital executives; five as leaders of integrated delivery systems; four in health plan management; two former presidents of the National Rural Health Association; three with high-level government experience; as well as several eminent academics. And, of course, some of us have more than one of these credentials in our background.

By law, our March report presents to the Congress our update recommendations for the various Medicare payment systems. Our statutory assignment from you is to recommend rates that are consistent with the efficient delivery of services to Medicare beneficiaries.

Our analysis of payment rates considers the supply of providers, their access to capital, their financial performance, and the quality of care they provide. In considering an update recommendation, we start with zero—in other words, keeping the rates at the current prevailing level. And then any increase in the rates or decrease needs to be justified with evidence in one of the categories I just mentioned.

Our March report this year includes a total 19 recommendations, including 4 related to special needs plans under Medicare Advantage. Across those 19 recommendations, there were a total of 302 "yes" votes from MedPAC Commissioners, 5 "no" votes, and 3 abstentions. So there is a substantial consensus in the Commission in favor of the recommendations in our report.

If I could highlight just one thing in my opening statement, it would be our recommendation to repeal the SGR system, the sustainable growth rate system, in the Medicare physician payment program. As you well know, CBO recently re-estimated the cost of repeal, and it is dramatically lower than it has been in recent years. From our perspective, SGR repeal is now on sale, and the sale price may not last. And so we urge you to take advantage of this opportunity.

We also urge you to include in the repeal legislation two other things: One is provisions aimed at rebalancing payments between cognitive and procedural services, with particular emphasis on primary care; and, second, provisions designed to encourage movement toward new payment systems.

As we see it, payment reform—that is, moving away from fee-for-service to new payment models like accountable care organizations, bundling around episodes of care, or medical home—movement to payment reform is the single most important step to improve quality for Medicare beneficiaries while minimizing taxpayer burden.

Payment reform is essential because it encourages and supports delivery system reform, whereby clinicians and other providers accept joint responsibility for both the quality of care and the total cost of care. Medicare's current payment systems, which are siloed payment systems based on provider type, in fact facilitate, if not encourage, fragmented care delivery and inhibit collaboration across providers and inhibit the smooth flow of resources to where clinicians think they can do the most good for Medicare payments.

So those are my opening comments, Mr. Chairman, and I look forward to answering your questions.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING AT 9:30 AM FRIDAY, MARCH 15, 2013

Report to the Congress: Medicare Payment Policy

March 15, 2013

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

Chairman Brady, Ranking Member McDermott, distinguished Committee 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 annual report on Medicare payment policy.

The Medicare Payment Advisory Commission is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

Introduction

The Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Part D). In this report we:

- consider the context of the Medicare program in terms of its spending and the federal budget and national gross domestic product (GDP).
- evaluate payment adequacy and in some sectors make recommendations concerning Medicare FFS payment policy in 2014 for: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice.
- review our position on repealing the sustainable growth rate (SGR) system.
- review the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare.
- make recommendations on the MA special needs plans.
- review the status of the plans that provide prescription drug coverage.

Health care accounts for a large and growing share of economic activity in the United States, nearly doubling as a share of GDP between 1980 and 2011, from 9.2 percent to 17.9 percent. Growth in spending slowed somewhat in 2010 and 2011, although the causes of this slowdown are debated and may not be long-lasting. Pressure on the federal budget will continue as Social Security, Medicare, Medicaid, other health insurance programs, and net interest are projected to account for more than 16 percent of GDP in 10 years, whereas total federal revenues have averaged 18.5 percent of GDP over the past 40 years.

The number of Medicare beneficiaries will grow notably faster in the next 10 years than in the past decade as the baby-boom generation ages into the program. In addition, the population aging into the Medicare program will present a new set of challenges since rising obesity levels put this population at a greater risk than previous generations for chronic disease. At the same time, growth in Medicare spending per beneficiary over the next decade is projected to be much smaller than in the past 10 years. Yet even under that assumption of slower growth, the Hospital Insurance trust fund is projected to be exhausted by 2024, and the program faces substantial deficits over the long term.

In this year's report, we continue to make recommendations to increase the efficiency of Medicare—that is, to find ways to provide high-quality care for Medicare beneficiaries at lower costs to the program. It is of note that, in light of our payment adequacy analyses, in this report we recommend no update for 2014 for five fee-for-service payment systems and a 1 percent update for the hospital inpatient and outpatient payment systems. For two sectors, skilled nursing facilities (SNFs) and home health agencies (HHAs), we have reiterated previous recommendations calling for an array of reforms including rebasing (lowering the base rate). For the physician and other health professional payment system we have called for repeal of the SGR, which governs physician fee schedule payments. We discuss each of these in more detail below.

The Commission's mandate

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services 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. Although this report addresses many topics to increase value, its principal focus—in accordance with our Congressional mandate—is the Commission's recommendations for the annual rate updates under Medicare's various FFS payment systems.

We recognize that managing updates and relative payment rates alone will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. To address that problem directly, two approaches must be pursued. First, payment reforms that encourage quality and coordination in the traditional FFS system, such as penalties for excessive readmission rates and linking some percentage of payment to quality outcomes, need to be implemented more broadly. Second, delivery system reforms that move away from FFS and encourage high quality, better care transitions, and more efficient provision of care—such as medical homes, bundling, and accountable care organizations (ACOs)—need to be monitored 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 fact alone makes unit prices—their overall level, the relative prices of different services in a sector, and the relative prices of the same services across sectors—an important topic. In addition, constraining unit prices in FFS creates pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

In all of our work we look at five principles to achieve value in the Medicare program:

- increase fiscal pressure—restrain payment rates so that providers strive for efficiency,
- ensure equity—make sure the payment system does not systematically favor some providers or patients with certain conditions over others,
- ensure program integrity—monitor patterns of use and reduce opportunities for fraud and abuse,
- improve care coordination—encourage providers to coordinate care across sectors, and

- move payment and care delivery from FFS to coordinated care models with more global payments.

Several examples may elucidate these principles:

- We have recommended rebasing the home health prospective payment system (PPS) to increase fiscal pressure. This sector has been enjoying double-digit margins on Medicare business for over a decade. The payment system has to be rebased to recognize how home health agencies have changed the service since the original PPS was defined so that they will be under fiscal pressure to improve efficiency. Additionally, the Commission has recommended changes to the underlying payment system to increase equity and several program integrity actions to control abuse.
- The Commission has recommended improving equity between primary care and specialist services paid for under the physician fee schedule. The current bias of higher pay for procedural services could influence physicians to avoid primary care careers, the service for which beneficiary access is most threatened and which arguably has the greatest chance of leading to more efficient use of health care.
- Some recommendations, such as our recommendation for a hospital readmission penalty, would both encourage care coordination and increase fiscal pressure. Ideally, a hospital readmission penalty would encourage a hospital to work more closely with the post-acute and ambulatory care systems to minimize readmissions through improved care transitions and coordination. At the same time, it would create fiscal pressure on hospitals to improve efficiency and minimize readmissions. Coupled with our recommendations for readmission penalties on other responsible providers such as SNFs, this policy would create even broader pressure to coordinate care to avoid readmissions.
- As another example improving program integrity, we have recommended increased attention to the extremely long lengths of stay (LOS) in some hospices. While very short LOS followed by death may mean a beneficiary entered hospice too late in the course of a terminal illness, excessively long LOS followed by discharge from a hospice may indicate inappropriate use. Where there is a pattern of such stays, it raises questions about the integrity of the hospice benefit.

Update recommendations

As required by law, the Commission makes payment update recommendations annually for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a PPS is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2013) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2014). As required by statute, we examine payment adequacy for an "efficient" provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

In considering updates, the Commission makes its recommendation for 2014 payments relative to the 2013 base payment. The Commission's recommendations may call for an increase, a decrease, or no change from the 2013 base payment. For example, an update recommendation of 1 percent for a sector means that we are recommending that the base payment in 2014 for that sector should be 1 percent greater than it was in 2013—that is, when all policy changes related to the base payment are made (e.g. adjustments for coding changes, sequester), the net increase in base payment should be 1 percent.

This year, we make update recommendations in 10 FFS sectors: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates prior year assumptions using the most recent data available to make sure its recommendations accurately reflect current conditions. We also consider changes that redistribute payments within a payment system to correct any biases that may result in inequity among providers, make patients with certain conditions financially undesirable, or make particular procedures unusually profitable.

For each recommendation, we present its rationale, its implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year

periods; unlike official budget estimates, they do not take into account the complete package of policy recommendations or the interactions among them. Although we recognize budgetary consequences, our recommendations are not driven by a budget target but instead reflect our assessment of the level of payment needed to provide adequate access to appropriate care.

Given that our payment adequacy indicators are positive, the Commission recommends no update to payment rates in 2014 for five sectors (ambulatory surgical center (ASC), outpatient dialysis facility, inpatient rehabilitation facility, long-term care hospital, and hospice). We expect that providers in those sectors will be able to continue to provide beneficiaries with appropriate access to care under current payment rates. In the case of ASCs we also recommend that the Congress require ASCs to submit cost data to enable analysts to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of an efficient provider. We also note that dialysis facilities appear to have become more efficient under the new payment method put in place in 2011; the Commission will return to examine rebasing that payment system as more complete information becomes available.

For two sectors, inpatient and outpatient hospital, we recommend a 1 percent update for 2014. The inpatient payment update recommendation is based on four factors. First, there is a need to restrain updates to maintain pressure to control costs. Second, most payment adequacy indicators are positive. Third, hospitals changed their documentation and coding in response to the introduction of Medicare severity–diagnosis related groups in 2008, and those documentation and coding changes need to be fully offset. (The American Taxpayer Relief Act of 2012 recovers past overpayments—at a more rapid pace then we recommended—but did not adjust for coding changes that started in 2010.) Fourth, while the average hospital's margin is projected to remain negative, the set of relatively efficient hospitals had a median overall Medicare margin that was positive. For inpatient services, we recommend that CMS should use the difference between the 2014 statutory update and the recommended 1 percent increase to offset the costs to the Medicare program of changes in hospitals' documentation and coding. In other words, the net increase in base payment rates from 2013 to 2014 should be 1 percent after all adjustments for documentation and coding are made.

We also recommend a 1 percent increase in outpatient rates in 2014. Despite negative overall Medicare margins, a 1 percent increase is appropriate for three reasons: First, there is a need to maintain pressure to constrain costs. Second, there is strong outpatient volume growth: 4.4 percent per Part B beneficiary in 2011, over 33 percent from 2004 to 2011. Third, hospital payment rates in outpatient departments (OPDs) are already substantially higher than payment rates for similar services in other sectors (e.g., rates for evaluation and management visits are 80 percent higher in OPDs than in physicians' offices) and increasing that difference would encourage further shifting of services from lower to higher cost settings. For example, from 2010 to 2011 the volume of echocardiograms in OPDs grew by 18 percent while it decreased by 7 percent in physicians' offices. Shifting to higher cost sectors results in higher costs for both the Medicare program and beneficiaries.

In the skilled nursing and home health sectors, we reiterated our recent multiyear recommendations that address not only the updates for those two sectors but also broader problems with the structure of the payment systems; our assessment of the payment adequacy indicators this year suggests that the trends that led us to make those recommendations continue.

For the skilled nursing sector we reiterate our recommendation from last year to first restructure the SNF payment system and then to rebase payments in the following year. Specifically, the Commission recommended revising the SNF PPS and, during the year of revision, holding payment rates constant (no update). The Commission discussed three revisions to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics (not services provided). Second, payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy would be added to the PPS. After the PPS is revised, in the following year CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

For the home health sector, we reiterate our recommendations from 2011. That multipart recommendation included: rebasing the home health PPS, changing the case-mix system, implementing a copay for certain home health episodes, and investigating and stopping fraud and

abuse in areas with aberrant patterns of use of home health services. Overpaying for home health services has negative financial consequences for the federal government and raises Medicare premiums paid by the beneficiary. Implementing the Commission's prior recommendation for rebasing would reduce payments and better align Medicare's payments with the actual costs of home health agencies.

For the physician and other health professional fee schedule we have restated our previous recommendations because the dominant concern is the SGR system and its issues, which are described in the next section.

Table 1 summarizes the recommendations in this report.

Table 1. March 2013 report recommendations

Sector	Recommendation
Hospital inpatient and outpatient	1 percent update
Physician and other health professional	Multipart SGR repeal from 2011
Ambulatory surgical center	Zero update, require cost data
Outpatient dialysis facility	Zero update, evaluate rebasing as data become available
Skilled nursing facility	Multipart recommendation from 2012
Home health agency	Multipart recommendation from 2011
Inpatient rehabilitation facility	Zero update
Long-term care hospital	Zero update
Hospice	Zero update
Special needs plans	Reauthorize some, not others

Sustainable growth rate (SGR) system

The Commission's deliberations regarding payment updates for physicians and other health professionals are driven by concerns with the SGR, which links annual physician fee updates to several factors including volume growth. The SGR has called for negative updates every year since 2002, and every year since 2003 the Congress has provided a short-term override of the negative updates. Because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, fees for physicians and other health professionals

would decline by about 25 percent in 2014 if the SGR went into full effect, according to the Congressional Budget Office (CBO).

The Commission laid out its findings and recommendations for moving forward from the SGR system in its October 2011 letter to the Congress http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf. We found:

- The SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it.
- Temporary, stop-gap fixes to override the SGR undermine the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may cause anxiety among beneficiaries.
- While our latest access survey does not show significant deterioration at the national level, the Commission is concerned about access—particularly for primary care. The Medicare population is increasing as members of the baby-boom generation become eligible for Medicare; at the same time, physicians in that generation are reaching retirement age.

The need to repeal the SGR is urgent. Deferring repeal of the SGR will not leave the Congress with a better set of choices as the array of new payment models is unlikely to change and SGR fatigue is increasing. We also note that the budget score for repealing the SGR is volatile. It depends on the relationship between growth in the volume of services and growth in the GDP. In each of the last three decades we have seen periods of rapid volume growth and periods of slower growth. CBO's most recent budget projections have substantially lowered the budget score for SGR repeal, and may present an opportunity for the Congress to act before the score changes again.

In Appendix B of the March report, we reproduced the Commission's October 2011 letter to the Congress. In that letter, the Commission presented a set of recommendations to eliminate the SGR and replace it with a set of fee-schedule updates, improve the accuracy of physician payments, and encourage movement into ACOs. The Commission recommended:

- the SGR should be repealed, severing the link between future payment updates and cumulative expenditures for services provided by physicians and other health professionals. In place of the SGR, the Commission outlined a 10-year path of legislated updates, including updates for primary care services that are different from those for other services.
- CMS should collect data to improve payment accuracy, identify overpriced services within the fee schedule, and be required by the Congress to achieve an annual numeric goal for their reduction.
- the Medicare program should encourage movement from FFS into risk-bearing ACOs by creating greater opportunities for shared savings.

Our recommendations follow these principles: The link between fee-schedule expenditures and annual updates is unworkable, beneficiary access to care must be protected, and the SGR should be repealed in a fiscally responsible way. We have offered the Congress a set of ideas for offsetting the cost of an SGR repeal within the Medicare program, but it is the prerogative of the Congress to choose among those and other options as it determines how best to finance SGR repeal.

Medicare Advantage, SNPs, and Part D

Thus far we have considered updates in Medicare's traditional FFS program, also known as Medicare Part A and Part B. In addition, we review the status of Medicare Part C (the Medicare Advantage program) and Medicare Part D (the Medicare prescription drug program).

Medicare Advantage (MA)

Each year the Commission provides a status report on the MA program, which is becoming an increasingly important part of Medicare. In 2012, MA enrollment increased by 10 percent to 13.3 million beneficiaries (27 percent of all Medicare beneficiaries). Virtually all Medicare beneficiaries now have access to an MA plan, and 99 percent have access to a network-based coordinated care plan, which includes HMOs and preferred provider organizations. We estimate that 2013 MA benchmarks (including the quality bonuses), bids, and payments will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively—all of which are closer to FFS spending this year than last year. This is important because the Commission has stressed

the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. For MA, the Commission has recommended that payments for MA plans relative to FFS be brought down from previous high levels and set so that the payment system is neutral and does not favor either MA or the traditional FFS program. We are seeing evidence of improved efficiency in MA as plan bids have come down in relation to FFS while enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering benefit packages that beneficiaries find attractive.

The Commission has also recommended that pay-for-performance programs be instituted in Medicare to promote quality. The Congress instituted a quality bonus program for MA with bonuses available beginning in 2012. The Commission supports the concept of the quality bonus program as called for in the statute. Such a pay-for-performance system, combined with continuing fiscal pressure, will help ensure that a strong MA program will do its part in the urgent need to ensure the continued financial viability of the Medicare program. However, CMS has implemented the quality bonus program in a flawed manner at very high program costs not contemplated in the statute, using demonstration authority to pay bonuses to plans with low ratings and increasing bonus amounts for other plans above the level authorized in the statute.

MA special needs plans (SNPs)

Special needs plans (SNPs) are MA plans that can limit their enrollment to one of three categories of special needs individuals. SNP authority expires at the end of 2014. Reauthorizing all SNPs would result in increased program spending because spending on beneficiaries enrolled in MA is generally higher than Medicare FFS spending for similar beneficiaries, and some beneficiaries would likely return to FFS. In response to several inquiries from the Congress, we evaluated each type of SNP on how well they perform on quality-of-care measures and whether they encourage a more integrated delivery system than is currently available in traditional FFS Medicare.

- The Commission recommends that the Congress should permanently reauthorize institutional SNPs (I–SNPs), which are plans for beneficiaries residing in nursing homes or beneficiaries living in the community that require a nursing home level of care. They perform well on a number of quality measures. In particular, hospital readmission rates for I–SNPs are much lower than expected. Reducing hospital readmissions for

beneficiaries in nursing homes suggests that I–SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.

- Chronic condition SNPs (C–SNPs) are plans for beneficiaries with certain chronic conditions. In general, C–SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures (but there are exceptions). The Commission recommends that the Congress should:
  - allow the authority for C–SNPs to expire, with the exception of C–SNPs for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions.
  - direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions. (In other words, incorporate the C–SNP model into standard MA plans.)
  - permit current C–SNPs to continue operating during the transition period as the Secretary develops standards.
  - except for the conditions noted above, impose a moratorium for all other C–SNPs as of January 1, 2014.

- The Commission recommends that the Congress should permanently reauthorize SNPs for beneficiaries dually eligible for Medicare and Medicaid (D–SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D–SNPs to expire. For D–SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes and direct the Secretary to remove other barriers to integration of Medicare and Medicaid benefits. For example, these D–SNPs would be able to market all the benefits they cover as a combined benefit package and it would be easier for them to give enrollees a single enrollment card to access their Medicare and Medicaid benefits. Under this recommendation, the Secretary would develop an example of a model Medicaid contract with a D–SNP for states to use as a resource.

Part D, the Medicare prescription drug program

Each year the Commission provides a status report on Part D, the Medicare prescription drug program. In 2012, nearly 65 percent of Medicare beneficiaries, over 30 million people, were enrolled in Part D. Most enrollees report high satisfaction with the Part D program. In 2013, the number of plans offered is about the same as in 2012. Beneficiaries will continue to have between 23 and 38 stand-alone prescription drug plans (PDPs) to choose from depending on the region, along with many Medicare Advantage–Prescription Drug plans. For 2013, slightly more premium-free PDPs will be available to enrollees who receive the low-income subsidy (LIS).

Between 2007 and 2011, Part D spending increased from about $47 billion to $60 billion (an average annual growth of about 7 percent), and CMS expects it will have reached $62 billion in 2012. These expenditures include the direct monthly subsidy plans receive for their Part D enrollees, reinsurance paid for very-high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their Medicare beneficiary retirees. In 2011, LIS payments continued to be the largest single component of Part D spending, while Medicare's reinsurance payments were the fastest growing component. While average costs for basic Part D benefits are expected to remain stable (growth of less than 1 percent) between 2012 and 2013, plan sponsors are expecting significant changes in costs for individual components: a decrease of over 9 percent for the direct subsidy and an increase of about 14 percent for the reinsurance component. In 2013, the base beneficiary premium is about the same as in 2012 ($31).

Chairman BRADY. Thank you, Mr. Chairman.

Let's start at the beginning. The report acknowledges what we all know, which is Medicare will be broke in 10 short years. How urgent is it for us to act now to make that program solvent over the long term?

Mr. HACKBARTH. Yeah, so, as I indicated in my comment, the most important thing for us to accomplish is to support reform and care delivery. That is where the action is.

And the sort of changes that we are talking about—for example, moving to accountable care organizations or bundling around episodes—require providers to develop new relationships with one another. And we believe those relationships are important to quality of care, let alone cost.

But they will take time to develop. And so moving in that direction now allows us to have the necessary delivery system reform in time to help us, you know, 5 or 10 or 15 years down the road.

Chairman BRADY. In your view, is it possible to make Social Security solvent for the long haul without reforming fee-for-service?

Mr. HACKBARTH. No. We think reforming fee-for-service is an essential part of the effort.

Chairman BRADY. In the report, you make two recommendations generally: one on the principles of SGR reform, breaking the link between expenditures and updates, and you outline some principles. Then you talk about offsets. Once we get the replacement right, which tells us the price, we have to do the hard work on the offsets.

Mr. HACKBARTH. Right.

Chairman BRADY. So can you talk for the Committee about some key principles on SGR reform in your mix of offsets for once we get that replacement right?

Mr. HACKBARTH. Yeah. So the major principles I touched on in my opening statement: repeal, rebalance payments within the physician fee schedule, and encourage movement to new payment systems.

In terms of offsets, in October 2011 we sent this Committee and the other committees of jurisdiction a letter with almost $300 billion in offsets. Actually, let me just clarify that. We had about $200 billion in offsets and $100 billion in suggested changes in the physician fee conversion factor. So, at the time, the total cost to repeal was about $300 billion, and we had a package that would roughly achieve that goal.

Since that time, as I indicated, the cost of repeal has fallen dramatically, so not all of the things on that list would be required. We do have roughly $100 billion worth of current unenacted MedPAC recommendations before this Committee and the Congress.

We would also think that it would be appropriate to have some balance between physicians and other participants in the Medicare system. In our October 2011 letter, we had the balance one-third physicians, two-thirds from all of the other participants in the Medicare system. There is no magic to that split, but it might be still a reasonable approach.

Chairman BRADY. Final question is really advice for the Committee. As we look at this, it sort of reminds me of *Parade* maga-

zine every year does an edition on what do people earn, you know. And you sort of thumb through it to find out what average people make.

You are tempted, in looking at this report, to look at the margins to sort of—in the past, it has been who is ripe for picking in provider cuts going forward. But that has been part of the problem. We are really not focused on quality, reforming this process so it is not so reimbursement-driven.

How should we as a subcommittee use this as a tool in designing a permanent, reliable, quality-driven SGR or replacement for the SGR?

Mr. HACKBARTH. Yeah. Well, as you say, we don't think that you only look at the margins. In fact, we think sometimes looking at average margins is deceptive. What you have asked us via our statute is to recommend rates consistent with the efficient delivery of service. And sometimes the average margins don't help you understand what the efficient level of payment is.

So we tend not to base our recommendations solely on average margins. That is just one input. In addition, we look at quality of care, the entrance and exit of providers in a particular area.

Within our recommendations, there are, however, certain provider groups, namely skilled nursing facilities and home health agencies, where we have seen persistently very high margins for a long period of time, double-digit margins. And, in those cases, we have recommended an actual rebasing of the rates. In other words, don't just update from the current rate; lower the current rate so that it is more appropriate given the cost of delivery.

So those are two areas where we think in particular there is an opportunity—skilled nursing facilities and home health agencies.

Chairman BRADY. Thank you, Chairman.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

One of the issues that we hear about, all of us go to various events, people come up and say, I can't find a doctor and I am on Medicare.

I know you do an annual survey. I would like you to talk about what you have found in that survey.

Mr. HACKBARTH. Yes. So each August, September we do a survey of 8,000 people—4,000 Medicare beneficiaries and 4,000 people who are just prior to Medicare eligibility by age and are privately insured. And we ask a series of questions about their access to care and then also ask them about their ability to find a new physician if, in fact, they are seeking a new physician.

On the issues about their satisfaction with access to quality of care, Medicare beneficiaries have consistently reported higher satisfaction with their access to care than the privately insured patients just under age 65. The differences aren't huge, but the pattern has been pretty consistent over time.

On the questions related to finding a new physician if you are seeking one, Medicare beneficiaries report about the same level of difficulty as the privately insured patients. Those numbers have bounced around a little bit in recent years, but they are basically the same.

Mr. MCDERMOTT. Is that basically the question of finding a primary care physician?

Mr. HACKBARTH. Yes. Actually, we ask questions on both. We ask if you are looking for a new primary care physician and then a separate question, if you are looking for a new specialist. The challenges, both in Medicare and in private insurance, tend to be in terms of finding a new primary care physician.

Mr. MCDERMOTT. So as we take on 30 million new people under the Affordable Care Act, we are going to be in some difficulty with primary care physicians?

Mr. HACKBARTH. We have not looked specifically at the implications of the Affordable Care Act, but we do see indications, particularly in some portions of the country, finding a new primary care physician is difficult, again, for both Medicare and privately insured patients.

This is the reason why, in talking about SGR repeal, I emphasized the importance of increased payment for primary care. That is where we see the potential access problems for Medicare beneficiaries.

Mr. MCDERMOTT. Could I ask a question about Medicare Advantage programs? They cover everything that traditionally Medicare covers. Are they allowed to play with co-pays and other things to make a difference in how they are used or to limit the risk or make people say, well, I think I am going to get out of here because I have something that isn't covered, or it costs too much, or——

Mr. HACKBARTH. Yeah. So they do have some flexibility around the benefit design. And for the reasons that we discussed in the hearing a couple weeks ago on benefit design, we think some flexibility is appropriate. In fact, we would like to see them have a bit more flexibility than they have currently in some areas—for example, having tailored co-pays for particular patients with particular illnesses. That is the idea behind value-based insurance design.

Having said that, though, you need to take care that benefit design is not used to enroll a favorable selection of risk and discourage the higher-risk patients. So that flexibility needs to be within a regulatory framework that protects against risk selection activity. So we are trying to strike a balance: flexibility for a more value-based insurance design without skimming behavior——

Mr. MCDERMOTT. Tell me about the spread. If I am in one plan and my diabetes is taken care of and it costs me $100 and in the other one it costs $40, is that spread possible between two Medicare Advantage programs and co-pays? Or is it a $5 difference? Or what are we talking about here?

Mr. HACKBARTH. Well, I can't answer that question off the top of my head, Dr. McDermott. I would be happy to respond to that in writing afterward.

Mr. MCDERMOTT. As a final thing, I notice in today's paper the FTC is suing a hospital in Idaho for buying a doctor's practice under the noncompetitive questions.

Mr. HACKBARTH. Uh-huh.

Mr. MCDERMOTT. Some of the things in the ACA, the Affordable Care Act, these accountable care organizations, it seems to me that there are a lot of problems out there about how you control costs and how medical systems can move to do that that are inher-

ent in the law. I would like to hear you say a little something about that.

Mr. HACKBARTH. Yeah. Well, this is another challenging area.

In general, we believe that developing formal relationships among different types of providers is a good thing and a necessary part of trying to improve the value of care. When providers of various types work independently without coordination, we know what the results are. That is the experiment we have run for the last 40 or 50 years. We get a high cost and uneven quality. So we favor some integration combinations. That doesn't always have to be in terms of a formal merger or ownership. There are a lot of different ways that configuration can happen.

Having said that, there is a fear that as these combinations develop, that they will have undue market power and be able to, using that market power, get very high rates of payment from private payers, if not from Medicare. And so there is a balance to be struck. And, you know, we don't want complete consolidation, but we do need some reorganization of care.

You know, this is one of the reasons why I personally favor physician-led ACOs. If all of the ACO development is hospital-focused, you tend to get more consolidation, more market power that can lead to higher prices for private payers. Having physician-led ACOs I think can be consistent with a more competitive system.

And so I am encouraged to see that, in fact, roughly half of the ACOs that have now been approved by CMS are, in fact, physician-led ACOs. I think that is a good sign.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Hackbarth, how many on your board are actually in private practice?

Mr. HACKBARTH. In private practice. It is going to be hard for me to do a quick count off——

Mr. JOHNSON. But you do have some?

Mr. HACKBARTH. Yes, we do.

Mr. JOHNSON. And not a preponderance, though, I would guess.

Mr. HACKBARTH. Well, as I said, in our current membership, we have six clinicians. For example, one, Tom Dean, Dr. Tom Dean, practices in a small town in South Dakota and brings to us the experience of a family practice physician in that environment.

Mr. JOHNSON. Good.

As you know, ambulatory surgery centers' payment updates are based on Consumer Price Index–Urban, which reflects inflation in the entire economy. MedPAC previously said CPI–U is a poor proxy for input price increases.

Since there is no empirical evidence to suggest that ASC inflationary challenges differ from hospitals—they both have to hire and retain nurses and purchase similar medical supplies—shouldn't their payment updates reflect the outpatient hospital market basket?

Otherwise, payments between the two sectors will continue to diverge over time, as CPI tends to lag market basket by about a percentage point.

Mr. HACKBARTH. Yeah. Well, as you indicated, Mr. Johnson, we don't think that the CPI–U is an appropriate adjustment factor for ASCs.

We have recommended that cost data be collected from ASCs, one of the purposes of which would be to develop a more appropriate index for ASCs. Although there are some similarities in the services and inputs used by ASCs and hospitals, the mix is significantly different. So even the hospital inflator wouldn't be tailored to ASC patterns.

Mr. JOHNSON. Well, how do you all adjust for those differences?

Mr. HACKBARTH. Well, as I said, right now, without cost data, it is very difficult to do that. And that is one of the reasons why we think ASCs should be required to submit some cost data to Medicare.

Mr. HACKBARTH. And they don't do that now?

Mr. HACKBARTH. They do not.

Mr. JOHNSON. Okay.

In the report, the Commission found the current system undervalues primary care and overvalues specialty care. I agree primary care physicians are different. I am also aware of potential primary care shortages. Over half the doctors in Texas aren't taking new Medicare patients.

However, is MedPAC concerned about the access to cognitive specialists, who bill a lot of office visits but would face cuts under your recommendation?

Mr. HACKBARTH. Well, so we have made over the years a series of recommendations about how the relative values are calculated in the physician fee schedule. In general, those recommendations would increase the value for what we refer to as cognitive services, nonprocedural services.

So specialists who provide a lot of those services actually could benefit from our recommendations, whereas those that are doing procedures or imaging would tend to be paid less.

Mr. JOHNSON. Okay. Well, thank you very much.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman.

Mr. Hackbarth, thank you again for your testimony today and the work that MedPAC does.

You are probably familiar with CBO's recalculation of Medicare spending between now and 2020. It just came out in February. They updated their baseline from just last August. This is what they found: They found a reduction in Medicare spending during that time period of 3½ percent, or $382 billion, which is significant, which tells me something is happening out there, something is churning. And it may be a little bit too early to tell what exactly, but it does, I think, give many of us hope that have been working with MedPAC throughout the years, as far as the recommendations you have been making to this Committee and to this Congress in regards to delivery system and payment reform, which was included in the healthcare bill.

And I don't know if you were familiar with the article that came out in *USA Today* last week on March 4 entitled, "Healthcare Spending is Transferred Out of ICU."

And, Mr. Chairman, I would ask unanimous consent to have this article inserted in the record at this time.

Chairman BRADY. Without objection.

[The information follows:]

USA TODAY
Health care spending is transferred out of ICU
By Dennis Cauchon
March 4, 2013

Health care spending last year rose at one of the lowest rates in a half-century, partly the result of cost-saving measures put in place by the 2009 health care law, a USA TODAY analysis finds.

Spending for medical care has increased modestly for five consecutive years, the longest period of slow growth since Medicare began in 1966. This respite comes just before a massive expansion of health insurance starts Jan. 1, 2014. Another 21 million people will get insurance, adding about $100 billion a year to total health care spending in 2014, according to the government's actuary.

Health care spending hit a record $2.67 trillion last year, but its share of the overall economy shrank, from 17.12% of gross domestic product in 2011 to 17.04%, because other parts of the economy grew faster, an analysis of Bureau of Economic Analysis data found.

Cost-saving measures under the health care law appear to be helping keep medical prices flat, according to health care providers and analysts. Also, weak demand may linger from the recession, which ended in June 2009, especially for optional care such as cosmetic surgery.

In 2012, the average price paid for medical care — a doctor's visit, an operation, a pair of glasses — rose at about the same rate as other prices in the economy, an inflation rate of less than 2%.

Total health care spending still rose 1.7 percentage points faster than inflation in 2012 because of an increased use of medical services, such as hospitals, home health care and drugs. However, even this extra demand for care was modest compared with past years, especially for an aging population.

"We're beginning a long period of adjustment in health care," says Dan Mendelson, CEO of Avalere Health, which advises health care companies and investors. "Institutions are taking both cost control and quality improvement more seriously."

He predicts modest cost growth is a long-term trend, not a short-term blip. "There's a lot more to squeeze without hurting quality," he says.

Also keeping costs lower:

Government insurance. More people are getting health insurance from Medicare and Medicaid, which pay less to doctors and hospitals than private insurers. Medicaid, which pays the least, covers 56 million poor people, up 10 million from five years ago. It will add nearly 20 million enrollees next year.

Generic drugs. About four of five drugs used today are less expensive generic medicines. The nation's top-selling drug, Lipitor, for high blood pressure, lost patent protection last year.

Competition. Health care exchanges, which start next year, may keep insurance prices down while limiting consumer choice. In early deals, hospitals and doctors are agreeing to lower rates than traditional private insurance in exchange for more volume.

New law has impact

USA TODAY computed health care spending from the nation's gross domestic product data to get the first comprehensive look at what happened in 2012.

In the four years leading to expanded health insurance, the government has used authority in the Patient Protection and Affordable Care Act to try to reshape the economics of health care through regulation and financial incentives. That appears to be keeping a lid on medical costs, at least in the short-term.

"It all goes back to (the Affordable Care Act) and how it changes so many components of the way we do business," says Peter Person, chief executive of Essentia Health, a 12,800-employee hospital system based in Duluth, Minn. "The language I use now in the health care business is completely different than the language I used even five years ago."

One big change is the government's revived push toward managed care. The government wants to pay a lump sum for a patient or diagnosis, demand higher standards and expect the medical provider to get the job done for that cost. Rather than cutting reimbursement rates, the government is raising the bar for what it expects for every dollar it spends.

Example: Medicare won't pay a penny more if a patient suffering congestive heart failure is readmitted to a hospital within 30 days of a discharge. The original lump sum is supposed to be enough and the refusal to pay more is designed to encourage hospitals to give top-notch care the first time.

How it saves money: Essentia now provides 300 of the sickest congrestive heart failure patients with electronic home scales that relay information, such as weight and symptoms, to a nurse

several times a week. The steady monitoring of small things has cut 30-day admissions to less than one-tenth of the national average and saved millions of dollars.

"Until now, the government has paid on volume. Now, it's trying to pay more on quality," says Person, a doctor of internal medicine, as well as CEO of Essentia, which has 18 hospitals and 68 clinics.

Incentives to lower costs

The government's new approach attaches financial rewards and penalties to a long list of practices — from giving antibiotics before surgery to using electronic medical records — in an effort to simultaneously improve quality and lower costs. In addition to changing how Medicare and Medicaid pay for medical care, the administration is providing grants and legal waivers to states and medical providers to experiment with approaches that try to align financial rewards with what studies show are best medical practices.

Among the most visible successes are efforts to save money on the most expensive patients by permitting the use of a hospice rather than a hospital for end-of-life care and emphasizing home health care over nursing homes.

Wisconsin's Family Care program now pays $3,200 monthly per person to provide mostly home health care to 40,000 poor seniors and disabled people. That's $600 a month less than it pays under an old program, which tends to use nursing homes to care for the most expensive population of patients, who are on both Medicare and Medicaid, the health program for poor people.

What's not clear is whether thousands of pages of new regulations and ideas can keep a lid on health care costs for long. In the past, regulations to solve one problem have created new financial incentives elsewhere in the reimbursement system.

The new efficiency push resembles earlier efforts, one under then-president Ronald Reagan and another under then-president Bill Clinton. In the 1980s, Medicare started paying fixed amounts for a diagnosis. In the 1990s, health maintenance organizations were widely seen as a powerful cost-containment tool.

Both initiatives tamed costs briefly and left managed care unpopular with many patients and medical providers. Managed care and other cost savings will stick this time because they aren't voluntary, says Person, the hospital chief.

"It is now the law, and it has teeth. We're getting paid less," he says. "We have to be more productive and efficient."

Mr. KIND. The article states, and I quote, "Cost-saving measures under the healthcare law appear to be helping keep medical prices flat, according to healthcare providers and analysts. Also, weak demand may linger from the recession, which ended in June 2009, especially for optional care, such as cosmetic surgery."

And then later in the article, Dan Mendelson, who is the CEO of Avalere Health, which advises healthcare companies and investors, was quoted as saying, "We are beginning a long period of adjustment in health care. Institutions are taking both cost control and quality improvement more seriously."

And a little bit later in the article, it states, "In the 4 years leading to the expanded health insurance, the government has used authority in the Patient Protection Affordable Care Act," the ACA, "to try to reshape the economics of health care through regulation and financial incentives. That appears to be keeping a lid on medical costs."

And then later in the article, Peter Person, the chief executive of Essentia Health, a 13,000-employee hospital system up in Duluth, Minnesota, was quoted as saying, "It all goes back to the Affordable Care Act and how it is changing so many components of the way we do business. The language I use now in the healthcare business is completely different from the language I used even 5 years ago."

And, again, there is more to the article in that.

So there is something happening that is starting to gain traction right now. And, obviously, we listened closely to what MedPAC was recommending throughout the years and included virtually all of the delivery system reforms that MedPAC was making and the payment reforms in order to help drive the system to better quality, better access, at a better price. And now CBO is saying almost a $400 billion savings in Medicare over the next 8 years. And the verdict is still somewhat out as far as what is driving that.

Mr. HACKBARTH. Uh-huh.

Mr. KIND. But these are all, I think, signs of hopefulness with where the healthcare system is going. And, in fact, the ACOs that you were talking about a little bit earlier, medical homes is moving forward, trying to reduce preventable hospital readmissions as part of ACA, wider testing, the bundle of payments and that.

What hope do you see as far as the implementation of these delivery system and payment reforms in regards to finally starting to bend the cost curve within the healthcare system and whether or not that might be sustainable in the long term?

Mr. HACKBARTH. Yeah. Well, I am hopeful. I think there is change afoot. It is hard to go around the country and talk to physicians and hospital executives and other providers without being convinced that there are changes, meaningful changes, happening.

As to what share of the change in the trend is attributable to those real changes in care delivery versus temporary factors like the economy, I don't know the answer to that. As you know, there is a robust debate about that issue.

I would say, though, that even if you believe, as I do, that there are real changes happening, that is not quite the same thing as saying that they will be sustained in the long run.

Mr. KIND. Right.

Mr. HACKBARTH. In the 1990s, I was a private health plan executive and then the CEO of a large multispecialty medical group. That was, as you will recall, the period of managed care. Real changes were happening in healthcare delivery in the 1990s, too. And, in fact, we saw a significant slowing of the rate of increase in healthcare costs.

That did not last, that was not sustained, in part because those changes in delivery, that change in healthcare spending provoked a reaction.

Mr. KIND. Uh-huh.

Mr. HACKBARTH. Whenever we try to bend the cost curve, there will inevitably be some winners and some losers. And we know that the losers will push back at some point.

Mr. KIND. Mr. Chairman, I would hope that in the future MedPAC might offer some recommendations on how we can accelerate some of the financial incentives or payment reforms, given the track record that is being established. That might be helpful for the Committee to consider, as well.

Chairman BRADY. Yes. And I think SGR reform is the perfect opportunity for us to start making those changes together.

Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

Mr. Hackbarth, thanks for your time today.

Back in your 2007 report, and now it is reiterated in this current report, you raise concerns about the ease with which critical access hospitals could manipulate the Medicare hospital wage index system by converting to a prospective payment system hospital and pull national Medicare dollars into one State entirely.

Since enactment of the Affordable Care Act, this very scenario has occurred and is referred to as the "Bay State boondoggle." Can you give us a sense of this, how real is it, why it is that you are concerned about it?

Mr. HACKBARTH. Yeah. So in our hospital payment system, we adjust the payments for local wages across the country since there is so much variation. And that is an appropriate thing to do.

The problem that we have had, Mr. Roskam, is that over the years there have been a lot of ad hoc changes in that system for adjusting wages—special rules, special categories created. And what we saw in Massachusetts, the case that you refer to, is one of those special rules being manipulated for the purpose of increasing Medicare payment.

We recommended in 2007, as you know, a complete overhaul of the wage index system, including wiping out all of these special rules that are subject to manipulation. Recently, the Institute of Medicine was asked by the Congress to look at the same issue and came up with recommendations quite similar to the ones that we made in 2007.

So we need to get away from these special provisions that are sort of rifle-shot additions to the law, because they are subject to manipulation.

Mr. ROSKAM. Because this is a zero-sum game, right?

Mr. HACKBARTH. Right.

Mr. ROSKAM. So when these things are manipulated—and I know that is a characterization, but I will characterize it as a ma-

nipulation—when they are manipulated, they are manipulated for benefit of one at the demise of another hospital or the demise of another State. Is that right?

Mr. HACKBARTH. That is correct. The wage index system is a zero-sum game. It is an index, and it redistributes a fixed amount of dollars.

Mr. ROSKAM. Let me just shift gears to the rehab side. As we all know, our former colleague and my Senator, Senator Kirk, had an incredibly difficult health experience in that he suffered a stroke. But we have all been heartened by the story of his recovery and now his return to the Senate. He gives an incredible amount of credit to an institution in Chicago, the Rehabilitation Institute of Chicago.

I have a sister institution out in the suburbs called Marianjoy. And I want to get to this question of the 60 percent rule and how this is—or the 75 percent rule and the 60 percent drama.

Mr. HACKBARTH. Right.

Mr. ROSKAM. Congressman Hyde, my predecessor, served in his last days at Marianjoy. And so it is an institution that has a great reputation, but they are under incredible downward pressure.

Mr. HACKBARTH. Uh-huh.

Mr. ROSKAM. And when I spoke to the president of Marianjoy, she said that they evaluated in the previous year more than 7,400 patients, only admitting 2,400 patients, which means that 2 out of 3 were turned away.

Mr. HACKBARTH. Uh-huh.

Mr. ROSKAM. It is a selective admission process. And their argument is, look, this shows that the system isn't being abused and so forth.

Can you speak to this 60 percent rule——

Mr. HACKBARTH. Sure.

Mr. ROSKAM [continuing]. And what happens if it moves to 75 percent? Because there is a number of us that have real concerns if we move in that direction.

Mr. HACKBARTH. Yeah. So in the post-acute portion of Medicare, we have several different types of providers. We have the in-patient rehab facilities, we have long-term care hospitals, we have skilled nursing facilities, and home health agencies. And patients requiring services after a hospital admission can end up in any one of those four places. And what we see in the data is that patients with the same diagnosis, the same clinical problem can often wind up in any one of the four.

The challenge is that the payment rates for those four different settings are dramatically different.

Mr. ROSKAM. Right.

Mr. HACKBARTH. And so, in the case of in-patient rehab facilities in particular, they are very important institutions for patients with a particular set of needs, that really need intensive rehabilitative therapy, but it is an expensive place to send patients who could be cared for just as well in a skilled nursing facility or home health. The cost is much higher in the in-patient rehab facility.

And so the 60 percent rule or the 75 percent rule is a crude attempt to assure that the in-patient rehab service, an intensive high-cost service, is focused on the patients who really need it and

not on patients who could be cared for just as well in a skilled nursing facility.

It is an arbitrary rule, it is a crude rule, and it is the sort of rule that you need to impose when you don't have an accountable party, a clinician, making that choice on where to send a patient, coupled with responsibility for cost and quality.

So the direction that we want to move is away from these arbitrary rules like the 60 percent or 75 percent to systems where a clinical organization would say, this patient with a hip replacement can go to a skilled nursing facility, this patient with a more complicated problem really needs to go to an in-patient rehab facility. And that person is accountable for the cost and quality of care. In a siloed payment system, there is no accountability.

Mr. ROSKAM. Thank you.

I yield back.

Chairman BRADY. Thank you for raising that issue. The whole challenge on post-acute care and the reimbursements in those settings is clearly going to be a focus of the Subcommittee going forward. So thank you.

Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Dr. Hackbarth, I must say that you may be 17 unelected bureaucrats, but I think MedPAC has over the years served us very well. It is too bad there isn't a mechanism for Congress to be required to respond to your recommendations. The healthcare system would have been better off, and we would have saved a lot of money.

Mr. THOMPSON. Is that a motion?

Mr. BLUMENAUER. Just an observation, and not a political comment.

There are three areas that I would appreciate your helping me with. One, you highlight in your report that we are overpaying some of the very low-performing Medicare Advantage programs; that, on balance, there was a concept of reward good ones, penalize poor ones. We have seen some improvement, but could you comment briefly about that problem that you see with the overpayment of the underachievers?

Mr. HACKBARTH. Yeah. So, in general, as I have said before this Committee many times, I believe, we believe that having private plans as an alternative, a choice for Medicare beneficiaries is an important thing, because often they can do things that traditional Medicare finds difficult to do in the current siloed payment systems, like coordinate and integrate care for chronically ill patients. So that is a good thing.

But that doesn't mean that all private plans are equally good and perform equally well at those activities. Some are truly exemplary and among, you know, the people that everybody points to as the very best in the country. But, in fact, there is a huge range of performance among Medicare Advantage plans.

One context in which this came up recently was the CMS demo for quality bonuses. And what they did in this demonstration project was extend the bonuses for quality basically to, like, 90 percent of all the plans participating in Medicare.

We had two objections to that. One is, 90 percent probably don't deserve quality bonuses. But even more important than that, this

demo, in effect, overrode the decisions made by the Congress in PPACA on how to structure a Medicare quality bonus for MA. So we thought the money was being spent indiscriminately.

Mr. BLUMENAUER. And I am hopeful that we will be able to return to that because we really do want to coax more capacity and quality. All Medicare Advantage programs aren't the same.

You also referenced hospice care——

Mr. HACKBARTH. Yes.

Mr. BLUMENAUER [continuing]. And some difficulties you see there. This is an area that I would deeply appreciate some brief comments here, but perhaps being able to follow up with you, because——

Mr. HACKBARTH. Sure.

Mr. BLUMENAUER [continuing]. We are seeing such dramatic advances in palliative care, that we are watching that people who choose this option in some instances actually have not just a higher quality of life but they actually live longer——

Mr. HACKBARTH. Right.

Mr. BLUMENAUER [continuing]. In that setting. And, coincidentally, it costs less than keeping people in intensive care or extreme procedures.

Do we need to be reevaluating our principles of hospice, do some fine-tuning so we are not having areas of abuse but we capture the potential of higher-quality and lower-cost care for others?

Mr. HACKBARTH. Yeah. It is, I think, safe to say that the current MedPAC Commissioners and all the Commissioners that I have served with in my tenure at MedPAC believe that the hospice benefit is extremely important for Medicare beneficiaries. And we are heartened by the fact that if you look back over the last 10, 15 years, in fact, utilization of the hospice benefit has increased over time. And we think that is a good thing, so long as that is what the beneficiaries want.

We do have some concerns about the hospice payment system, however. And we believe that the current payment system is subject to manipulation. And the form that manipulation takes is very, very long hospice stays, in fact, often multiple recertifications of eligibility for hospice. And our concern is that is what the payment system currently rewards. And so we have made some recommendations about how to address that problem.

So let me stop there. And I would welcome the chance to talk in more detail about that.

Mr. BLUMENAUER. Mr. Chairman, I think this is an area that is worthy of some consideration of the Committee. There may be adjustments that need to be made clearly in the payment system, but, by the same token, the definition that we started with was in a different era in terms of palliative care and what we know.

And I am hopeful that there is a way that we can get a little deeper into this, maybe with the help of MedPAC or others, that both assures the integrity of the program but targets it in a way to maximize the benefit and minimize some gaming of the system.

Chairman BRADY. Right.

Mr. BLUMENAUER. Thank you very much.

Chairman BRADY. Thank you, Mr. Blumenauer. My pleasure.

Dr. Price.

Mr. PRICE. Thank you, Mr. Chairman.

Welcome, Mr. Hackbarth, back. We appreciate your testimony, and appreciate your report.

I want to touch very briefly on the comment you made on fee-for-service, that we ought to be moving away to a different model. It is not in your testimony, however, is it, that fee-for-service ought to be outlawed?

Mr. HACKBARTH. Not outlawed, but we do think that we ought to be encouraging movement to new payment systems. And, you know, there is so much talk about how they can reduce cost.

Mr. PRICE. Yeah.

Mr. HACKBARTH. I really want to emphasize that we think that the new payment systems increase quality for Medicare beneficiaries.

Mr. PRICE. But you wouldn't outlaw fee-for-service. You wouldn't recommend that.

MedPAC looks at utilization, correct?

Mr. HACKBARTH. Correct.

Mr. PRICE. You look at overutilization, whether or not things are being—tests are being ordered too much, procedures are being done——

Mr. HACKBARTH. Uh-huh.

Mr. PRICE [continuing]. Too often. And you do that because increased utilization increases costs, right?

Mr. HACKBARTH. Uh-huh.

Mr. PRICE. Do you look at the practice of defensive medicine?

Mr. HACKBARTH. We have in the past.

Mr. PRICE. What kind of estimates do you have about how much that adds to costs?

Mr. HACKBARTH. Well, we don't have an independent estimate of that. We have looked at the literature on that.

My own view on that is that there may be too much emphasis on trying to calculate precisely what increment it adds to cost. Having worked with physicians as CEO of a very large group, I think that those estimates sort of understate the impact it has on medical practice.

Mr. PRICE. There are some estimates that it may be as much as 1 out of every 3 or 4 healthcare dollars. Is that—which is——

Mr. HACKBARTH. Well, again, we——

Mr. PRICE [continuing]. Hundreds of billions of dollars.

Mr. HACKBARTH. Yeah. We have not tried to calculate——

Mr. PRICE. Wouldn't that be wise, to look at that?

Mr. HACKBARTH. Well, it is a very difficult estimate to make, and I am not sure that we would be able to do it better than the various people that have tried to do that.

Mr. PRICE. I think it would be wise for MedPAC to begin considering that. I think it is hundreds of billions of dollars of waste in our system. And when you talk about the kind of need for providing coverage for folks and the need for more resources, this is an area where I think we could make great progress.

I want to shift to the treatment of patients, the incentive for treatment of patients in certain settings. And I am confused by why the same service for a patient in an outpatient setting, non-hospital outpatient setting, and that same service, that same exact

procedure, that same exact service being provided in a hospital outpatient setting, why those payments are different.

Your report last year, I believe, looked at the potential——

Mr. HACKBARTH. Yes.

Mr. PRICE [continuing]. For equalizing those payments.

Mr. HACKBARTH. Yes.

Mr. PRICE. And what was your conclusion or what were your thoughts about moving in that direction?

Mr. HACKBARTH. So we have already made recommendations to move toward equalizing the payment for evaluation of management services. And we are in the process of looking at other services beyond that initial group where we ought to move toward equalizing the payments.

It does not make sense to us to pay dramatically different rates, as you know, for the same service simply based on what name is over the door. And right now, given the transitions that are under way in medical care organization, the program is at risk and Medicare beneficiaries are at risk for much higher costs even when they go to the same physician——

Mr. PRICE. Exactly.

Mr. HACKBARTH [continuing]. Just because of changes in ownership.

Mr. PRICE. Have you looked at combining the fee schedules?

Mr. HACKBARTH. Pardon me?

Mr. PRICE. Have you looked at combining the fee schedules?

Mr. HACKBARTH. Well, what we have done, consistent with our assignment from the Congress is we want to set the payment levels at the level of the efficient provider. So if the physician office is the efficient provider of a service, we think we ought to be paying at the physician office level.

Now, there are some services where we think that the right level might be between the physician office level and the hospital outpatient department level. We are looking at some of those services right now.

Mr. PRICE. What are your metrics for efficiency?

Mr. HACKBARTH. So right now, in this particular example, if we can get an adequate supply of a particular service and physician office under the physician fee schedule, that is the efficient provider. Adequate supply at this rate. Why should we be paying more in a hospital outpatient department for the exact same service?

Mr. PRICE. And how much do you think you could save by equalizing payment?

Mr. HACKBARTH. Well, again, we looked initially at our recommendations on evaluation and management services. And maybe Mark can—yeah, so $900 million. About $200 million of that would accrue to the Medicare beneficiary from our past recommendation.

Mr. PRICE. That is just for E&M.

Mr. HACKBARTH. That is E&M alone. Now we are looking at additional groups of services beyond E&M that potentially would add to that number.

Mr. PRICE. Great. Thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Did I hear that right? Site-neutral reimbursement on office visit evaluation would be about $900 million, and of course then obviously to the senior themselves?

Mr. HACKBARTH. Yeah, $200 million to the beneficiaries, $900 million total.

Chairman BRADY. Great. Thank you.

Mr. Thompson.

Mr. THOMPSON. Well, thank you, Mr. Chairman, and thank you for holding the hearing.

Mr. Hackbarth, thank you for being here.

I want to talk about access to primary care. And you cover this in your testimony. Is it as difficult for Medicare folks as it is for private insurers? Is it difficult for both? Or is it just a Medicare thing?

Mr. HACKBARTH. No, this is a general problem beyond Medicare. It is Medicare and private.

Mr. THOMPSON. Yesterday, I had a visit from a constituent who is a med student. And his concern was that when today's med students get out of school, they are carrying considerable debt. And I think this is a problem for all students, but for medical students it tends to be a little bit more. He told me that he didn't think there was anyone in his class, unless they were going through school as part of the military that would leave without at least $200,000 in debt.

And his feeling was that high debt would, in turn, help those students determine what field of medicine they want to pursue and, because primary care is historically low reimbursement, it stands to reason that there is going to be a shortage of docs.

Is it your belief and MedPAC's belief that the cost of medical school is a factor in this?

Mr. HACKBARTH. It is a factor. It is not the only reason that people elect to go into specialty care, but it is a factor.

Mr. THOMPSON. And, no, it is probably not; you are probably right. But I would assume that there are folks who want to go into primary care but, once they get over the sticker shock, that it pushes them over the edge into going into——

Mr. HACKBARTH. Right.

Mr. THOMPSON [continuing]. A type of medicine that maybe they didn't set out to go into. Maybe they wanted to be primary care docs, but once they come to the realization they are going to have a pretty hefty bill to pay, then that causes them to go into specialty?

Mr. HACKBARTH. Yes.

Mr. THOMPSON. Are there other professions, medical professions, nurse practitioners and things of that nature that because of the cost of care, they tend to go into areas with a higher reimbursement than in primary care?

Mr. HACKBARTH. So you are asking whether we have evidence that nurse practitioners, for example, elect to engage in specialty care versus——

Mr. THOMPSON. Correct.

Mr. HACKBARTH [continuing]. Primary care? I don't know the answer to that.

Mr. THOMPSON. Is that something that you look at or should look at?

Mr. HACKBARTH. We have not looked at that in the past. You know, we can try to do that. I don't know what issues might be raised in doing that analysis.

Mr. THOMPSON. It might be worth looking at, because especially now with the distribution of labor and what nurse practitioners and physician's assistants and the likes are doing, I am assuming it would have some impact on primary care.

Mr. HACKBARTH. Yeah. And I would say that I believe that nurse practitioners and physician assistants are a necessary part of dealing with our primary care issues. I think we have not taken full advantage of the capabilities of non-physician practitioners, and, frankly, I think we are going to have to.

Mr. THOMPSON. I agree with you.

Mr. HACKBARTH. Even if we decided today to increase the number of primary care physicians trained, it takes a long time for that pipeline to produce physicians.

Mr. THOMPSON. Well, given the fact that these reimbursement rates are affecting the delivery of health care, particularly as it applies to primary care, the Commission's proposal on the SGR freezes the existing reimbursement rates.

How do you square that with what you just told me?

Mr. HACKBARTH. Yeah. So the proposal that you are referring to is our October 2011 letter to this Committee and others. The context for that letter was, at that point, SGR repeal cost $300 billion over 10 years. And since we knew that the cost of repeal was the single biggest reason why SGR had not been repealed, we felt obliged to come up with a package to cover that $300 billion cost.

The only way that we felt we could get there was to take $200 billion from hospitals and other participants in the system and about $100 billion worth of the cost out of the physician fee schedule. That necessitated cuts in the conversion factor for specialty physicians and a freeze on primary care.

Now that the cost of repeal is much larger, you know, you would have a different set of options for how to structure that, thankfully. And, potentially, you could elect to have some increases for primary care if you so desired.

Mr. THOMPSON. Well, I think it is important that we get something back, Mr. Chairman, on that. Because if, in fact, part of any proposal would be to freeze primary care, when we all acknowledge that the lack of primary care is one of the reasons that the healthcare costs, you know, are where they are and that this is one way to lower or bend that cost curve and provide a more sensible delivery of medicine, I would think that we wouldn't want to miss that point.

Mr. HACKBARTH. Right. So, you know, there are two ways to look at this. One is, you know, how much it costs to go to medical school and the like. And, in that context, a freeze obviously is not helpful to future primary care physicians.

The other way to look at it is the relative fees paid to primary care versus specialty care. And our proposal in October 2011 said, if you are constrained on the number of dollars you have, maximize that gap by cutting specialty fees while holding primary care con-

stant. If you have more money available, though, it would obviously be desirable to increase primary care.

Mr. THOMPSON. Thank you, Mr. Chairman.

Chairman BRADY. Thanks, Mr. Thompson.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you, Mr. Hackbarth, for sharing your perspective and insight on some very important issues today.

It is my understanding, and I think this topic was touched on briefly, but there are various factors that are perhaps leading to more and more provider consolidation. Could you elaborate more on that and perhaps share what you see as the impact to insurance premiums as a result?

Mr. HACKBARTH. Yeah. Well, I would say there are basically two. One, there is consolidation that is aimed at developing new organizations that are better able to effectively care for Medicare patients and other patients. So they are integrating in a way that they collaborate to better coordinate and integrate care. That is the good type.

Then there is the other type that is basically aimed at maximizing market power. And so there have been a lot of what antitrust lawyers would refer to as horizontal mergers where, you know, hospitals are joining together. They are not integrating with physicians, they are just building hospital systems that have more leverage vis-á-vis insurance companies. That is more problematic.

Now, the tricky part is that some of the good type of integration also leads to market power that can lead to higher prices for private parties.

Mr. SMITH. And I can appreciate a lot of things about how differently health care is delivered across the country, certainly, representing a very rural area. And I think there is still some consolidation out there, too, for various reasons. So I appreciate that.

Now, shifting gears a bit, in terms of reimbursement, I notice that the Commission has recommended steps that Medicare can take to make sure that it is paying accurately for each individual physician service. And without getting into the details too much here, why would you say it is important that the determinations are accurate? And what are the implications, perhaps, for getting them wrong?

Mr. HACKBARTH. Yeah. Well, there are two types. One we just discussed a minute ago. If the prices are wrong, it can influence the physician pipeline for the future. So if we consistently underpay for primary care, in the long run we will have too few primary care physicians. And we fear that is happening.

The other type of problem is that if you overpay for certain services, you are likely to get more of them. And an example of that, we believe, would be around imaging services, where we think Medicare has paid too much. We have encouraged a lot of investment in imaging equipment to take advantage of that mispricing. And once the equipment is in place, the profitability goes up dramatically. And you want to use that equipment more, more, more because the marginal cost of using it is low.

So you can have two types of ill effects. One is on supply of physicians, and one is on the type of services rendered.

Mr. SMITH. And so could you elaborate on how we shift to a system that more accurately reflects the actual costs and how we may not have a Federal policy that tends to put things out of balance?

Mr. HACKBARTH. Yeah. So the physician fee schedule, as it is constructed, is focused on what are the costs involved in providing a particular service. There are 7,000 different services under the fee schedule, and relative values are established for each of these services. And the goal is to accurately measure the inputs and costs that go into producing those services.

We think there are errors in those measurements, and not small occasional errors but pretty broad errors in those measurements. So we have made a series of recommendations both to the Congress and to the Secretary about correcting those errors.

The other less discussed challenge in the physician schedule is that it focuses only on measuring the input costs. In the market for all other goods and services in the country, prices not only reflect the input costs, they reflect the value of the product, and they also move to reflect imbalances in supply and demand. The construct of the Medicare physician fee schedule pays no attention to the value of the service to the patients nor to imbalance in supply and demand.

The latter is why we have recommended and Congress has enacted a primary care bonus. It is a way of dealing with that value and supply part of the equation that the fee schedule ignores.

Mr. SMITH. Okay. Thank you.

And thank you. I yield back.

Chairman BRADY. Thank you.

Mr. Gerlach.

Mr. GERLACH. Thank you, Mr. Chairman.

Mr. Hackbarth, thank you very much for testifying today.

I want to focus on the home health agency issue, if I can.

Mr. HACKBARTH. Uh-huh.

Mr. GERLACH. First, I want to offer you a constituent case that we experienced a few years ago and get your reaction to that. And then, also, I want to focus on a couple of your recommendations from a few years ago in this area.

On the constituent matter, we had a constituent that came to us after having 3 days of home health care, and the home health agency billed $1,500 for that care. It was submitted to the Medicare program, and the reimbursement back to the provider was actually double that, $3,000. So the reimbursement was actually double what was billed by the home health agency, and the explanation from CMS was that, well, we base our reimbursements on a 30-day episode of care; based on the nature of the care over 3 days and a 30-day episode, that was what the reimbursement amount is.

Is that a particular issue you are aware of, that we would pay, reimburse a provider double what was actually billed? And, if so, what would be your recommendation on how best to deal with that situation?

Mr. HACKBARTH. Yeah. Actually, Mr. Gerlach, we exchanged some correspondence on this, I think, when it first came up a couple years ago.

So in the home health area and many of the other Medicare payment systems, we pay on a per-episode basis, and do so recognizing that some episodes will cost less, some will cost more, but those differences will tend to average out.

The reason for paying on an episode basis is that it creates an incentive for effective management of the services. You eliminate the incentive to do more home health visits by paying on an episode basis. So that is——

Mr. GERLACH. So, in this instance, paying double what was billed incentivizes who to do what? Wouldn't it incentivize providing more care because you are going to get reimbursed more than what your actual, in essence, retail billing would be for that service?

Mr. HACKBARTH. So in some cases the episode payment will be higher than the costs incurred, but in other cases it will be less than the costs incurred. And, as I say, the idea is——

Mr. GERLACH. Over a spectrum of service, you are saying?

Mr. HACKBARTH. Yeah, over all of the patients that a home health agency cares for. Some they will make money, some they will lose some money, and it will tend to average out. And the reason for using that approach is to create incentives to not provide more visits than are necessary.

Now, a problem that we have in the home health——

Mr. GERLACH. Wouldn't it make more sense, though, if a home health agency bills for, say, the $1,500, that the formula for reimbursement ought to be the lesser of what that episode of care was under the current formula or what is billed, whichever is less? Wouldn't that make more sense?

Mr. HACKBARTH. Well, I suspect that over time what you would have is that all of the people who have fewer visits in the episode would start to gravitate up, saying, well, we want to maximize the payment, and so we will just increase the number of visits until we get to the limit.

Mr. GERLACH. Okay.

Mr. HACKBARTH. And so that is why Medicare avoids that.

But there is a very important issue in home health, and that is that the payments are way too high, on average.

Mr. GERLACH. Yeah, and that is where I was going. Back in March 2011, it was recommended that the Secretary should implement new authorities to suspend payment in the enrollment of new providers if they indicate significant fraud. What has been the progress from your recommendation 2 years ago that you can see from your position at MedPAC? What progress has been made at CMS to address that particular problem?

Mr. HACKBARTH. Well, I can't provide a quantitative answer to that, but there has been a fairly intense focus on fraud in home health in particular areas of the country, like south Florida.

Mr. GERLACH. Yeah. Yeah.

Mr. HACKBARTH. And I think there is probably more that needs to be done there, but it is increasingly the focus of attention at HHS.

Mr. GERLACH. Uh-huh. Okay.

And then real quickly, you also recommended 2 years ago a per-episode co-pay for home health episodes that aren't preceded by

hospitalization or post-acute-care use. What is that rationale for that recommendation?

And, in particular, for low-income beneficiaries—and I visited a number of those types of homes in the last few years—I can't foresee some of these individuals being able to provide any co-pay for the services they are getting in their home. What is the rationale for your recommendation? And what do you think the impact would be if a co-pay was established, particularly for low-income individuals?

Mr. HACKBARTH. So, under our proposal, the duly eligible Medicare beneficiaries would not be subject to the co-pay. So if we used that as the definition of low-income, they would be protected.

We think having a co-pay for all services is important in a fee-for-service insurance program like Medicare. That is one of the only tools that is available to manage costs.

With regard to home health in particular, as you noted, our recommendation focuses on what we refer to as admissions from the community. So these are not patients coming out of a hospital or a skilled nursing facility; these are patients who are just admitted from the community. There are not clear clinical guidelines about when that community-initiated home health service is necessary and appropriate. It is a gray area, kind of like some medical services.

And, in fact, in the last hearing, Mr. McDermott and I had an exchange about this. You know, you don't worry about the patient initiating demand when the service is something that is painful or risky. Nobody wants to undergo that. But home health is different. There is no risk involved. There is no inconvenience involved. In fact, it often lightens the burden on family members and friends, so it is very attractive in that regard. And if it is a free service, you know, why not use it?

Mr. GERLACH. Uh-huh.

Mr. HACKBARTH. And so what we have recommended is quite a modest co-pay, like $150 per admission. For the average home health episode, that works out to about $8 a visit, which we think is an appropriate sort of check for people to say, is this really something that I need?

Mr. GERLACH. Uh-huh. Okay. Very good. Thank you, Mr. Hackbarth.

I yield back.

Chairman BRADY. Thank you, Mr. Gerlach.

We are not going to do a second round, but I would like to recognize the Ranking Member for a comment and question and then Dr. Price for the final question.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I just want to take a second to enter into the record, or ask unanimous consent to enter into the record, an article from *The Washington Post* by Sarah Kliff dated today. And it is called, "Want to debate Medicare costs? You need to see this chart first."

It shows that hospital readmissions in Medicare are dropping, and it shows that the percent of GDP in the future, if you use what has gone on in the last few years, is going to stay level rather than continue to rise to 0.7.

I think you are familiar with these numbers.

Mr. HACKBARTH. Yes.

Mr. MCDERMOTT. And I think Members of the Committee ought to be aware of this particular article that shows that the ACA is already having an effect before these things go into impact, or before they went into impact last year.

Mr. HACKBARTH. Uh-huh.

Chairman BRADY. Without objection.

[The information follows:]

WASHINGTON POST

Want to debate Medicare costs? You need to see this chart first.

By Sarah Kliff
March 15, 2013

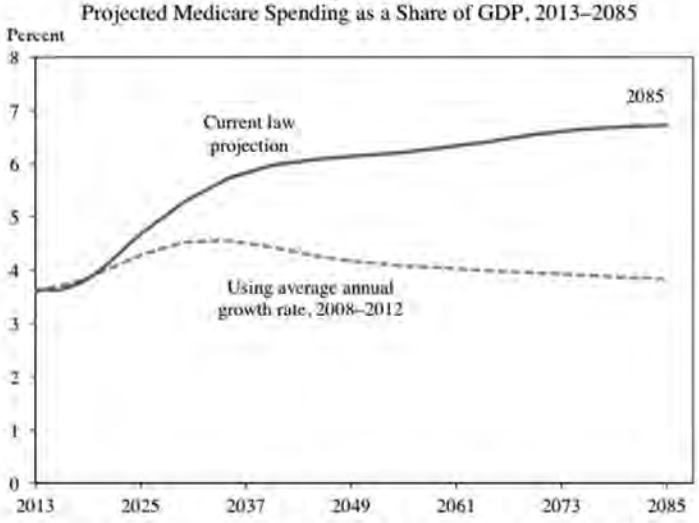
It's taken as an article of faith inside the beltway: Policy makers need to do something to tamp down on out-of-control health-care costs.

If we don't get our Medicare and Medicaid spending under control, the thinking goes, it will crowd out spending on other important budget items, things like defense or education.

President Obama agrees with this idea. So does House Budget Chairman Paul Ryan. But what if, it turns out, both parties have gotten it all wrong?

The White House is out Friday with its annual Economic Report of the President. It contains this chart that shows Medicare as a percent of the economy if it grows on pace with prior projections — or if it grows at the same rate as it has since 2009. The difference is very stark.

Figure 5-8
Projected Medicare Spending as a Share of GDP, 2013–2085



Source: Medicare Trustees (2012); Social Security Trustees (2012); CEA calculations.

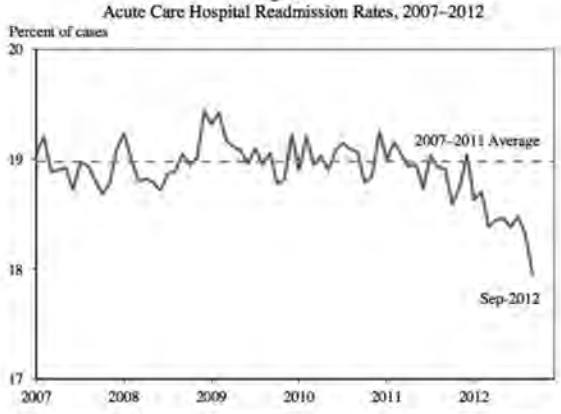
If that cost growth persists, it could make all the difference for Medicare: The entitlement program would, by 2085, make up 4 percent of the economy instead of the previously projected 7 percent.

The "if" there is crucial: We don't know whether this cost growth slowdown is permanent or temporary, a factor of Americans cutting back on care during the recession.

This report presents some evidence to believe that the downturn could be here to stay. It includes data on the level of hospital readmissions for Medicare patients. These are typically considered a sign of unnecessary, costly care — patients don't usually return to the hospital because they're feeling in top shape.

For years now, that number has hovered around 19 percent of patients being readmitted to the hospital. Then, in September 2012, it dropped down to 17.8 percent.

Figure 5-5
Acute Care Hospital Readmission Rates, 2007–2012



Source: Center for Medicare and Medicaid Services, Office of Enterprise Management.

Either way, this data underscores how important the changes happening in our health-care system, right now, will be to the future of health-care spending. If they stick around, they could completely reorient the typical Washington discussion of Medicare as a budget-buster.

Chairman BRADY. Dr. Price.

Mr. PRICE. Thanks, Mr. Chairman. I appreciate the indulgence, and just a few quick questions.

This whole issue of post-acute care and the venue for care and the differential treatment, I think you mentioned that it ought to be a clinical organization that ought to be making the decision about the venue of treatment for a patient. You wouldn't consider MedPAC a clinical organization?

Mr. HACKBARTH. No, no. I am referring to a provider.

Mr. PRICE. Great. I just wanted to make that clear.

And I want to visit home health for just a second, because a lot of issues are about overpayment in home health and the like. Isn't it true, though, that if you look at the number of counties in this country and where the real challenges are, it is like 25 counties out of 3,000 or something like that?

Mr. HACKBARTH. Yeah. So the patterns of home health use vary dramatically. In fact, the variation in home health is much greater than the variation——

Mr. PRICE. Yes.

Mr. HACKBARTH [continuing]. In almost any other service.

Mr. PRICE. Shouldn't we be looking at those targeted counties?

Mr. HACKBARTH. We should look at those areas in particular. But across the whole country, we are still overpaying for home health services.

Mr. PRICE. And let me just touch on that, if I may, very briefly. The margins that you have talked about—and I think that your margin analysis comes from methodology of the HCFA era, really, right?

Mr. HACKBARTH. No. This is our own methodology.

Mr. PRICE. But what margins—refresh my memory on the margins that you believe—the proper margins that they are making?

Mr. HACKBARTH. For home health, we are projecting for 2013 around 11, 12, 13 percent.

Mr. PRICE. Are you familiar with an Avalere study, analysis, 2013 study, that uses financial reports that are filed with the SEC that put the margin—and take into account significantly greater information than I think your methodology—that puts the margin at around 2.5 to 3.5 percent?

Mr. HACKBARTH. I am not familiar with that report. Keep in mind, the information that we are using is the information supplied on cost reports by home health agencies.

Mr. PRICE. Great.

Well, maybe we can follow up on that, Mr. Chairman, and see if we can't get more accurate data. Because this is a real concern. Because if we lower, if we allow the lowering of reimbursement for home health, then we may significantly adversely incentivize movement of those individuals into actually higher-cost venues. And I think that is probably the last place we want to go.

Mr. HACKBARTH. Yeah. Well, I would agree that we don't want to do that. And I would be happy to follow up in detail with you on this. We don't think that there is a risk of that by lowering the home health base rate.

Mr. PRICE. Thank you.

Chairman BRADY. Thank you, Dr. Price.

Thank you for this hearing. There is a lot in this report to digest. I know there will be followup questions from the Members. We have 14 days to submit questions, and I am sure there will be a number of them, including related to what are driving some of the lower costs, including the economy, the shift into Medicaid by a number of patients, issues like that. And I would ask if questions are submitted by the Members that you respond promptly, as you have in the past.

With that, this Subcommittee is adjourned.

[Whereupon, at 10:50 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

Comments for the Record

U.S. House of Representatives

Committee on Ways and Means

Subcommittee on Health

Hearing on MPAC's March Report to Congress

March 15, 2013, 9:30 AM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Brady and Ranking Member McDermott, thank you for the opportunity to submit my comments on this topic. As there has been turn-over in the membership of the committee, we will largely repeat our comments from last year, which provide real alternatives to current policy, as well as current problems that no one is talking about relating to the implementation of the Affordable Care Act. We are always available to brief members and staff individually on our comments or respond to any questions.

It is always important to note that the whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act). There is a middle ground and the Subcommittee's job is to find it.

Resorting to premium support, along with the repeal of the ACA, have been suggested to save costs. Without the ACA pre-existing condition reforms, mandates and insurance exchanges, however, premium support will not work because people will have no assurance of affordable coverage. This, of course, assumes that private insurance survives the imposition of pre-existing condition reforms. We do not have to wait until implementation to examine this question. Now that the Supreme Court has spoken, the stock market will examine it for us. There may well be a demand for reform before the election if the prospects for private insurance are found wanting. Conversely, if stock prices are maintained, it is the market expecting mandates to be adequate.

Assuming mandates are seen as inadequate, the questions of both premium support and the adequacy of provider payments are moot, since if private insurance fails the only alternatives are single-payer insurance and a pre-emptive repeal of mandates and protections in favor of a subsidized public option. The funding of either single-payer or a public option subsidy will dwarf the requirement to fund adequate provider payments in Medicare and Medicaid.

Resorting to single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

The question of Accountable Care Organizations and cost sharing with payments is also relevant. The Senate Finance Committee addressed this question last year. Hearing witnesses focused on Accountable Care Organizations and other possible solutions to bend the cost curve. This emphasis is all well and good of most beneficiaries of Medicare, Medicaid and other forms of directly and indirectly subsidized insurance in most years. Focusing on results is a worthy goal for both patient well being and cost control, provided the patient can be treated. Medicare, however, devotes significant resources to the expensive care found in the last year of life, which may involve multiple hospitalizations, full time nursing services through Medicaid or a period of intensive care which ultimately proves unsuccessful. In all of these circumstances, particularly the last, unless we are willing to either have doctors deny care or force survivors to pay bills that the government refuses to pay, some form of fee for service is necessary.

In April of 1998, our Principal's father, Jim Bindner, had a heart attack, due in part to either an undetected acute episode of diverticulitis (which was not detected until autopsy) and in part to a lack of oxygen resulting from successful radiation treatment for metastatic lung cancer. Had this attack occurred today, there is a chance that advances in emergency medicine, including cooling of the patient, might have resulted in a successful outcome. This strategy, however, did not exist in 1998 and is still not widely practiced. As a result, resuscitation was incomplete and Mr. Bindner was left in a coma in intensive care for almost a week before he passed.

The relevant question is, what would a results based medicine scenario pay for in situations such as this? Would the government have forced Mercy Medical Center to simply eat the costs? If so, would there have been pressure from the hospital to end care sooner? Would the alternative have been a copayment for these services for the family?

Worse yet, would someone have forced the choice on Mrs. Bindner to either agree to payment or discontinue life support earlier to save cost? These are the questions that such modalities as results based payment bring forward loud and clear and they will hit every family with children of a certain age. This is not the specter of the death panel. It is something much worse – a demand to agree to pay or make a tragic decision at the most difficult time in anyone's life.

Tragically, Mrs. Bindner followed her husband in death last year one month after our last comments. We were not faced with a decision to disconnect before we were ready, although we did withdraw support and allow her to die in peace once it was confirmed there was no brain function. If it had been the choice of some insurance bureaucrat rather than our choice, a tragic situation would have been made worse.

While some families could, of course, afford to pay for greater end of life services, the prospect that money might by longer life, or a greater chance for miraculous recovery to occur, would turn such care from what is now a right to a commodity. The Center finds this unacceptable.

In fee for service medicine, this choice is simply not required. Certainly the richest society on the planet can afford to allow women facing imminent widowhood to avoid such heart breaking choices if possible. Recent reforms have essentially turned the Medicare Part A Payroll Tax into a virtual consumption tax already by taxing non-wage income above $250,000 a year. It would be as easy to shift from a payroll tax to a value added or VAT-like net business receipts tax (which allows for offsets for employer provided care or insurance) and would likely raise essentially the same amount of money, as most non-wage income actually goes to individuals now liable for increased taxes. If a VAT system is used, tax rates can be made lower because overseas labor will essentially be taxed, leaving more income for American workers while raising adequate revenue.

Premium support systems would not have any impact at all on end of life care decisions, except to the extent that they lead to cost cutting and the kind of choices mentioned above that we can all hopefully agree are abhorrent. Ultimately, this negates much of the cost savings that could come from premium support, so this idea should be dropped.

A single-payer catastrophic plan would guarantee payment by the widow of any difference between the catastrophic deductible and the accumulated health savings account. This, again, is the last thing any widow should have to face, even if the survivors have adequate insurance.

Replacing payroll taxes with Value Added Tax (VAT) funding will have no impact on whether fee for service medicine at the end of life continues, except for the fact that more adequate funding makes the need to save costs less urgent.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

One form of increased funding could very well be higher Part B and Part D premiums. This has been suggested by both the Fiscal Commission and the Bipartisan Policy Center. In order to accomplish this, however, a higher base premium in Social Security would be necessary. Our proposal is that to do this, the employee income cap on contributions should actually be lowered to decrease the entitlement for richer retirees while the employer income cap is eliminated, the employer and employee payroll taxes are decoupled and the employer contribution credited equally to each employee at some average which takes in all income. If a payroll tax is abandoned in favor of some kind of consumption tax, all income, both wage and non-wage, would be taxed and the tax rate may actually be lowered.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding), regardless of whether Part B and D premiums are adjusted. If the same consumption tax pays both retirement income and government health plans, the impact on the taxpayer is exactly nil in the long term.

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Adoption of the NBRT does offer some interesting questions to the extent that offsets are allowed. This shifts the ethical locus from the government to employers, although the government would, of course, require superior coverage to use any offsets. Still, the decision-makers on the ground would not be someone at CMMS, but someone in the corporate benefits office. While the practice of buying life insurance for employees with the firm as beneficiary certainly mitigates the cost, it might also appear ethically problematic if the payout encourages the disconnection of support earlier than the family finds comfortable.

The form of the employer's company providing care in lieu of tax payment matters in this case. A firm with outside shareholders, even if it is a model of compassion, will always be looked upon as potentially untrustworthy in allocating end of life care, especially given their greater incentive to do so to minimize costs which would otherwise go to profit. Employee-owned firms, however, might be regarded as more trustworthy making these decisions, since employees would be responsible to each other rather than to outside owners for cost minimization. We believe such firms are less likely to force hard end of life choices on widows, at least for financial considerations.

As we have stated previously, shifting the Old Age, Survivors and Disability Insurance Employer Payroll Tax to a VAT-like Net Business Receipts Tax can facilitate the accumulation of employee-owned shares, especially if a faster transition which includes current retirees, who must be made whole (with some of these transition funds being provided by the U.S. Treasury from the OASI Trust Fund), will result in a lower NBRT levy immediately and in the future. Converting retained equity to employee-ownership may give some firms the opportunity to transition far quicker than any other plan envisions.

These proposals can solve the problem of rural health care as well. Provided employers don't relocate (and more employee-ownership makes this less likely), the infrastructure which provided health care to workers would continue to exist for retirees. Employee-owned firms might also take on sponsoring the training of doctors with the condition that they locate in rural areas where they operate and have retirees.

In a single payer or public option system, incentives can be paid to doctors who move to rural areas. Of course, if we simply expanded the Uniformed Public Health Service to a British style National Health System, there is no issue of where doctors want to practice, they would simply be assigned to the areas where they were needed.

Currently, much in the way of rural health care comes from members of the Catholic Health Association. In our previous example, end of life care was provided in such a hospital in a rural area. As long as these hospitals continue to exist, there will be some base of health care in rural areas – provided we as a nation do not take advantage of their charity by cutting provider rates with the expectation that they will always be a low cost provider or raise money to pick up the slack. The Sisters who own and run these hospitals have a retirement income crisis of their own, so deliberately underpaying them is not a good long term strategy for assuring rural health care exists in the long term.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304
571-334-8771
fiscalequity@verizon.net

Committee on Ways and Means

Subcommittee on Health

Hearing on MPAC's March Report to Congress

March 15, 2013, 9:30 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

March 27, 2013

Ways and Means Committee Office
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Attention Chairman Kevin Brady (R-TX):

Report to Congress: Medicare Payment Policy Submission

I am pleased that the Committee will be receiving Dr. Glenn Hackbarth, Medicare Payment Advisory Commission (MedPac), to deliver a testimony on the annual review of Medicare Payment policies and related recommendations. Accord to MedPac (2013), the 2013 report includes payment policy recommendations for 10 of the health care provider sectors in fee-for-service (FFS) Medicare. MedPac also reviews the status of Medicare Advantage (MA) plans and prescription drug plans (Part D) and makes recommendations of MA special needs plans.

Whereas, I have read the 2013 Annual Report delivered to Congress, and I applaud MedPac for its quality data and sound recommendations that it makes, I do have only a few concerns with a few of the FFS payment update recommendations. It is my hopes that the Committee would address my concerns with the witness, during the hearing.

1. Physicians and other healthcare professionals: The Congress should repeal the substantial growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program. ***I am very concerned that if the Congress accepts the Commission's recommendation of annually reducing payments coupled with freezes, it will result in a public health crisis for America's seniors. With an increasing proportion of Baby Boomers becoming eligible for Medicare, more of this population will depend on Medicare to provide not only lower costs, but also high quality and equal access to healthcare services. Please have Dr. Hackbarth explain how the Commission recommends this is to be done. Until we get definitive effectiveness and evidenced based data from CMS Innovation Center, I humbly believe this recommendation should be postponed.***

2. Home health agencies: The Congress should direct the Secretary to change the Medicare payment system for hospice to have relatively higher payments at the beginning of the episode and relatively lower payments per day at the length of the episode increases. ***Again, is there data that states that the severity of a hospice patient's condition lessens as the time progresses? I would hypothesize that as the severity worsens, palliative treatment increases, and costs rise. I am all for decreasing costs, but we must protect the right for patients to end life with comfort, dignity and respect. And, no payment reform should interfere with basic human rights or the provision of basic medical care.***

Mr. Chairman, thank you kindly for reviewing my concerns. If there are any questions or concerns, I can be contacted at the means below.

Kindest Regards,

Brandon G. Wilson, MS (Candidate)
George Mason University Health Systems Management Student
11704 Potomac Crossing Way, Apt. 34
Fairfax, VA 22030
Bwilso15@masonlive.gm.edu
Report to the Congress: Medicare Payment Policy

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