Hearing on the Current Status of the Medicare Program, Payment Systems, and Extenders

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

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

WITNESS

Mark Miller
Executive Director, Medicare Payment Advisory Commission
Witness Statement

WAYS AND MEANS
CHAIRMAN KEVIN BRADY

Chairman Tiberi Announces Medicare Hearing

Current Status of the Medicare Program, Payment Systems, and Extenders

House Ways and Means Health Subcommittee Chairman Pat Tiberi (R-OH) announced today that the Subcommittee will hold a hearing to review the current status of the Medicare program, changes needed to Medicare's payment systems, and Medicare programs that are set to expire before the end of the year. **The hearing will take place on Thursday, May 18, 2017 in 1100 Longworth House Office Building, beginning at 2:00 PM.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments 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 make a submission, 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 Thursday, June 1, 2017**. For questions, or if you encounter technical problems, please call (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 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 not in compliance with these guidelines will not be

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All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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 at http://www.waysandmeans.house.gov/

THE CURRENT STATUS OF THE MEDICARE PROGRAM,
PAYMENT SYSTEMS, AND EXTENDERS
Thursday, May 18, 2017
House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 2:01 p.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [chairman of the subcommittee] presiding.

Chairman Tiberi. Good afternoon. The first hearing of the Health Subcommittee of Ways and Means will come to order. As members are aware, the full subcommittee organized earlier this year ratified our subcommittee assignments. However, I would like to take the opportunity to introduce members on my side of the aisle and then will recognize Ranking Member Levin to do the same on his side of the aisle.

I will just introduce members who are actually here right now, and then will recognize members as they get here later. So to my right, Mr. Adrian Smith from Nebraska, Lynn Jenkins from Kansas, Mr. Kenny Marchant from Texas.

With that, I will yield to the gentleman from Michigan.

Mr. Levin. Thank you very much.

Mr. Thompson is next to me, a veteran member of this institution. And Brian Higgins, we welcome you back doubly. And others will be coming.

We have votes at 2:15, I think. So I guess each of us will make a brief opening and then we will go vote.

Chairman Tiberi. We will.

Mr. Levin. I yield back. Thank you.

Chairman Tiberi. Thank you, Mr. Levin. I look forward to working with members.

Mr. Levin. Mr. Blumenauer has arrived.

We are just introducing ourselves.

Chairman Tiberi. With that, I will tell you that I look forward to working together as we have talked about before.

And I would like to recognize our staff, and I will recognize Mr. Levin to do so on his side of the aisle.

First, on the Republican side, Staff Director Emily Murry, behind me, who is joined by our professional staff of Lisa Grabert, Nick Uehlecke, Stephanie Parks, and Alyssa Palisi. And also down on the end there our legislative assistant, Taylor Trott, and my personal staff, Whitney Daffner, wherever she might be, and Abby Finn.

Mr. Levin, you are recognized.

Mr. Levin. My staff led by Amy Hall, the Subcommittee staff director, Sarah Levin, no relation, and Melanie Egorin. And from our office also, Daniel.

Thank you.

Chairman Tiberi. Well, it is my pleasure to welcome Mr. Miller back to the Health Subcommittee to help us continue the discussion on our Medicare program, payment systems, and extenders. It is time we took the next steps in strengthening our Medicare program. As the committee continues to look for ways to reform Medicare, the Commission's insights and analysis will be very valuable to our efforts.

Today is a great opportunity for us to hear advice from a nonpartisan congressional support agency in order to better understand policies that will improve the program and ensure that we are making good use of taxpayer dollars. This year's March report brings us new information and data that should help strengthen our discussion in this particular area.

In his testimony, Mr. Miller will highlight numerous inefficiencies in the post-acute care space. One statistic that I personally found quite staggering is that nearly $30 billion, with a "B," in the current post-acute care baseline is being used inefficiently.

Mr. Miller will also highlight the expiring Medicare extenders. MedPAC has commented on these programs over the years, and we will use today's hearing to give everyone a refresher course.

Extending these programs has a cost, and every time we spend money in one area, we are making a decision not to fund priorities in other areas. Clearly, there are many areas that are in need of reform within the Medicare space and the Medicare program. MedPAC has proposed innovative solutions, and I look forward to hearing more from the report.

In meetings with Medicare providers around my district and State recently, there has been a resounding concern that I have heard from all of them, and that is overbearing regulations are increasing, burdening providers, and seem to be driving out and discouraging small providers in particular.

I am worried about the direction we are heading in this area. I am hopeful that my colleagues on the subcommittee, the full Ways and Means Committee, and this Congress can work together with the new administration to not only spur innovation, but reduce regulatory burdens across the Medicare program.

With that, I would like to introduce today's witness, Mark Miller, the executive director of the Medicare Payment Advisory Commission, MedPAC.

Welcome back, Mr. Miller.

And before I recognize Ranking Member Levin for an opening statement, I ask unanimous consent that all members' written statements be included in the record.

Without objection.

I recognize Ranking Member Mr. Levin.

Mr. Levin. Thank you very much, Mr. Chairman, and it is a pleasure for all of us to work with you and your colleagues.

And to you, Dr. Miller, thanks for joining us today and for the important role that MedPAC plays in informing Medicare policy. We have had a chance to look at your report, maybe not read each page, it is the long one, but an excellent executive summary.

And, unfortunately, as Mr. Tiberi and I have discussed, this is the first hearing of this subcommittee. And I regret that we did not have an earlier hearing on the consequential health legislation that the Republicans introduced and passed.

That bill, as we know, would have taken away coverage from 24 million Americans while handing out nearly $1 trillion in tax cuts, primarily for the wealthy, indeed, the very wealthy, and corporations. It would cut Medicaid by cutting more than $800 billion from the program and shifting costs to patients. It would allow States to eliminate or weaken crucial market reforms, including essential health benefits, community rating, and protections for older workers.

It was opposed by doctors, hospitals, patients, AARP, almost everybody who is a participant in the work that you do, Dr. Miller, though all of our colleagues here on the Republican side did vote for it.

But this hearing is about Medicare. With all that is deeply harmful in the basic law or legislation that the Republicans passed, there has been much less attention paid to the damage that bill would do to Medicare.

The bill eliminates the 0.9 percent payroll tax on high earners, depriving the Medicare Hospital Insurance Fund of $75 billion in order to benefit people making more than $200,000. It grants a windfall to wealthy investors by eliminating the tax on unearned income, including capital gains and dividends.

And it would provide a $28.5 billion tax break to pharmaceutical companies, which will create a shortfall in the part B trust fund. Beneficiaries will be directly responsible if that were to pass for a portion of this shortfall, causing an $8.7 billion premium increase.

These provisions would shorten the solvency of the Medicare trust fund. What is more, they would fundamentally break a promise we heard over and over again from the President that he would not cut Medicare or Medicaid.

The Republicans have also neglected to address other important issues that Medicare faces. And let me comment briefly on perhaps the most important one, the prescription drug spending crisis. I hope we can spend some time today on that.

Skyrocketing drug costs have devastating consequences for the middle class and for Federal health programs. The Medicare trustees have told us that program spending in part D increased by 15 percent in 2015 alone.

In part B, GAO has found that Medicare often pays more for physician-administered drugs than other Federal payers, including Medicaid and the VA.

MedPAC has made a number of recommendations to address Medicare prescription drug spending. Notably, the Commission has pointed out perverse incentives that impact industry behavior and contribute to higher costs for the public.

So I hope this hearing will provide us an opportunity to discuss this and other important issues that you raise with so much depth, Dr. Miller, in your report.

I yield back.

Chairman Tiberi. Thank you, Mr. Levin.

I would remind members that this hearing is called the "Hearing on the Current Status of the Medicare Program, Payment Systems, and Extenders." I gave tremendous leeway to Mr. Levin in his opening statement, more than ever has been given to me in the minority, but we are going to keep this topic from here on out on the topic that was given to members when this committee hearing was released.

And before I ask Mr. Miller to begin, I just want to recognize some constituents in the audience. Mr. Mike Demana, a teacher at Orange Middle School in Delaware County, and some eighth grade students.

Can you stand up in the back? Mr. Demana, are you back there? Did you leave already? He left?

Mr. Levin. Is there anybody here for me?

Chairman Tiberi. Oh, no. They heard a guy from Michigan and they all bolted. Just kidding.

Mr. Levin. That is taking rivalry too far.

Chairman Tiberi. Mr. Miller.

Mr. Levin. Michigan beat Ohio State.

Chairman Tiberi. It has been a while.

Mr. Miller, you are recognized for 5 minutes. Thank you.

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

Mr. Miller. Thank you.

Chairman Tiberi, Ranking Member Levin, distinguished committee members, I am Mark Miller, the executive director of the Medicare Payment Advisory Commission. And on behalf of the Commission, I would like to thank you for asking us to testify today. As you have already mentioned, we are a small, independent congressional support agency required by law to provide analysis and recommendations to the Congress.

Our work in all instances is guided by three principals: assuring beneficiary access to high-quality care, protecting the taxpayer dollar, and paying providers and plans in a way to accomplish these goals.

With respect to the program status, Medicare spending is about $650 billion annually, 3.5 percent of GDP. Given the enrollment of the baby boom and the rates of spending per beneficiary, the Medicare program is projected to grow faster than the economy is projected to grow and continue to raise issues of affordability for both the taxpayer and the beneficiaries that finance the program.

By law, our March report makes a series of payment recommendations on various fee-for-service sectors. Each year, we produce analysis on access, supply, utilization, private equity markets, quality, and financial status.

I have recommendations across a range of fee-for-service sectors that I can discuss, but I want to focus on the fact that over the last many years the Commission has paid particular attention to the post-acute care sector. I am referring to skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

The Commission has made recommendations to restrain unnecessarily high payments, improve the equity of payment systems for both patients and

providers, improve quality measurement, and also to direct the Secretary's attention to program integrity issues.

For 2018, we recommend a 2-year payment freeze for skilled nursing facilities, a 5 percent payment reduction for home health agencies, and a 5 percent payment reduction for inpatient rehabilitation facilities. Medicare profit margins in each of these sectors is 13 percent or more and have been that way for over a decade.

In each of these sectors, we are again recommending that changes in the payment system would be made so that we pay more on the basis of patient need, and that will result in greater equity across different types of providers. We believe that if the Congress were to follow this recommendation, something like $30 billion over the next 10 years in unnecessary payments could be avoided.

In other reports, the Commission has recommended moving away from the siloed approach to post-acute care delivery and instead move towards a unified payment system for post-acute care providers, and, again, pay on the basis of patient need rather than site of care. And also, this would increase the potential to measure quality of care more accurately.

Turning to part C and part D, managed care in Medicare has continued to show strong growth, currently accounting for 31 percent of enrollment. There are multiple plans available in virtually every county of the U.S. On average, plans are bidding below fee-for-service, which is a significant improvement since 2010.

The dollar value of extra benefits that they provide has been increasing, and the Commission has made a few recommendations in this area; most notably, to recapture payments from excess coding that targets plans that are most aggressively engaged in that coding, and we have also recommended increasing the overall benchmark in MA, in order to treat plans more fairly.

In the part D drug program, beneficiary enrollment has been increasing, and there continues to be access to standalone plans, managed care plans, and plans for the low-income population.

Overall, spending growth is about 7 percent annually, but the portion of the program paid predominently by the government has been increasing at an annual rate of 20 percent. This is because the number of beneficiaries reaching

the catastrophic cap has accelerated over the last few years. They currently account for more than 50 percent of the spending.

The Commission has made three recommendations in this area to address this problem, but most notably, we recommend shifting more risk to the plans for these catastrophic costs, and to couple that with additional tools for the plans to manage that risk.

With respect to extenders, I will note that over the last several years the Commission has done work on ambulance payments, including a more targeted rural assistance policy; therapy caps, where we have tried to strike a balance between cap restraints and exceptions for needy beneficiaries; and then we have specific recommendations on each of the special needs plans categories; and finally, we have made several proposals for rural hospital payment adjustments.

And with that, I am happy to take your questions.

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Report to the Congress: Medicare Payment Policy

May 18, 2017

Statement of
Mark E. Miller, Ph. D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

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Chairman Tiberi, Ranking Member Levin, distinguished Committee Members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to discuss the Commission's March Report to the Congress 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

By law, 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 (Medicare Part D). In this year's report, we:

- consider the context of the Medicare program in terms of the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2018 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- consider post-acute care (PAC) as a whole and note that payment levels in several of the payment systems are too high and the payment systems themselves need to be revised.
- review the status of the MA plans (Medicare Part C) that beneficiaries can join in lieu of traditional FFS Medicare and recommend a change to the calculation of MA benchmarks.

- review the status of the plans that provide prescription drug coverage (Medicare Part D).

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. Our March 2017 report to the Congress includes a recommendation on MA and provides information on Part D, but most of its content focuses on the Commission's recommendations for the annual payment rate updates under Medicare's various FFS payment systems and aligning relative payment rates across those systems so that patients receive efficiently delivered, high-quality care. This testimony will also report some related recommendations from previous Commission reports including those on PAC, MA, and Part D from our March and June 2016 reports to the Congress.

We recognize that managing updates and relative payment rates alone will not solve what have been fundamental problems with Medicare FFS payment systems to date—that providers are paid more when they deliver more services without regard to the value of those additional services and are not routinely rewarded for care coordination. To address these problems directly, two approaches must be pursued. First, payment reforms, such as incentives to reduce excessive hospital readmission rates and a unified payment system for post-acute care, need to be implemented more broadly, coordinated across settings, and pursued expeditiously. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care need to be enhanced and closely monitored, and successful models need to be 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 service across sectors—an important topic. In addition, constraining unit prices could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

Context for Medicare payment policy

Part of the Commission's mandate is to consider the effect of its recommendations on the federal budget and view Medicare in the context of the broader health care system. In 2015, total national health care spending was $3.2 trillion, or 17.8 percent of GDP. Private health insurance spending was $1.1 trillion, or 5.9 percent of GDP. Medicare spending was $646.2 billion, or 3.6 percent of GDP.

Health care spending growth shows signs of acceleration after several years of historic lows. From 1975 to 2009, total health care spending and Medicare spending grew, at average annual rates of 9.0 percent and 10.6 percent, respectively. Then from 2009 to 2013, those rates fell to 3.6 percent and 4.1 percent. From 2013 to 2015, Medicare actuaries estimate that spending grew faster: National health care spending grew at an average annual rate of 5.6 percent, and Medicare spending grew at an average annual rate of 4.6 percent.

The aging of the baby-boom generation will have a profound impact on both the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary will decline. By 2030 (the year all boomers will have aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary, down from 4.6 around the time of the program's inception and from 3.3 in 2012. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2040, under federal tax and spending policies specified in current law, Medicare spending combined with spending on other major health care programs, Social Security, and net interest on the national debt will exceed total projected federal revenues and will thus either increase federal deficits and debt or crowd out spending on all other national priorities. Projected Medicare spending has the potential to increase the national debt—which was 74 percent of the GDP in 2015—to even higher levels. The Medicare trustees project that nominal Medicare spending will grow at a rate of 7 percent per year, outpacing nominal GDP growth of 5 percent per year.

Some health care spending is inefficient. For Medicare, eliminating such spending would result in improved beneficiary health, greater fiscal sustainability for the program, and reduced federal budget pressures. Certain structural features of the Medicare program pose

challenges for targeting inefficient spending, but the Commission has a framework to address those challenges that focuses on payment accuracy and efficiency, care coordination and quality, information for patients and providers, engaged beneficiaries, and an aligned health care workforce.

Update recommendations

As required by law, the Commission annually makes payment update recommendations 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 payment system 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 (2017) 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 (policy year 2018). As part of the process, we examine payments to support the efficient delivery of services consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professionals, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health care agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years using the most recent data available to make sure our recommendations accurately reflect current conditions. We may also consider recommending changes that redistribute payments among providers within a payment system to correct biases that may make patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. Finally, we may also make recommendations to improve program integrity.

In light of our payment adequacy analyses, we recommend no payment update in 2018 for four FFS payment systems (long-term care hospital, hospice, ambulatory surgical center, and skilled nursing facility) and reductions of 5 percent of the base payment for the home health and inpatient rehabilitation facility payment systems. We have determined that the resulting

payments will be adequate and will not undermine beneficiaries' access to services in these sectors. For four of these sectors, we include additional elements beyond the payment update to improve payment accuracy:

- requiring ambulatory surgical centers to submit cost data;
- freezing skilled nursing facility payment rates for two years while the payment system is revised, to better tie payments to patient characteristics;
- reducing the home health base payment and revising the payment system to better tie payments to patient characteristics; and
- reducing the inpatient rehabilitation facility base payment and expanding the inpatient rehabilitation facility outlier pool to more equitably cover the cost of expensive patients.

More broadly, changes need to be made in the post-acute care payment systems (i.e., the skilled nursing facility, home health agency, inpatient rehabilitation facility, and long-term care hospital payment systems), and the cost of inaction is mounting. Ideally, the post-acute care sectors would be brought together under a unified payment system that would base payments on patient characteristics. Such a system could both lower costs and ensure access for patients who may be financially less desirable under current payment systems.

In the other sectors (acute care hospital, physician and other health professionals, and outpatient dialysis), we recommend the updates in current law. For the hospital sector, we also recommend tracking claims at off-campus stand-alone emergency department facilities to allow CMS to monitor this growing class of providers.

Hospital inpatient and outpatient services

In 2015, the Medicare FFS program paid 4,700 hospitals $178 billion for about 10 million Medicare inpatient admissions, 200 million outpatient services, and $8 billion of non-Medicare uncompensated care costs. This sum represents a 3 percent increase in hospital spending from 2014 to 2015. On net, inpatient payments increased by $2 billion and outpatient payments increased by almost $4 billion. Inpatient payments increased because of

slight increases in prices, patient severity, and inpatient volume. Outpatient payments rose because of volume increases, price increases, and the continued shift of services from lower cost physician offices to higher cost hospital outpatient settings.

Most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. However, in 2015, hospitals' aggregate Medicare margin was –7.1 percent. While average Medicare payments were lower than average costs, Medicare payments were higher than the variable costs of treating Medicare patients in 2015—resulting in a marginal profit of about 9 percent. Therefore, hospitals with excess capacity still have a financial incentive to serve more Medicare patients. Thus, the Commission recommends that the Congress update the inpatient and outpatient payment rates by the amounts specified in current law (approximately 1.85 percent) for 2018.

It is imperative that Medicare continue to restrain payment rates for hospitals. Although hospital margins on Medicare are negative, hospital all-payer margins reached a 30-year high in 2014, averaging 7.3 percent nationwide. This is possible because commercial rates on average are 50 percent higher than hospital costs and Medicare rates, in part because of hospitals' increasing market power resulting from continued hospital consolidation. Furthermore, high commercial rates are linked to high costs. When a hospital receives higher payments from commercial payers, the financial pressure on the hospital is lower. It therefore has less incentive to keep its costs low. For example, we found that hospitals with high private-payer profits from 2009 to 2013 had higher standardized Medicare costs per case in 2014—2 percent above the national median—and lower Medicare margins (–8 percent). In contrast, hospitals with low private-payer profits over the same period had much lower costs per case (9 percent less than the national median). What is more, they were far more likely to have positive Medicare profit margins, posting a median Medicare margin of 6 percent.

A recent phenomenon is the growth in stand-alone emergency departments (EDs). In 2016 there were over 500 stand-alone EDs, almost all in metropolitan areas with existing ED capacity. Moreover, they tend to be located in ZIP codes with higher household incomes and higher shares of privately-insured patients. Some are independent facilities, while others are off-campus EDs associated with a hospital that bills Medicare. Available data suggest that

the mix of patients served by stand-alone EDs more closely resembles the mix of patients treated at urgent care centers than the mix of patients treated in on-campus hospital EDs. However, Medicare pays stand-alone EDs at the same rates as on-campus hospital EDs. An issue to investigate is whether Medicare may be paying too much for these services. (This also can be an issue for privately-insured patients, who may receive a "surprise" bill for services that they thought would be covered at an in-network urgent care rate and instead were billed at an out-of-network ED rate.) Problematically, CMS is currently unable to track growth in off-campus ED claims because the claims are not distinguished from hospitals' on-campus ED claims. Therefore, the Commission recommends that the Secretary require hospitals to add a modifier on claims for all services provided at off-campus stand-alone EDs to allow CMS to track payments to this growing category of providers.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. In 2015, Medicare paid $70.3 billion for physician and other health professional services, accounting for 15 percent of FFS Medicare benefit spending. About 919,000 clinicians billed Medicare—over 581,000 physicians and nearly 338,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

The Commission's payment adequacy indicators suggest that payments for physicians and other health professionals are adequate. Access for Medicare beneficiaries is largely unchanged from prior years and comparable to access for those with private insurance. In addition, the share of providers enrolled in Medicare's participating provider program remains high. Medicare pays for the services of physicians and other health professionals using a fee schedule. Under current law, Medicare's conversion factor for the fee schedule will be updated by 0.5 percent in 2018. The Commission recommends an update for 2018 consistent with current law.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not

require an overnight stay after the procedure. In 2015, nearly 5,500 ASCs treated 3.4 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about $4.1 billion.

Most of the available indicators of payment adequacy for ASC services are positive. For example, the number of ASCs and the volume of ASC services per beneficiary both grew in 2015, indicating increased access to these services. In addition, Medicare payments per FFS beneficiary increased by an average of 2.8 percent per year from 2010 through 2014 and by 5.2 percent in 2015. Because ASCs do not submit data on the cost of services they provide to Medicare beneficiaries, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy. Based on available indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2018. In addition, the Commission again recommends that CMS collect cost data from ASCs without further delay.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2015, nearly 388,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from nearly 6,500 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services using a prospective payment system (PPS) based on a bundle of services. The bundle includes certain dialysis drugs and ESRD-related clinical laboratory tests that were previously paid separately. In 2015, Medicare expenditures for outpatient dialysis services were $11.2 billion, a slight decline of 0.1 percent compared with 2014 Medicare dialysis expenditures.

Our payment adequacy indicators for outpatient dialysis services, including access and quality, are generally positive. For example, growth in the number of dialysis treatment stations was slightly faster than growth in the number of dialysis beneficiaries. We estimate that the aggregate Medicare margin was 0.4 percent in 2015, and the rate of marginal profit was 16.6 percent. The Commission recommends that the Congress increase the outpatient dialysis base payment rate by the update specified in current law for 2018 (approximately 0.7 percent).

Post-acute care

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2015, FFS program spending on PAC services totaled $60 billion.

For more than a decade, the Commission has worked extensively on PAC payment reform, proposing closer alignment of costs and payments, more equitable payments across different types of patients, and tying payment to outcomes-based quality measures. But, though there has been some progress on the quality and value-based purchasing fronts, payments remain high relative to the costs of treating beneficiaries. Over the last decade, HHA and SNF Medicare margins averaged 15.6 percent, even after rebasing and productivity and other payment adjustments mandated by the Congress. IRF margins have been high as well, averaging 10.9 percent over the last decade. The average margin for LTCHs has been considerably lower, though still above 5 percent for most of the last decade and higher for stays that meet the new criteria to receive LTCH PPS payments. Within each setting, disparities in financial performance across providers reflect differences in costs, admitting practices, coding strategies, and the amount of therapy provided.

Because the level of PAC payments has been high relative to the cost of treating beneficiaries, the Commission, for many years, has recommended lowering and/or freezing Medicare's payment rates. The Commission has recommended no updates to payments (a 0 percent update) or reductions to payments each year since 2008 for HHAs, SNFs, and IRFs and since 2009 for LTCHs. Yet during this period, without Congressional action, SNF, IRF, and LTCH payments were increased. For HHAs, although the Patient Protection and Affordable Care Act of 2010 calls for annual rebasing of payments, the mandated reductions have been offset by payment updates and, consequently, do not go nearly far enough in realigning payments to costs.

In addition to the high levels of payment, there remain inequities in payments to PAC providers that encourage patient selection and financially advantage some providers over

others. The Commission has recommended key revisions to the SNF (in 2008) and HHA (in 2011) payment systems that would increase the equity of payments. The Commission's recommended changes would base payments on the clinical, functional, and demographic characteristics of patients, not on the amount of therapy furnished. The revised designs would rebalance payments between therapy cases and medically complex cases, which would shift payments from the relatively more profitable (typically for-profit and freestanding facilities) to the relatively less profitable (typically nonprofit and hospital-based) providers. For example, we estimate that a redesigned SNF PPS would have raised payments to facilities with low shares of therapy days (by 16 percent), facilities with high nontherapy ancillary costs (by 12 percent), facilities with low shares of intensive therapy (by 21 percent), and nonprofit facilities (by 4 percent). These shifts in payments would have narrowed the differences in financial performance across the industry. CMS has conducted extensive research on a new SNF PPS design and recently issued an advance notice of proposed rule-making that could make much-needed changes to the payment system. However, implementation continues to be delayed. CMS has proposed an alternative design for the HHA PPS, but there is no time line for its implementation.

For IRFs, in 2016 the Commission recommended changes to the outlier policy that would redistribute FFS payments among IRFs, ameliorating the financial burden for providers that have a relatively high share of costly cases whose acuity may not be well captured by the case-mix system. That same year, the Commission also recommended that the Secretary conduct focused medical record reviews of IRFs with unusual patterns of case mix and coding as an initial step in discerning whether observed differences reflect real differences in patient acuity. As early as 2007, the Commission identified the need to limit IRF payments to only patients appropriate for this intensive level of care and since has supported CMS's efforts to do so.

The cost to the program of not implementing the Commission's recommendations is substantial. Medicare is paying more for services than it needs to. Across the PAC settings, if this year's update recommendations were enacted, we estimate that FFS program spending would be reduced by more than $30 billion over the next 10 years, all else being equal. Looking back, the cost of past inaction is also considerable. For example, we estimate that,

had the 2008 update recommendations for HHAs and SNFs (for fiscal year 2009) been implemented, FFS program spending would have been $11 billion lower by 2017, all else being equal. Failure to implement payment reforms also unfairly advantages some providers over others and sends the wrong price signals, encouraging providers to furnish unnecessary care and to prefer to treat some patients over others. Further, since FFS payment rates form the basis of Medicare Advantage benchmarks and a variety of current and future alternative payment models, the overpayments and payment system design issues affect non-FFS payments as well. In addition, unnecessarily high payments contribute to the projected insolvency of the Hospital Insurance Trust Fund, estimated to occur in 2028.

The Commission has also sought to increase the equity in payments across PAC settings. In 2015, the Commission performed an extensive comparison of the patient characteristics and outcomes for 22 conditions frequently treated in both IRFs and SNFs. The Commission concluded that there were no substantial differences in the patients treated and the outcomes in the two settings and recommended that the payment differences between IRFs and SNFs for these conditions be eliminated. By paying IRFs the lower SNF payment rates for the select conditions, we estimated that spending would be lower by between $1 billion and $5 billion over five years. In 2014, the Commission recommended changes to LTCH payments that would restrict LTCH payments to patients who are chronically critically ill (CCI). Payments for non-CCI patients would be aligned with those paid for similar patients under the acute care hospital PPS (the hospital PPS rates are much lower).

Finally, in June 2016, as required by the Congress, the Commission outlined the key design features of a unified payment system that would span the four PAC settings. Underpinning this work is the recognition that many similar patients are treated across the four settings. Like the recommended designs for SNF and HHA PPSs, the unified PAC payment system would base payments on patient characteristics, not services furnished, and would redirect program payments toward medically complex patients and away from patients who receive therapy services unrelated to their care needs. CMS could begin to implement a uniform PAC PPS as soon as 2021, using a transition that blends setting-specific and PAC PPS rates.

In the meantime, the Congress and CMS need to correct the considerable overpayments in the existing PAC payment systems, and CMS should move forward with revisions to the SNF and HHA PPSs. With consistent incentives, those revised payment systems will give providers valuable experience in managing care under payment systems that tailor payments to the care needs of patients. The Commission's 2017 recommendations for the four PAC settings are described below.

Skilled nursing facility services

SNFs provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2015, about 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million FFS beneficiaries. Medicare FFS spending on SNF services was $29.8 billion in 2015.

Key measures indicate that Medicare payments to SNFs are adequate. Access to SNF care remains good. The number of SNFs participating in Medicare is stable, and the vast majority (88 percent) of beneficiaries live in a county with three or more SNF options; less than 1 percent of beneficiaries live in a county without a SNF option. Measures of quality are stable or improving. We also find that relatively efficient SNFs—facilities identified as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies. In 2015, the average Medicare margin was 12.6 percent—the 16th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities, reflecting differences in costs and shortcomings in the SNF PPS, which favors treating rehabilitation patients over medically complex patients. The marginal profit was at least 20.4 percent. Medicare needs to revise the PPS and rebase payments. Over time, the overpayments for therapy services have gotten larger (giving providers an even greater incentive to furnish therapy services of questionable value), and payments for nontherapy ancillary services (most notably drugs) are even more poorly targeted than in prior years. In addition, Medicare Advantage (managed care) payment rates to SNFs are considerably lower than the program's FFS payments.

The Commission recommends that no update to SNF payment rates be made for two years (2018 and 2019) while the SNF PPS is revised. Then, in 2020, the Secretary should evaluate

the need to make further adjustments to payments to bring them into better alignment with costs. This recommendation is consistent with our recommendation from 2016, and it reflects concerns about the SNF PPS that we have expressed for many years. The Commission has been frustrated by the delay in lowering the level of payments and revising the payment system.

Home health care services

HHAs provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2015, about 3.5 million Medicare beneficiaries received care, and the program spent about $18.1 billion on home health care services. In that year, over 12,300 agencies participated in Medicare.

The indicators of payment adequacy for home health care are generally positive. Access to home health care is adequate, with 86 percent of beneficiaries living in a zip code with five or more agencies, and more than 99 percent living in a zip code with at least one agency. In 2015, agencies increased the volume of services provided to beneficiaries. Agencies' performance on quality measures improved. Medicare margins for freestanding agencies averaged 16.5 percent between 2001 and 2014 and were, on average, 15.6 percent in 2015. The marginal profit for HHAs in 2015 was 18.1 percent.

The high Medicare margins of HHAs over multiple years have led the Commission to recommend a 5 percent reduction in the home health base rate for 2018 and a two-year rebasing beginning in 2019. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and taxpayers without impeding access to home health care services.

We also are recommending, as we have for the last five years, that Medicare revise the payment system to base payments on patient characteristics and eliminate the use of the number of therapy visits as a payment factor in the home health PPS, beginning in 2019. A review of utilization trends and further research by the Commission and others suggest that this aspect of the PPS creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care. Eliminating the number of therapy visits as

a payment factor would base home health payment solely on patient characteristics, a more patient-focused approach to payment.

Inpatient rehabilitation facility services

IRFs provide intensive rehabilitation services to patients after an illness, injury, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology services, as well as prosthetic and orthotic services. In 2015, Medicare spent $7.4 billion on FFS IRF care provided in about 1,180 IRFs nationwide. About 344,000 beneficiaries had more than 381,000 IRF stays. On average, Medicare accounts for about 60 percent of IRFs' discharges.

Our indicators of Medicare payment adequacy for IRFs are generally positive. Although the volume of IRF cases increased in 2015, capacity remains adequate to meet demand. Most measures of quality are stable or improving. Between 2014 and 2015, the aggregate IRF Medicare margin rose from 12.4 percent to 13.9 percent. The aggregate margin has risen steadily since 2009. Medicare payments to hospital-based IRFs in 2015 exceeded marginal costs by 20.5 percent, indicating that hospital-based IRFs with available beds have a strong incentive to admit Medicare patients. Medicare payments to freestanding IRFs exceeded marginal costs by 41.5 percent.

The Commission has recommended that the update to IRF payments be eliminated each year since fiscal year 2009. However, in the absence of legislative action, CMS has been required by statute to apply an adjusted market basket increase. Thus, payments have continued to rise.

Based on these factors, the Commission recommends that the IRF payment rate for fiscal year 2018 be reduced by 5 percent. The reduction in the payment rate should be coupled with an expansion of the high-cost outlier pool, as previously recommended by the Commission, to redistribute payments among IRFs and reduce the impact of potential misalignments between IRF payments and costs.

Long-term care hospital services

LTCHs provide care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and certain Medicare patients must have an average length of stay greater than 25 days. In 2015, Medicare spent $5.3 billion on care provided in LTCHs nationwide. About 116,000 FFS beneficiaries had roughly 131,000 LTCH stays in about 426 LTCHs. On average, Medicare FFS beneficiaries account for about two-thirds of LTCHs' discharges.

The indicators for payment adequacy are stable. A Congressional moratorium on new LTCHs has limited growth in the number of providers, but the average LTCH occupancy rate suggests that capacity is adequate to meet demand. The number of LTCH cases per FFS beneficiary has declined about 2 percent per year since 2012. The aggregate 2015 Medicare margin was 4.6 percent. The 2015 margin for cases that would qualify to receive the full LTCH payment rate under new payment policies beginning in 2016 was 6.8. Marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit more Medicare patients, equaled 20 percent in 2015. We expect changes in admission patterns and cost structure will occur in response to the patient-specific criteria implemented beginning in fiscal year 2016.

Based on these indicators, the Commission concludes that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs with no update to LTCH payment rates in 2018.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2015, more than 1.38 million Medicare beneficiaries (accounting for nearly 49 percent of decedents) received hospice services from about 4,200 providers, and Medicare hospice expenditures totaled about $15.9 billion.

The indicators of payment adequacy for hospices are positive. For example, hospice use, the number of hospice providers, and the proportion of beneficiaries using hospice services at the end of life all continued to grow in 2015. The aggregate 2014 Medicare margin was 8.2 percent. In addition, the rate of marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was roughly 11 percent in 2014. Because the payment adequacy indicators for which we have data are positive, the Commission recommends eliminating the update to hospice payment rates for 2018.

The Medicare Advantage program

In 2016, the MA program included 3,500 plans, enrolled more than 17.5 million beneficiaries (31 percent of all beneficiaries), and paid MA plans about $190 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk-coding practices, and current quality indicators in MA. As a result of the analyses, we include a recommendation to improve how benchmarks are calculated. In our March 2016 report to the Congress, the Commission made additional recommendations concerning coding intensity, quality measurement, and payment for quality.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from previous levels, which were generally higher than FFS, and be set so that the payment system is neutral—not favoring either MA or the traditional FFS program.

Legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending

while enrollment in MA continues to grow. The pressure of lower benchmarks has led to improved efficiencies that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive. Lower benchmarks have also led plans to bid more competitively; bids have decreased from about 100 percent of FFS to about 90 percent of FFS in 2017. For 2017, about two-thirds of plans, accounting for about 75 percent of projected enrollment, bid below FFS.

Including quality bonuses, we estimate that 2017 MA benchmarks will average 106 percent of FFS spending, bids 90 percent of FFS, and payments 100 percent of FFS. (However, because MA plans code more intensively, we estimate payments are effectively about 104 percent of FFS rather than the nominal 100 percent.) On average, the quality bonuses in 2017 will add 4 percent to the average plan's base benchmark and will add 3 percent to plan payments. Removing quality bonuses from the benchmarks, base benchmarks would average 102 percent of FFS in 2017.

In addition, there are county-level equity issues regarding the calculation of MA benchmarks and payments. When CMS calculates the county-level FFS spending measure, on which the benchmarks are based, it includes all of a county's FFS beneficiaries, regardless of whether these FFS beneficiaries are enrolled in both Part A and Part B. MA beneficiaries, however, are required to enroll in both Part A and Part B to join an MA plan. To make the calculation equitable across counties, the Commission recommends that the Secretary calculate benchmarks using FFS spending data only for beneficiaries enrolled in both Part A and Part B.

Making this change would increase spending under the Medicare program, which could be offset by implementing our March 2016 recommendation on coding intensity. The Commission recommended that CMS change the way diagnoses are collected for use in risk adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity. Specifically, the Commission recommended the use of two years of diagnostic data (and excluding diagnoses from health risk assessments) for risk adjustment and applying a coding adjustment that fully accounts for any remaining differences in coding between FFS and MA plans. We also

outlined a three-tier approach for that adjustment rather than the current across the board adjustment. An additional recommendation to improve equity across counties was to eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties.

The Medicare prescription drug program (Part D)

In 2015, the Medicare program spent $80.1 billion for the Part D benefit, accounting for 12 percent of total Medicare outlays. Enrollees' out-of-pocket spending for premiums and cost sharing totaled $11.5 billion and $15.1 billion, respectively. In 2016, 41 million individuals (72 percent of all Medicare beneficiaries) were enrolled in Part D; of those enrolled, 60 percent were in stand-alone prescription drug plans (PDPs) and 40 percent were in Medicare Advantage–Prescription Drug plans (MA–PDs). In general, Part D has improved Medicare beneficiaries' access to prescription drugs, with plans available to all individuals.

Our status report on the Medicare prescription drug benefit established under Part D describes beneficiaries' access to prescription drugs, enrollment levels, plan benefit designs, and the quality of Part D services. For example, beneficiaries have between 18 and 24 PDPs to choose from depending on where they live, as well as typically 10 or more MA–PD options. In addition, all regions of the country continue to have at least 3 and as many as 10 PDPs available at no premium to the 12 million beneficiaries receiving the low-income subsidy. The report also analyzes changes in plan bids, premiums, and program costs.

Part D program spending grew at an annual rate of 7.1 percent from 2007 to 2015. The growth rate of its four components (reinsurance and direct, low- income, and retiree subsidies) varies widely. For example, reinsurance, the largest of the four components of Part D spending in 2015 ($34.3 billion), grew at an annual rate of 20 percent from 2007 to 2015. In contrast, the direct portion of the Part D subsidy has grown at an annual average rate of less than 1 percent over the same period. Medicare reinsurance pays 80 percent of an enrollee's spending above the out-of-pocket threshold; the catastrophic phase of Part D's benefit. Nine percent of enrollees reached the catastrophic phase in 2014 and accounted for over half of the value of gross claims.

The Commission made a set of recommendations in its June 2016 report to the Congress to address concerns about Part D's financial sustainability and affordability for its enrollees while maintaining the program's market-based approach. One component of the Commission's June 2016 recommendations would reduce Medicare's reinsurance while, at the same time, increasing capitated payments to plan sponsors. The recommendations would also provide sponsors with greater flexibility to manage their drug formularies in return for accepting more risk.

Collectively, the recommendations make up a package of interrelated steps. One set of changes would give plan sponsors greater financial incentives and stronger tools to manage the benefits of high-cost enrollees. Medicare's overall subsidy of basic Part D benefits would remain unchanged at 74.5 percent, but plan sponsors would receive more of that subsidy through capitated payments rather than open-ended reinsurance. Over a transition period, Medicare would significantly lower the amount of reinsurance it pays plans from 80 percent of spending above Part D's out-of-pocket (OOP) threshold to 20 percent. When combined with the Commission's recommendation to provide greater OOP protection, the insurance risk that plan sponsors shoulder for catastrophic spending would rise commensurately from 15 percent to 80 percent.

At the same time, plan sponsors would be given greater flexibility to use formulary tools to manage benefits (e.g., more opportunities to update their formularies, removing some protected classes of drugs (antidepressants, immunosuppressants), better tools for managing specialty drugs). Other parts of the Commission's recommendations would exclude manufacturer discounts on brand-name drugs from counting as enrollees' true OOP spending, but would also provide greater insurance protection to all non-LIS enrollees through a real OOP cap that would have no cost sharing once a beneficiary reaches the cap (although some enrollees would incur higher OOP costs than they do today). The recommended improvements would also moderately increase financial incentives for LIS enrollees to use lower cost drugs and biologics.

Chairman Tiberi. Thank you, sir.

Mr. Miller, your testimony reflected some of the Medicare extenders in writing and these programs that Congress needs to address and determine whether we should extend them or not. Many of these programs have been extended several times in the past without any policy modifications.

And, by the way, for members, that is a vote that is occurring. And there are two votes, my belief is. And so we are going to begin asking questions, and Mr. Miller has agreed to sit tight while we go vote and come back. So I am going to begin the questioning. If you feel you need to skedaddle over there, please do and please come back after the votes. Yes, we will come back.

So, Mr. Miller, can you talk through each of the extenders and what MedPAC has concluded about each one of them?

Mr. Miller. In 5 minutes, that is a little bit difficult. Well, what I do want to say really quickly is all of this has analysis and detailed work behind it, but I will just try and hit you with the top line.

Special needs plans. We have made recommendations for each of the categories. We have recommended continuing the institutional special needs plans.

With respect to Dual-Eligible special need plans, we have recommended that you continue those, but you have a requirement for integrated care between Medicare and Medicaid.

For the chronic care special needs plans, we have said that for dominant conditions like AIDS and ESRD they make sense, but for conditions like diabetes and congestive heart failure, we would create greater flexibilities in the regular MA plans to basically replicate a special needs type of model in the regular plans and would discontinue those.

On hospital payment, there is a low-volume adjuster, which we originally made recommendations that the Congress should take up, which it did. And with all respect, our point here is that it hasn't been constructed properly. It keys off the number of Medicare admissions when it should key off of the total admissions. And I can take that up on questions, just in the interest of keeping moving along.

We also think that there are adjusters like Medicare-dependent hospitals, those types of adjusters. And the two concerns I will express there is often two adjusters that are aimed at the same problem: Medicare-dependent hospital, a low-volume adjuster, as the case may be.

We think you should be very conscious of duplication. And when the adjuster goes to the provider, be conscious of the distance it is from another provider, because you don't want to be sending a subsidy to two hospitals that are, say, within 10 miles of each other and you are basically propping up two operations that are having a hard time meeting their fixed costs.

On ambulance, we have generally let the extenders expire and then reorganized the fee schedule to focus less on basic life support transports and more on advanced life support, basically rebalanced the payments there. And then we also took one of the adjusters for rural providers and target it to low-density counties where you would have a harder time covering your fixed costs.

And I can stop any time.

Chairman Tiberi. No, keep going.

Mr. Miller. On the therapy cap, what we have said is that there is an extreme variation in the utilization of outpatient therapy. I want to be really clear, we think it is a very valuable benefit and we are thinking that there is evidence that it helps beneficiaries, but we also think it is relatively open to abuse.

So we would adjust the caps downward to about the 70th percentile of the distribution, but couple that with a review of exceptions that make specific decisions about the exceptions outside of the cap instead of a blanket check box type of exception.

I am going to stop there. I am sure I have left something out.

Chairman Tiberi. We can come back to it if you remember later, or we can ask you a question on the second round.

Mr. Miller. I am sure I left something out.

Chairman Tiberi. Mr. Miller, you and I have had private discussions in the past about the freestanding emergency departments that are popping up around parts of the country, and there seems to be a new one popping up every month or so in my State of Ohio.

This is a topic that I know MedPAC will be publishing in its June report and be released about a month from now. Can you give us a preview? Are you allowed to do that?

Mr. Miller. I will do that. I will also go back a little bit in history. We have talked about this in our June 16 report, and we have also talked about it in the report we are talking about here. This is the one where we said that we should be collecting claims identified for on and off campus, because we are really blind right at the moment in kind of analyzing this phenomenon.

The Commission is very concerned about this. There has been a lot of growth. There is concern that growth is occurring in markets where they are either saturated or relatively high income, not necessarily poor populations. And in June, we won't have additional recommendations, but we are going to identify three or four issues for us to think about and then come back with recommendations.

So one thing we are beginning to get concerned about is that the mission of an off-campus emergency room in the patient population and the intensity of service may not look like your standard on-campus emergency room. And so maybe we need to start thinking about a payment structure that reflects the fact that they have a different patient mix and in some ways a different mission.

A second thing is, in the legislation that the Congress passed on site-neutral, where the Congress was saying after a certain date if you purchase a physician practice you don't get the richer outpatient rates, we are concerned that there is a provision in there that if you attach services to an emergency room, you can actually get around that prohibition. And we will be discussing that.

The last thing I wanted to bring up is in the rural areas. We think there may be a role for freestanding emergency rooms in isolated rural communities or in isolated rural communities that don't have the patient population to support a full-scale inpatient operation. And we have ideas that we have been talking through where you could restructure the inpatient subsidies and support freestanding emergency rooms in isolated rural areas.

So it is not that freestanding emergency rooms have no role anywhere. We have concerns about their growth in certain areas of the country, and then we think we have probably not got quite the right incentives out in the rural areas.

Chairman Tiberi. One follow-up. So if you have the Diane Black main hospital, so you have the main hospital with the main emergency department,

and then 10 miles away you have the freestanding emergency department. Does Medicare get data on the visits to that 10-mile-away facility, or is it part of the main hospital emergency department?

Mr. Miller. It is all mashed together.

Chairman Tiberi. So Medicare or you at MedPAC, can't discern if I go to the freestanding one or the main one.

Mr. Miller. We cannot, and we are concerned about that. And that was the recommendation we made here in this report to say that CMS should begin to develop a modifier so that when this claims flow comes in, we know it is occurring on or off campus.

Chairman Tiberi. Great. Thank you. Thank you so much.

Mr. Miller. I understand you have got to break.

Chairman Tiberi. When we get back, I am going to yield to Mr. Levin for his questioning. And we will be back in a few minutes.

Thank you. This hearing is recessed until we get back. Thank you.

[Recess.]

Chairman Tiberi. Our hearing is going to come back to order. I have been joined by a few of my colleagues who weren't here when I did the introduction. So I just want to recognize the members who are here now. Peter Roskam from Illinois, Eric Paulsen from Minnesota -- did I say that right, Minnesota? And Tom Reed from New York. With that, I will yield 5 minutes to the gentleman from the State up north from Ohio, Mr. Levin.

Mr. Levin. You are still bitter about some of the back and forth between our two States. I don't think Ron Kind was here when we introduced ourselves, or Judy Chu. And Earl was here part of the time.

So Dr. Miller, welcome. As I read your report, your testimony, and also the executive summary, I was just struck by the thoroughness of the work you do. A lot of the issues are controversial. I remember when we first talked about controlling payments to physicians, and the heck that we received, and how much controversy there was. And you thought the sky was falling and it would never work out for physicians.

And I mention that because I really think your report -- and it has areas where there are differences of opinion -- your report shows how successful this has been, this program. It is in some respects a public, but not only public, but public and private partnership, and with a lot of back and forth from the private sector, as reflected in your report.

And I just want to comment for each of us on this committee, on this subcommittee, that when we go home we have lots of meetings with the various providers, the various groups, and they have differences of opinion, and they have some urgent pleadings. But I really think your report shows why Medicare is such a necessary and popular program for the people of this country. And not only for those who are covered by it, but by their families who benefit, because those who are older than others in the family have the security of healthcare.

So without saying I agreed with everything you said, I wanted to congratulate you on your work. And I hope, Mr. Chairman, that we will be able to have some further discussions in depth about each of these important components, because I think there is a danger that each of us kind of picks and chooses one particular area where we think there is a special problem or grievance instead of looking at the program more comprehensively.

So let me start off, I think others are going to follow up on this, because prescription drugs has become so urgent an issue, begin to discuss with us how MedPAC has begun to look at this issue. And my time will run out and others will carry on. Thank you.

Mr. Miller. If I could just say one thing -- thank you for saying that. Remember, I have a tremendous staff, and also GAO has done a great job of appointing solid commissioners. So that is why you have the work that you have in front of you.

Chairman Tiberi. Thank you, Mr. Levin. With respect to the issue that you just brought up, I think that that is a really good suggestion in terms of looking at these things together. And I hope that we can do that in a bipartisan way.

Mr. Levin. I would like to. So start talking about prescription drugs. You have 48 seconds. And others will carry on.

Mr. Miller. Okay. We have done two areas of work in prescription drugs. Most relevant to our current conversation is in part D, what we have seen is generally you look at part D, more beneficiaries are being covered,

people have high degrees of satisfaction, and the premiums have been relatively level in part D.

But if you look a little bit closer at the program, there is a portion of payment that is covered by the Federal Government predominently, the catastrophic portion of the benefit, and that has been growing at a rate of about 20 percent. And so the Commission has been concerned about that growth rate. There is a couple things --

Mr. Levin. Mr. Chairman, you want to gavel me down? Dr. Miller, others will carry on. I will keep within the time limit. Thank you.

Mr. Miller. Okay.

Chairman Tiberi. Do you want me to gavel you down?

Mr. Levin. No, I think everybody wants their 5 minutes.

Chairman Tiberi. Speaking of 5 minutes, the gentleman from Illinois is recognized for 5 minutes.

Mr. Roskam. Thank you.

Dr. Miller, thank you. And I will pick up a little bit on the holistic theme of Mr. Levin, that is, there is a general recognition that Medicare is a program that everyone celebrates.

To his point, let me bring up a particular concern that has been brought to my attention based on feedback from an inpatient rehabilitation facility in my district, and really one of the leading ones in the Midwest. The concern is that the March report recommends an aggregate reduction in payments by 5 percent for that group. And I am talking specifically about those that are in the nonprofit sector. Their margin is only 3.6 percent. And so this is, parochially, a crown jewel rehabilitation facility in my constituency. Their margins right now under Medicare are minus 20 percent. So the notion of putting more pressure on them is difficult to fathom.

Can you give me a perspective on that? Is this a final word? Is this dispositive? Are you looking for feedback? Kind of what is the state of play? I guess the first question is do you agree with my characterization? And if so, then what can we do about it? If not, why not?

Mr. Miller. Okay. So I think you have asked and made a completely fair comment. We have talked to a ton of inpatient rehab facilities and people in the industry. We do understand the phenomenon. And our data makes your point very clearly. So in the post-acute care sector in general, and in the inpatient rehab facility sector in particular, what you see are very high aggregate margins, and then you see differences in financial performance.

And as you said, it often is between for-profit and not-for-profit. But it is often tied to what kinds of patients that the different facilities tend to focus on. There is a whole section of the report, I won't go through it in a lot of detail because I know we are under pressure here in terms of time, but we have seen coding practices that raise questions, patient selection types of practices that have raised questions.

So what we have tried to do in all of these instances is say, okay, total payments can be lower, but they have to be redistributed across the different kinds of providers. And we generally try and do that by tying payment to particular types of patients. And so if you are talking medically -- the more medically complex, we would tend to shift the payments in that direction, which would have the effect of creating better or more support for the kind of facility that you are talking about.

Here is the last thing I will say and you can get back in, I am sorry. In the inpatient rehab sector, the other thing we said, in addition to bringing it down, is to increase the size of the outlier pool so that more payments would come out of the general payments and go to those kinds of facilities that have the financial circumstance that you are talking about. So there was a recognition and an attempt to get at that.

And then we also think there is some coding practices that the Secretary or the IG or people like that should be looking very hard at on the very profitable side of the industry.

Mr. Roskam. Okay. Thank you. That is helpful for me. And maybe we can engage further. You know, this is the white knight sort of place that you want to be successful. They are doing, from my point of view, all the right things. So this is exactly the type of facility to support.

Mr. Miller. More than happy to talk to you about that.

Mr. Roskam. Thank you. Yield back. Thank you, Mr. Chairman.

Chairman Tiberi. Thank you. Mr. Thompson, you are recognized for 5-minutes.

Mr. Thompson. Thank you, Mr. Chairman. Thank you for this opportunity to talk with Mr. Miller.

Mr. Miller, thank you for being here. I appreciate the work that you and your staff do a great deal.

As you probably know, in March this committee approved legislation -- the Republicans did, the Democrats voted against it unanimously -- that was a trillion dollar tax cut that included a $75 billion reduction in the revenues in the Medicare Trust Fund. And it is my understanding this is going to obviously shorten the life of the trust fund.

Do you know were there any provisions in that legislation or do you know of other legislation that would codify any of the recommendations by MedPAC to save enough money in the Medicare program to cover that $75 billion loss?

Mr. Miller. I am not aware of legislation that would offset that loss, if that is what you are asking me.

Mr. Thompson. Which?

Mr. Miller. I am not aware of legislation that includes MedPAC recommendations that would --

Mr. Thompson. So $75 billion taken out of the Medicare program will affect the access to care for the millions of Americans who rely on that?

Mr. Miller. I can't comment on the effect of that particular provision. But your other question, I am not aware of an offset for it.

Mr. Thompson. Does MedPAC have recommendations to find $75 billion worth of efficiencies?

Chairman Tiberi. I am going to interrupt here real quick. Just a reminder, this is about MedPAC's report, recent report, as well as the extenders.

Mr. Thompson. That is what I am asking, Mr. Chairman.

Chairman Tiberi. About the report, the March report?

Mr. Thompson. I am asking if there are recommendations --

Chairman Tiberi. In the March report?

Mr. Thompson. In any report.

Chairman Tiberi. This is about the March report.

Mr. Thompson. Of recommendations by MedPAC that would cover the $75 billion loss that was brought about because of the legislation that was passed by the Republicans in this committee in March.

Mr. Miller. So without, you know, comment on the pending legislation, there are an array of recommendations in the MedPAC report that result in savings. And so for example the post-acute care things that we just talked through. You know, we don't do estimates. That is CBO and all the rest of it. But we think we are talking in the neighborhood of $30 billion.

I mentioned the MA coding issues. I mean there is potentially savings there, for example. We also think, you know, the changes in the part D recommendations could yield savings. And then also there is a couple of other places we haven't even talked about where we restrain the updates that would produce savings.

Mr. Thompson. So those savings, the $30 billion worth of savings, how would they come to fruition? Would it require legislation?

Mr. Miller. Almost everything I have referred to would require legislation. I have to think about that for a second. But yeah, generally legislation, yes.

Mr. Thompson. So of the $75 billion that will be stripped from Medicare because of this American Health Care Act, you can identify possibly $30 billion that could make up some of that difference. But to get there, we would have to pass separate legislation?

Mr. Miller. Yeah. To get the $30 billion you have to pass separate legislation. And I don't know that I could ballpark the number for you, there is more savings in that report than the $30 billion.

Mr. Thompson. And that additional savings, would that require legislative action?

Mr. Miller. I think as a blanket response to your question, in general it would require legislation.

Mr. Thompson. Do you happen to know if any of that legislation has been introduced?

Mr. Miller. I don't happen to know that.

Mr. Thompson. So we have a $75 billion hole in Medicare with no legislative attempt to address that loss.

Mr. Miller. I am not aware of introduced legislation. I wouldn't necessarily be the person who would be aware of introduced legislation.

Mr. Thompson. Are you the person or could you in your position give us some idea of what sort of problems a $75 billion loss to Medicare would bring about?

Mr. Miller. You know, again, on that particular provision I don't feel real versed in talking about what the implications of it would be.

Mr. Thompson. Thank you very much.

Chairman Tiberi. The gentleman's time has expired. Mr. Smith, you are recognized for 5 minutes.

Mr. Smith. Thank you, Mr. Chairman. And thank you, Dr. Miller, for your presence here today. And certainly your responsibilities are large and you have a big job to do. So we appreciate your effort.

It is no secret that rural America has some challenges, especially with the agriculture economy and many of the challenges of access to care. Critical access hospitals are very important to serving the rural population of America. And I know that they face challenges with funding and so forth.

But one concern that I have been working on, and my colleague, Ms. Jenkins has as well, is the enforcement of the physician supervision requirements for critical access hospitals. And as you know, these rules require a physician's presence and supervision over nearly all routine procedures administered in hospitals. And this arbitrary regulation has been especially burdensome for hospitals and doctors in the very rural areas. It seems unnecessary.

But the 21st Century Cures Act requires MedPAC to report to Congress on the economic and staffing impacts of this regulation on rural hospitals by the end of this year.

I was just wondering, we are about 6 months in already, I was wondering if you might have an update on what has been found so far, if anything?

Mr. Miller. I really don't at this point in time. And I don't mean to be unhelpful, but I don't have anything to say about it at the moment.

Mr. Smith. Okay. I would hope that we can have as much information as is practical and possible in a timely fashion.

To look at another issue, shifting gears here a little bit, I know that in the past the Commission has recommended allowing the ambulance add-on payments to expire. Despite this recommendation, I know I hear from suppliers in my district that they need these payments. Is there any cost report data available to CMS that indicates these payments are needed in rural areas?

Mr. Miller. My understanding is there is not cost report data available. And I think there has been discussions in the environment. We had some discussion in our particular ambulance report about how cost reports could potentially work.

One big issue in trying to go after it is there is very large or even reasonable sized operators where submitting a cost report probably makes a lot of sense. But you also probably have a segment of the industry where you are talking about volunteer fire departments and that type of thing where, you know, a full-scale cost report is probably something of an issue.

There is probably a way to square that circle, a relatively slim cost report and ambulance providers and then excluding certain small ones from the reporting requirements, which might be a pathway. That is nothing the Commission recommended, but there is sort of a discussion to that effect in our report.

Mr. Smith. Okay. I appreciate that. I know the one-size-fits-all approach is not always helpful. In fact, it rarely is. And as rural providers do face these challenges, I hope you will certainly keep in mind the flexibility that oftentimes needs to occur. And I appreciate your efforts.

Mr. Miller. Unless we are done, I do want to say in our recommendation, you know, this principle that I tried to say in the introduction of if you are going to

provide support for rural providers, which the Commission fully supports, it is really about targeting, not duplicating, not supporting two providers who are right next door to each other and may be in effect, you know, not able to fully cover their fixed costs and then you are trying to subsidize both of them.

And so in the ambulance situation, we took one of the add-ons that was targeted to rurals and redistributed and target it to counties that had very low population density. We end up covering about 70 percent, 75 percent of the same areas, but you can provide a much larger subsidy.

And basically, you are moving the subsidy away from places that are near metropolitan areas and giving it more truly to the isolated areas, and in our opinion, and people disagree, making that dollar go further.

Mr. Smith. Okay. Thank you. I yield back.

Chairman Tiberi. Thank you. Mr. Higgins, you are recognized for 5 minutes.

Mr. Higgins. Thank you, Mr. Chairman. Mr. Miller, the New York Times on Monday reported that United Healthcare, among the largest private health insurance companies in America, is being sued for defrauding the American people in the Medicare program under the Medicare Advantage program, estimated to be between, well, billions of dollars each year out of the past decade.

The article also went on to name four other private insurance companies that participate in the Medicare Advantage for defrauding the Federal Government and the Medicare program as well. Potentially tens of billions of dollars each year.

Yesterday, the Department of Justice joined that lawsuit, and is rigorously investigating those allegations. If these allegations are true, that would represent among the most egregious defrauding of a Federal program in a long time. What is your knowledge of this? And my understanding is several audits have been done over the last several years that identified a problem.

And why hasn't more decisive action from an administrative point occurred, which presumably the consequence of which is this legal action?

Mr. Miller. So let me try and answer what I think might be three questions in there. Yes, we are aware of the lawsuit. In fact, we have gone through it in some detail ourselves just as a way of educating ourselves. And I agree with

you. There are some relatively egregious things in there. I don't know how much of it you got into, but the email traffic back and forth among the company and people in the company is certainly an issue.

Number two, on the auditing, and then I will get you to something. On number two on the auditing, obviously we are a small operation, we advise the Congress, we don't do any of that oversight. That falls to CMS. But what we have been doing is we have made estimates of looking at, you know, over time the coding in managed care plans relative to what is assumed and built into the risk models. We think that there is excess coding occurring, and we have recommended that it be taken out. And we have also recommended that it be taken out differentially based on how much activity is occurring within the plans.

And the only other thing I want to say, and I want to say this carefully, because you may have a different view, not all of it is fraudulent. Plans are collecting these codes in order to understand what their mix of patients are.

Mr. Higgins. Let me just reclaim my time. This is not one company. It is the largest provider under the Medicare program. Seventeen million people in this country get their healthcare under the Medicare program through Medicare Advantage. It is four others as well. So that says to me that this is a systemic problem within the system. It needs to be fixed because they are defrauding the American people and the Medicare program, number one.

Number two, the CEO of United Healthcare in 2014 was compensated $66 million, one person, one salary, 1 year. The Republican healthcare bill that was passed by this House included on page 67 a $15.5 million tax cut to United Healthcare's CEO and their top executives, $15.5 million in total.

The other companies that are in question for overbilling, defrauding the Medicare program, that bill provided their top executives with a $78 million tax cut. At the same time that that company and four others are under investigation for defrauding the Medicare program. You can parse it any way you want. To me, it is a blatant violation of the trust that every Member of this Congress took an oath to uphold and to protect.

I will yield back.

Chairman Tiberi. The gentleman's time has expired. Mr. Miller, thank you for attempting to answer that question.

I want to remind my colleagues of the scope of this hearing. And I am going to give an opportunity once again to remind everybody of Mr. Miller's valuable time and the scope of this hearing. I don't want to get into tit for tat.

The allegations that the gentleman brought up are very serious. Individuals or companies are innocent until proven guilty. But I want to also remind my colleagues that I don't want to waste Mr. Miller's time to get into a tit for tat about the American Health Care Act or quite frankly the Affordable Care Act, because we can spend all day debating with each other about the Affordable Care Act or the American Health Care Act.

Mr. Miller and his staff have graciously given their time today to talk about the report and how we can work together in a bipartisan way to improve Medicare. And I hope my colleagues will spend the rest of the time respecting Mr. Miller's time on how we can work together in implementing some of those recommendations.

With that, I will recognize the gentlelady from the great State of Kansas for 5 minutes.

Ms. Jenkins. Thank you, Mr. Chairman. And thank you, Mr. Miller, for being here. Medicare is a program that was created with a promise to our seniors. And we talk a lot about how we are going to keep that promise and reform the system to shore it up.

One way to improve the long term viability of the trust fund and the care paid for by that program would seem to me to move to a value-based payment model for services that have not yet moved in that direction.

In your March 2017 report, MedPAC points out that skilled nursing facilities are able to control the amount of money Medicare will pay them based on their current payment model. I just wanted to get your sense of the impacts of a move to a value-based payment model in the skilled nursing facility space.

So just a couple questions. The American Healthcare Association has a value-based payment idea that the March 2017 report discusses. It states that the model, while reducing payments to for-profit facilities, will increase payments to nonprofit facilities. Could you talk briefly about MedPAC's belief that the idea will strengthen the skilled nursing facility system as a whole?

Mr. Miller. So if I follow the question, and if not just redirect, there is a few things that I think we are saying that you are responding to here.

The first is not dissimilar to the conversation with Mr. Roskam. Inside the skilled nursing facility payment system, we think overall spending is too high, but we also think that the way the system is currently structured -- and we can get into some of the technical, but for the moment just trust me -- the way the system is currently structured, it is not paying properly for different kinds of patients. So it incents people to take sort of your basic physical rehab patient, it incents avoiding the complex medical patient.

The recommendations we have made would be based on patient need and bring a greater balance, we think, you know, and improve the value for the beneficiary, a greater balance in how that payment works. And you mentioned quickly the not-for-profit and for profit. That isn't about making the payment system peculiar to for profit and not-for-profit, that just happens because the way the payments shift based on the patients that those two different types of providers take.

The other two quick comments on value, and I will get out of your way, is we do talk about the notion of tying payments to different outcomes, avoiding returning to the hospital, avoiding going to the emergency room.

And then we have other conversations about reorganizing the entire payment system, having a unified payment system, but also ultimately moving towards more episode of care in which inside the clinicians would have the flexibility to engage in practices and delivery practices that they would hopefully bring lower costs and higher quality. So we have a few threads in this particular area.

Ms. Jenkins. Okay. Just to follow up on that, the reform payment system proposed by the American Healthcare Association is based on the creation of clinical groupings that would include an array of different patient types. And CMS has studied this type of payment basis.

And I would like to know if you believe that a move to patient characteristics instead of length of stay is feasible for CMS and providers and if it results in a better outcome and cost savings?

Mr. Miller. Yes. And our work is -- we think the starting point for this thought process where we constructed a different way to do the payment system based on care, patient characteristics, we have models that do that. And I think what you are referring to, the industry's notion, is taking that and sort of aggregating it up into patient categories.

As long as the underlying tying of payment to patient need is not lost in the process of doing that, then it is consistent with the direction that we have been talking about going. If I follow what you are saying.

Ms. Jenkins. Thank you. I yield back.

Chairman Tiberi. Mr. Blumenauer, you are recognized for 5 minutes.

Mr. Blumenauer. Thank you, Mr. Chairman. We appreciate your being here. MedPAC over the years has helped deconstruct the hopelessly complex system that Congress routinely makes more complex, and helping us dive into some of the details that otherwise we wouldn't have. And I appreciate the chairman's latitude so we can explore some of this, because otherwise we wouldn't.

And I am hopeful that one of the things, once we can move past some of the current controversies, we can do a better job of diving into what some of these elements are to understand them better, look for areas of being able to rebalance some of the complexities, coax more value, and incent more appropriate behaviors. Because regardless of what happens on ObamaCare or the Republican bill, we still pay about twice as much as anybody else in the world, and too many Americans get mediocre to poor care.

The people in Canada, and France, and Great Britain, and Japan, live longer than we do, they get well faster, they don't get sick as often, and they pay far less. And you are helping us understand some of the elements that are a part of that and how we can use some of these large healthcare programs that we finance to get better performance.

I want to turn to one specific item that you had in your report talking about hospice. This is an area, in part because of our death panel work over the years, spent a lot of time dealing with end of life care, hospice treatment.

And in your report you reference that people can get this Medicare hospice benefit if they are terminally ill, with a life expectancy of 6 months or less. They can elect the Medicare hospice benefit, but they agree to forego Medicare coverage for conventional treatment of terminal illness and related conditions.

You may not have hard data on this. I know there is a pilot project currently underway looking at what the implications are for continuing curative care while allowing people to access the palliative care in terms of hospice

treatment. I think there is some evidence that this is a decision point for people approaching hospice that it is a difficult decision to be in that mind-set, kind of letting go. Foregoing curative has kind of a note has kind of a note of finality to it.

I wonder if there aren't some incentives, therefore, for some people who would dramatically benefit from hospice care, they and their families, and maybe scale down some of the curative activity if it didn't have to be an either/or.

Could you comment on whether or not there might be some savings overall in terms of healthcare if people were given hospice care that might be more appropriate to them and not force them to jump off that cliff?

Mr. Miller. I am aware of the issue. The issue has come up a couple times in the Commission conversations. There is no inherent hostility to the notion.

A couple thoughts just to follow up on. You are right, there is a demonstration or some kind of pilot out there, and we are looking to that to sort of see the answer to some of these questions. It is very hard to get your arms around it because the counterfactual is always difficult to sort out.

We also made recommendations that hospice should be included in the MA benefit, which it currently isn't, where in a full episode beneficiary structure the notion of those trade-offs being made by the clinicians on the ground makes a lot more sense. This is a typical problem where it might make sense in a certain context, but you take it out into fee-for-service, where a lot of different things and a lot of people can get involved, it becomes harder to be sure that you are really making the trade-offs.

Again, it is not a hostility to it, it is a concern whether it really plays out the way people hope it will play out in fee-for-service. We are looking at that demonstration too.

Mr. Blumenauer. Thank you, Mr. Chairman. I wholeheartedly concur with the notion that it ought to be wrapped into Medicare Advantage. It makes a lot of sense.

And watching this pilot project, if there is a way to feather it in some fact to get the best of both. And I appreciate having a chance to talk about this.

Chairman Tiberi. Thank you for your leadership in the hospice area, sir. Mr. Paulsen, you are recognized for 5 minutes.

Mr. Paulsen. Thank you, Mr. Chairman. And Mr. Miller, thanks for being here today and testifying on a very important topic, obviously, on the future of the Medicare program.

I do think it is critical for Members across the board to have a very firm understanding of how the program operates as we look for ways to continue to strengthen Medicare for the future. And as has been discussed, the Medicare Advantage program plays a pretty critical role within the Medicare system. Almost a third of all beneficiaries around the country are now enrolled in a Medicare Advantage plan. And those numbers are only going to continue to grow. They are projected also to continue to grow.

I know in Minnesota, our seniors are particularly interested in enrolling in a program. Last year I think 55 percent of Minnesota seniors were enrolled in an MA plan, which is actually the highest in the country. And that is why I remain focused on ensuring that this program is going to continue to deliver high quality benefits for seniors.

So the report that you released in March, it highlights the growing trend of seniors in the fee-for-service plans choosing to enroll in Medicare part A only instead of enrolling in both Medicare part A and part B.

And given that Medicare Advantage enrollees must enroll in both parts A and B, can you briefly discuss the impact of more beneficiaries enrolling in part A, what that has had on the MA program?

Mr. Miller. Yeah. And you picked up on something that we said in the report and talked about in the report. So you are getting more of this phenomenon of beneficiaries being enrolled in A only or B only. But really the B only is kind of a small phenomenon. It is really the A only.

So what happens in that circumstance is if you are an A only beneficiary, your expenditures tend to be below average. And then if you think about the way the payment system works, which you sound versed in, you know, for a given county you accumulate all the fee-for-service beneficiaries and you set a benchmark and then, you know -- and you know there is some administrative adjustments to that benchmark. Plans bid against it.

So what we started to become concerned about is to the extent that you get more A only, and somewhat this is geographic in its impact across the country, but we are concerned it is going to grow over time, you are basically saying I

am going to set a benchmark that includes a large body of people or growing body of people that the plans can't enroll. And it compresses the benchmark.

So we have said, you know, this is something that CMS needs to look at because it may need to be a different way to set the benchmark using the A-B, just to use jargon for a second, the A-B beneficiaries in setting that benchmark.

Now I want to quickly add something here. This would add costs, because it would potentially raise the benchmark that the plans are bidding against. And we have pointed out at the same time that there is this coding phenomenon that also needs to be taken into account and those dollars need to be taken back out.

Mr. Paulsen. So let me just follow up on that. Just looking at you mentioned the possibility of adding costs. But can you just mention what would the benefits be to the beneficiaries themselves if we moved to that system of calculating the Medicare benchmark only using data fee-for-service beneficiaries enrolled in both part A and B?

Mr. Miller. Well, I hadn't thought about the question quite that way. So I think it is a good question. I mean what happens now is to the extent that you bid below the benchmark, a portion of that dollar has to be converted to a benefit that goes back to the beneficiary. Mostly plans do it through lower cost sharing.

Arguably, the plans are basically bidding below the benchmarks now and offering those additional benefits. If the benchmark went up, in theory they would be able to offer, all else equal, and there is a lot of behavioral response out there, they would be able to -- if they can continue to bid below that benchmark, which in theory they should, they should be able to offer more benefit.

Mr. Paulsen. All right. Thank you, Mr. Chairman.

Thanks Mr. Miller. I am also hopeful that over the next few months we will be able to also continue to examine and explore and address the expiring Medicare extender policies that are in place such as the therapy cap, exceptions process, the ambulance add-on payments, because I think it is critical that we ensure there is not a disruption, that those critical services that are provided to seniors around the country and they rely on as we strengthen the overall program in the future. So thank you.

I yield back.

Chairman Tiberi. Thank you. Mr. Kind, you are recognized for 5 minutes.

Mr. Kind. Thank you, Mr. Chairman.

Dr. Miller, thank you for your testimony here today and the good work that you and your staff do and the report that you submit to us every year.

Just to follow up with my friend and colleague from Minnesota, I appreciate his interest in it, and I also appreciate the MedPAC's report as far as the benchmark caps and what you are recommending.

And for my colleague's edification, I introduced legislation last year, H.R. 4275, along with our colleagues Mike Kelly, Mike Doyle, and Brett Guthrie, that gets at this very issue as well. So we are glad to see MedPAC focusing additional attention on the benchmark cap issue. And we would be interested in following up with you on as far as any type of cost impact that this is going to have, a little bit more data that you are looking at that would benefit us and the legislation that we are moving forward.

Also along those lines, you are probably aware that Chairman Brady and I have introduced a post-acute care reform bill in order to begin the conversation and start getting feedback. We are appreciative of the effort that MedPAC and Paul, you in particular, the work that you are doing in this field. We will be looking to following up with you on policy recommendations because we feel that there is more coordination and more integration that can be had, more efficiency, better outcomes at a better price within the post-acute care world. And that might be the next iteration of healthcare reform. And where we can get better outcomes at a much better price, cost savings ultimately.

We will try to follow up with that. I too share the concern that we have heard here from the dais from a number of my colleagues of the impact that $75 billion worth of cuts in the Medicare program under the Republican healthcare bill proposal, the impact that is going to have on my rural healthcare providers. That is going to be on top of over $800 billion in cuts to Medicaid, BadgerCare as we know it in Wisconsin, and the disproportionate impact that is going to have on our rural providers.

And I will look forward to following up with MedPAC as you do a deeper analysis. It is my understanding you are not in a position today to comment to detail as far as the impact that is going to have, but to follow up with you in the future so we know what to prepare for with the adverse consequences of those huge cuts that are being proposed in their legislation and the impact it is going

to have in rural America on our rural providers. They are struggling already with the thin margins as it is. And this could just be adding onto their woes.

And then finally, getting back to Mr. Higgins' line of questioning too, and the New York Times article that he cited and that is in front of me today -- and Mr. Chairman, I would ask unanimous consent to have that article submitted for the record. It is dated May 15, 2017, authored by Mary Williams Walsh, titled, A Whistleblower Tells of Health Insurers Bilking Medicare.

Chairman Tiberi. Without objection.

A Whistle-Blower Tells of Health Insurers Bilking Medicare

By MARY WILLIAMS WALSHMAY 15, 2017
New York Times

Benjamin Poehling, a former finance director at UnitedHealth Group, in Minneapolis. He contends that his company and other insurers have been systematically bilking Medicare Advantage for years.CreditAckerman and Gruber for The New York Times

When Medicare was facing an impossible $13 trillion funding gap, Congress opted for a bold fix: It handed over part of the program to insurance companies, expecting them to provide better care at a lower cost. The new program was named Medicare Advantage.

Nearly 15 years later, a third of all Americans who receive some form of Medicare have chosen the insurer-provided version, which, by most accounts, has been a success.

But now a whistle-blower, a former well-placed official at UnitedHealth Group, asserts that the big insurance companies have been systematically bilking Medicare Advantage for years, reaping billions of taxpayer dollars from the program by gaming the payment system.

The Justice Department takes the whistle-blower's claims so seriously that it has said it intends to sue the whistle-blower's former employer, UnitedHealth Group, even as it investigates other Medicare Advantage participants. The agency has until the end of Tuesday to take action against UnitedHealth.

In the first interview since his allegations were made public, the whistle-blower, Benjamin Poehling of Bloomington, Minn., described in detail how his company and others like it — in his view — gamed the system: Finance directors like him monitored projects that UnitedHealth had designed to make patients look sicker than they were, by scouring patients' health records electronically and finding ways to goose the diagnosis codes.

The sicker the patient, the more UnitedHealth was paid by Medicare Advantage — and the bigger the bonuses people earned, including Mr. Poehling.

In February, a federal judge unsealed the lawsuit that Mr. Poehling filed against UnitedHealth and 14 other companies involved in Medicare Advantage.

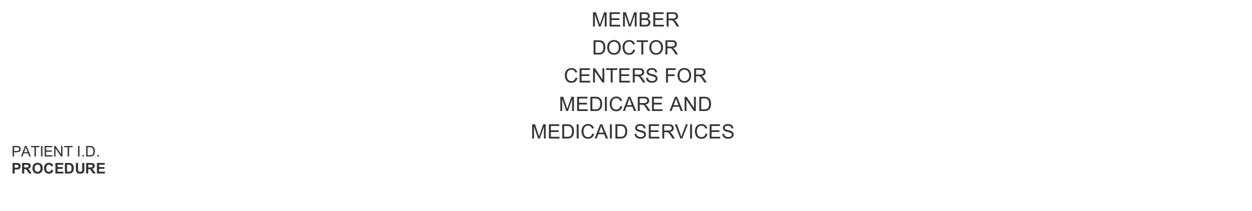
“They've set up a perfect scheme here,” Mr. Poehling said in an interview. “It was rigged so there was no way they could lose.”

A spokesman for UnitedHealth, Matthew A. Burns, said the company rejected Mr. Poehling's allegations and would contest them vigorously.

How Medicare Payments Work

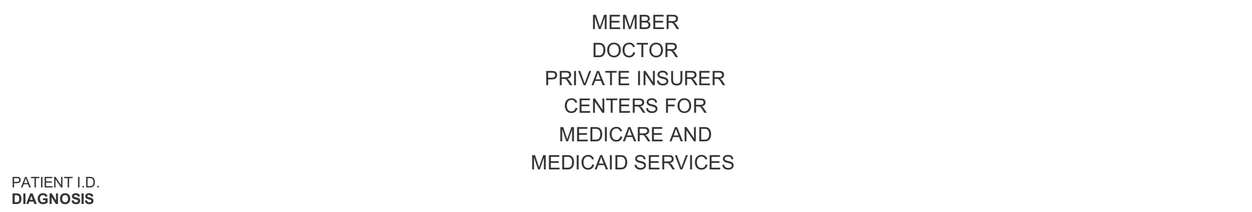
The traditional Medicare program reimburses doctors directly for procedures they perform — but that can promote unnecessary treatments and inflate costs. So Medicare Advantage was set up differently: The government contracts with for-profit insurers to manage health care for the elderly, and pays insurers a yearly fee for each member they enroll. That fee is higher for patients recently treated for certain conditions, creating an incentive for Medicare Advantage insurers to search for diagnoses of illness in their patients, even where none may exist.

Traditional Medicare



1. Traditional Medicaremembers pay a monthly premium to the Centers for Medicare and Medicaid Services (C.M.S.), whether or not they visit a doctor. C.M.S. also receives funding from U.S. taxpayers.
2. If members see a doctor, the doctor sends a copy of their medical report to C.M.S., to get paid.
3. C.M.S. pays the doctor. Traditional Medicare compensates doctors according to the procedures they perform — lab tests, scans, operations, etc.

Medicare Advantage



1. Medicare Advantagemembers also pay a monthly premium to C.M.S., and often a separate premium to a private insurance company.
2. If members see a doctor, the doctor sends a copy of the medical report to the private insurer, who then pays the doctor.
3. C.M.S. pays the private insurer a base rate for each member. If the private insurer tells C.M.S. that the member required treatment for certain conditions, C.M.S. pays the insurer more.

By The New York Times

> “We are confident our company and our employees complied with the government’s Medicare Advantage program rules, and we have been transparent with C.M.S. about our approach under its murky policies,” he said, referring to the Centers for Medicare and Medicaid Services, which administers Medicare Advantage.

Mr. Burns also said Mr. Poehling's complaints and similar ones held UnitedHealth and other Medicare Advantage participants to higher standards than the ones used by the original Medicare program.

Mr. Poehling's suit, filed under the False Claims Act, seeks to recover excess payments, and big penalties, for the Centers for Medicare and Medicaid Services. (Mr. Poehling would earn a percentage of any money recovered.) The amounts in question industrywide are mind-boggling: Some analysts estimate improper Medicare Advantage payments at $10 billion a year or more.

At the heart of the dispute: The government pays insurers extra to enroll people with more serious medical problems, to discourage them from cherry-picking healthy people for their Medicare Advantage plans. The higher payments are determined by a complicated risk scoring system, which has nothing to do with the treatments people get from their doctors; rather, it is all about diagnoses.

Diabetes, for example, can raise risk scores by varying amounts, depending on a patient's complications. So UnitedHealth gave people with diabetes intensive scrutiny, to see if they had any other conditions that the diabetes might have caused.

As Mr. Poehling's lawyer, Mary Inman, described it, the government would pay UnitedHealth $9,580 a year for enrolling a 76-year-old woman with diabetes and kidney failure, for instance, but if the company claimed that her diabetes had actually caused her kidney failure, the payment rose to $12,902 — an additional $3,322. Ms. Inman is with the law firm of Constantine Cannon in San Francisco.

Mr. Poehling said the data-mining projects that he had monitored could raise the government's payments to UnitedHealth by nearly $3,000 per new diagnosis found. The company, he said, did not bother looking for conditions like high blood pressure, which, though dangerous, do not raise risk scores.

He included in his complaint an email message from Jerry J. Knutson, the chief financial officer of his division, in which Mr. Knutson urged Mr. Poehling's team "to really go after the potential risk scoring you have consistently indicated is out there."

"You mentioned vasculatory disease opportunities, screening opportunities, etc., with huge $ opportunities," Mr. Knutson wrote. "Let's turn on the gas!"

There were bonuses when Mr. Poehling and his team hit their revenue targets, Mr. Poehling said, but no bonuses for better health outcomes or for more accurate patients' charts.

The Price of Risk

The Medicare Advantage program pays insurance companies a yearly fee for each person they enroll. And it pays more for people who are sick, to keep insurers from rejecting them because their care will cost more. The practice, called “risk adjustment,” gives insurers an incentive to tell the government that people are sicker than they may, in fact, be.

MEDICARE ADVANTAGE PROGRAM

	ANNUAL RATE
Male, age 70-74	$3,866
ADDITIONAL PAYMENT TO INSURER FOR SELECTED CONDITIONS	
Diabetes without complications	$1,058
Breast, prostate and other cancers and tumors	1,490
Diabetes with acute complications	3,251
Drug/alcohol dependence	3,910
Major depressive, bipolar and paranoid disorders	4,039
Lung and other severe cancers	9,904
Metastatic cancer and acute leukemia	26,795

Source: Center for Public Integrity
By The New York Times

“You or I or the average person is probably appalled by this,” Mr. Poehling said. “But the scheme here was not about delivering better care to members — the thing you would expect from a health care company. It was about increasing the bottom line.”

He went to work for UnitedHealth in 2002, filed his lawsuit in 2011 and left the company at the end of 2012, while the case was still under seal.

Mr. Poehling’s allegations, if true, could help explain why insurers are staying in the Medicare Advantage program even as they pull out of the Affordable Care Act exchanges in some states: Medicare Advantage offers a way to get extra money from the federal government.

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Already the Justice Department has declined to intervene in some smaller whistle-blower cases with similar allegations. But in March, it did say it would join a whistle-blower suit filed by James Swoben, a former data manager of SCAN Health Plan, accusing UnitedHealth and several other companies of cheating Medicare Advantage by looking improperly for ways to raise people's risk scores.

In 2016, the United States Court of Appeals for the Ninth Circuit vacated a lower court's decision to throw out Mr. Swoben's case. After reviewing the allegations, Judge Raymond C. Fisher wrote, "We do not see how a Medicare Advantage contractor who has engaged in such conduct can in good faith certify" that the diagnosis codes it reports to the Centers for Medicare and Medicaid Services "are accurate, complete and truthful."

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"That case could provide further clarity on the program rules," Mr. Burns of UnitedHealth said. He added that the government seemed to be trying to delay so that the two whistle-blower lawsuits could go first.

The Justice Department has said it is investigating four other Medicare Advantage insurers: Aetna, Humana, Health Net and Cigna's Bravo Health. That suggests that there are more whistle-blowers in the wings, potentially snarling more insurers in litigation and ultimately forcing a rethinking of the entire program.

A UnitedHealth branch in Flushing, N.Y. A company spokesman said, "We are confident our company and our employees complied with the government's Medicare Advantage program rules."CreditMichael Nagle/Bloomberg

"C.M.S. could do a lot to change the rules so it's not so easy to get away with this stuff," said Timothy Layton, an assistant professor at Harvard Medical School who researches insurer behavior in health-insurance markets. He is not involved in Mr. Poehling's lawsuit.

"It's a huge waste of money," Professor Layton said of the quest for higher risk scores. "What the insurers are doing is not socially valuable at all."

The Centers for Medicare and Medicaid Services declined to comment for this article.

Auditors and analysts have warned for at least a decade that Medicare Advantage has been vulnerable to cheating since risk scoring was phased in, from 2004 to 2008. The inspector general of the Department of Health and Human Services, where the centers reside, audited a small sample of Medicare Advantage plans early on and found overpayments of up to $650 million in 2007. It predicted even more in 2008, but then came budget cuts and those audits stopped.

The Government Accountability Office reported last year that the Centers for Medicare and Medicaid Services had identified $14.1 billion of overpayments to insurers in 2013 and did not have a clear plan for recovering the money. It also faulted the agency's auditing methods.

"I recall a feeling of frustration verging on outrage," said Ted Doolittle, the deputy director of the Medicare and Medicaid agency's Center for Program Integrity at that time.

In 2014 the Center for Public Integrity, a nonprofit research group, analyzed the only available Medicare Advantage data and reported that insurers had reaped about $70 billion in overpayments from 2008 to 2013.

Fred Schulte, who led the center's research and now works for Kaiser Health News, also sued the Centers for Medicare and Medicaid Services to get more data. In January, he reported getting confidential documents showing that the agency had tried to recover $128 million of overpayments to five insurers in 2007 but, "under intense pressure from the health insurance industry," settled for just $3.4 million in 2012.

Last month, Senator Charles E. Grassley wrote to the agency's administrator, Seema Verma, complaining that it had trumpeted the $3.4 million recovery to him as a sign of good fiscal oversight, without mentioning that it could have gone after $128 million.

"The difference between the assessment and the actual recovery is striking and demands an explanation," Mr. Grassley, an Iowa Republican, wrote.

As lawmakers and others try to get their arms around the issue, few insurance insiders have come forward with firsthand accounts. Mr. Poehling said he had done so reluctantly.

"I came to the point where I just couldn't participate in what they were asking me to do anymore," he said.

Mr. Kind. Thank you. Obviously, we are talking billions of dollars potentially that are being affected by the upcoding issue. DOJ obviously has an interest in it.

We are going to need I think more guidance and information from MedPAC as far as how real this problem is and what policy steps we ought to be thinking about taking to guard against the upcoding that potentially could be occurring and costing the Medicare program billions of dollars every year.

So I think MedPAC's focus in this area in a more detailed fashion and recommendations that you are willing to bring forth would be helpful.

Finally, and I have been almost a Johnny One Note on the need for delivery system reform and payment reform, getting to a more quality, value, outcome-based reimbursement system within Medicare, but throughout the entire healthcare system. But with your analysis with the Medicare program alone, what is your assessment of the progress being made as far as the integration and the delivery system reform proposals that are part of the Affordable Care Act, or ObamaCare now, as well as the alternative payment models and the value-based payments that are taking place within Medicare today? Are we making progress? Are we moving the needle?

Mr. Miller. I mean what I would say is that there is progress in the sense that I think there is movement out in the environment and there is greater degrees of organization in terms of things like accountable care organizations, for example. I think what remains to be seen is how large of an impact those models are going to have.

There is some evidence that they have affected spending, and also generally on the quality front. Quality seems to be as good or slightly better in those kinds of models, which is not to be dismissed. But the kind of large spending impacts, that hasn't really materialized yet.

But there does seem to be a lot of motion out in the environment, so I think there is still things to be seen there. The other thing I will say quickly about that is that, you know, this is a period where utilization slowed down historically.

And then these models come in to try and control utilization. It may be having a harder time of it at the moment.

Mr. Kind. Okay. Thank you. Thank you, Mr. Chairman.

Chairman Tiberi. Thank you. Ms. Chu, I am sorry that I did not recognize you properly. It had nothing do with my friend being from Wisconsin and the Big 10 country. Ms. Chu, you are recognized for 5 minutes.

Ms. Chu. Thank you so much, Mr. Chair. Mr. Miller, I am always concerned about my dual eligibles in my district. About one in five, or 35,000 people, are dual eligible. And that is involved in both the Medicaid and Medicare program. These people are often low income seniors that rely on both programs for their care, which is often chronic and expensive. And nationally, about 10 million people are dually eligible.

So I know that you have numerous proposals here to rein in spending on Medicare. But what would happen if there was a drastic cut to Medicaid? For instance, in the AHCA there is a proposed $838 billion cut in Medicaid. But I would like to know what the impact on a big cut in Medicaid would be to Medicare.

Mr. Miller. In Medicaid you are saying?

Ms. Chu. Yeah.

Mr. Miller. I don't feel like I have done enough work to either understand the nature of the cuts and what its backlash would be on Medicare. So I don't feel very versed in being able to answer this question for you at the moment.

Ms. Chu. Okay. Then I will talk about a different topic, which is I was interested in the proposals to rein in spending on prescription drugs.

And I know that there was the proposal to realign Medicare part D and part B drug coverage to better manage prescription drug costs, but that this spring MedPAC also voted 15 to zero to recommend changes to how Medicare pays for prescription drugs under part B. And that is expected to appear in your June report.

You have several options for reining in those costs. And I noted with interest the ones to require prescription drug manufacturers to pay rebate to Medicare if their drug price increase exceeds inflation, which is similar to the Medicaid inflation rebate.

And also the proposal to create new private entities that could negotiate drug prices on behalf of physicians. Why did these proposals rise to the top? And

how valuable would they be to rein in costs? And how viable are these proposals?

Mr. Miller. The Commission has been very concerned about drug costs and spending in Medicare and price growth. You know, we spent a lot of time looking at part D. And then it seemed natural to move to part B.

Part B, $26 billion, growing at something like a 8 or 9 percent growth rate. We think a lot of that was price driven. That is why these things rose to the attention of the Commission. You are correct in describing both of the things that you said.

There is a rebate that says if prices grow faster than X, then the manufacturer is asked to rebate the difference back to the program. And then we would also tie the beneficiaries' cost sharing to the lower growth rate so that the beneficiary also gets the benefit as well.

And then your second point that you raised was we also said maybe like part D, you have the physicians in part B, because this is a physician-administered drug situation, organize, create formularies and negotiate directly with the manufacturers to see if they can bring the price down even below what is paid now in the standard buy and bill sector.

So we have done both. We have said both of those things.

Ms. Chu. I guess what I was wondering is why those proposals came to the front. Was it because of viability or would it rein in the costs more efficiently?

Mr. Miller. Oh, yeah, I am sorry, I thought that was the first part of the response. This is a concern, the growth rate, this is a big spend, and yes, this would result in savings. Is that what you are asking?

Ms. Chu. I guess it is a combination of viability and reining in the costs.

Mr. Miller. Viability?

Ms. Chu. Yeah. Whether the proposal would actually have some chance of succeeding.

Mr. Miller. I would really have to defer to you on that. I mean these proposals take legislative changes. So whether they come to fruition is a function of the Congress. Is that what you are asking or am I missing you?

Ms. Chu. I will change to a different question, which is about the astonishing price of generics and their drug prices increasing by 57 percent. But even more astonishing, the brand drugs that are increasing by 142 percent. Can you discuss why this dynamic is occurring and how this is affecting out-of-pocket costs to beneficiaries?

Mr. Miller. Yeah. I believe both of those numbers come right out of our report. We track the prices overall and separately. Those are contributing, to the point I made in the opening statement, of driving more beneficiaries into the catastrophic cap. That drives the Federal expenditures.

And obviously, to the extent that the beneficiary has to take a name brand drug and there isn't a generic substitute, then they are likely to be facing more out-of-pocket throughout the benefit period until they hit the catastrophic cap.

Ms. Chu. Thank you.

Mr. Miller. I am sorry I missed your other question there.

Chairman Tiberi. The gentlelady from Tennessee is recognized for 5 minutes.

Mrs. Black. Thank you, Mr. Chairman. And thank you, Dr. Miller, for coming here and discussing the recommendations that are in the March report.

As we take a deeper look into the recommendations and also the possible extension of several of the specific Medicaid programs that are set to expire this year, I think it is also important that we continue to pay attention to the future of the Medicare program as a whole.

I know these are very many specific things, but both the report and your testimony discuss solutions that go beyond simply updating payment provisions and try to more broadly address the fundamental problems with the fee-for-service program.

I also noted in your testimony that you wrote that Congress should, and I quote this, "enhance delivery system reforms that have potential to encourage high quality care, better care transitions, and more efficient provision of care."

So with that, can you tell us what types of reforms? I know there are specifics in here, but other types of reforms that MedPAC would envision considering this statement of the three pieces here, higher quality care, better care transitions, and more efficient provision of care?

Mr. Miller. Okay. I think we would approach this from a couple of different perspectives.

First of all, in the existing systems, even without major reform, we have tried to create payment incentives, as I have described a couple of times, so that there is not patient selection, there is not arbitraging, and we are trying to make linked payments to quality measurements like avoiding readmissions, avoiding unnecessary hospitalizations, avoiding emergency room use, that type of thing. So that the experience of the patient is they get their care and then something doesn't go wrong and they have to go back to the hospital or go to the emergency room, and build in financial incentives to the provider that says, you know, if this happens this is not going to play well in terms of your finances. That type of thing.

But then we also have a set of thoughts where we have talked about delivery system reform where you are trying to take the risk and the delivery of the care to the entire patient. I mean we have made a number of recommendations inside the managed care space in order to address those types of issues because there you have a model and a payment system where you are directed to the entire patient and you are trying to measure quality and outcomes for that patient. And so we have made recommendations there, which given time I won't blow through.

And then the other thing that we have tried do is support the development of similar models in the fee-for-service environment, like an accountable care organization, and how a set of fee-for-service providers can have a top line, you know, benchmark and manage against that with quality metrics and manage against that benchmark so that they can control expenditures, improve the quality of the beneficiary, but again thinking about that beneficiary as their entire experience and not a specific, you know, set, you know, this service or that service.

And we have made a set of recommendations and given advice to the Secretary on how to improve the accountable care organization. The very last thing I will speak to very quickly is we have also been having some conversations about how to reorient MIPS on the physician side and the APMs on the physician side, or broader than the physicians, but on the physician side, in order to get more of this movement to kind of an organized look at the beneficiary as a whole experience rather than service by service. There are sort of three, four areas in there. This will be in our June report.

Mrs. Black. Yes. So you just spoke about models. Are there any models that are being tested that you would come back and say these models are being tested and this is what is working and not working?

Mr. Miller. There are a number of models that are being tested in the CMMI, and both at the patient level, ACOs. There is a model around chemotherapy and oncology services, sort of building a bundle around that. There are models around different post-acute care types of experiences, you know, kind of a smaller episode, not the whole patient episode.

There is not a tremendous amount of final, clear evidence that says this is working, everything is good to go. That is still, you know, feels like it is not quite there yet.

Mrs. Black. Thank you. I yield back.

Chairman Tiberi. Thank you. And last but not least, Ms. Sewell is recognized for 5 minutes.

Ms. Sewell. Thank you, Mr. Chairman.

Thank you, Dr. Miller, for being here today and giving us your insight on the current state of Medicare.

My home State of Alabama has the fourth highest rate of Medicare beneficiaries in the country and the lowest hospital Medicare reimbursement. Our population is very dependent upon Medicare, and we often feel that the way the wage index works against us is not very fair.

This is quite alarming to me, not only because it seems unfair, but also, when you think about the fact that we are contemplating making Medicare trust fund even less solvent, it just means that we need to make sure as policy makers that we are not going in the wrong direction when it comes to Medicare and Medicaid.

As I visit my hospital administrators, and physicians, and nurses, across my district I am concerned about the impact of proposed Medicare cuts and Medicaid's uncertainty on primary care shortage.

I have an article that I would like to submit for the record about the primary care physician shortage in the Black Belt rural counties of Alabama that was in the New York Times --

Chairman Tiberi. Without objection.

The New York Times https://nyti.ms/2rjpo66

DealBook WITH FOUNDER ANDREW ROSS SORKIN

A Whistle-Blower Tells of Health Insurers Bilking Medicare

By MARY WILLIAMS WALSH MAY 15, 2017

When Medicare was facing an impossible $13 trillion funding gap, Congress opted for a bold fix: It handed over part of the program to insurance companies, expecting them to provide better care at a lower cost. The new program was named Medicare Advantage.

Nearly 15 years later, a third of all Americans who receive some form of Medicare have chosen the insurer-provided version, which, by most accounts, has been a success.

But now a whistle-blower, a former well-placed official at UnitedHealth Group, asserts that the big insurance companies have been systematically bilking Medicare Advantage for years, reaping billions of taxpayer dollars from the program by gaming the payment system.

The Justice Department takes the whistle-blower's claims so seriously that it has said it intends to sue the whistle-blower's former employer, UnitedHealth Group, even as it investigates other Medicare Advantage participants. The agency has until the end of Tuesday to take action against UnitedHealth.

In the first interview since his allegations were made public, the whistle-blower, Benjamin Poehling of Bloomington, Minn., described in detail how his company and others like it — in his view — gamed the system: Finance directors like him monitored projects that UnitedHealth had designed to make patients look sicker than they were, by scouring patients' health records electronically and finding ways to goose the diagnosis codes.

The sicker the patient, the more UnitedHealth was paid by Medicare Advantage — and the bigger the bonuses people earned, including Mr. Poehling.

In February, a federal judge unsealed the lawsuit that Mr. Poehling filed against UnitedHealth and 14 other companies involved in Medicare Advantage.

"They've set up a perfect scheme here," Mr. Poehling said in an interview. "It was rigged so there was no way they could lose."

A spokesman for UnitedHealth, Matthew A. Burns, said the company rejected Mr. Poehling's allegations and would contest them vigorously.

"We are confident our company and our employees complied with the government's Medicare Advantage program rules, and we have been transparent with C.M.S. about our approach under its murky policies," he said, referring to the Centers for Medicare and Medicaid Services, which administers Medicare Advantage.

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At the heart of the dispute: The government pays insurers extra to enroll people with more serious medical problems, to discourage them from cherry-picking

healthy people for their Medicare Advantage plans. The higher payments are determined by a complicated risk scoring system, which has nothing to do with the treatments people get from their doctors; rather, it is all about diagnoses.

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"I came to the point where I just couldn't participate in what they were asking me to do anymore," he said.

A version of this article appears in print on May 16, 2017, on Page A1 of the New York edition with the headline: Ex-Insurer Says 'Perfect Scheme' Bilks Medicare.

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Ms. Sewell. Thank you. Perry County, which is in my district, not only does it have one of the lowest number of doctors, I think it only has two and only has two ambulances, but most recently it had a terrible outbreak in TB, tuberculosis, and it was 100 times higher than the national average and higher than rates in India and Kenya.

So you can imagine I was quite alarmed having that right in my backyard in my district. Well, there are only three physicians countywide, and only one is in Marion where most of the outbreak was.

Studies indicate that the addition of a single primary care physician to a community causes the local economy to grow. Unfortunately, it is predicted that America will be short as many as 30,000 primary care doctors by 2025. In your March 2017 report, the nature of the fee for service payment leads to, quote, "Undervaluing of primary care." end quote.

So, Dr. Miller, my question is, can you expound upon the report's findings with respect to primary care and the salary disparity between primary care and specialty care and the impact that it has on our shortage, the shortage?

Mr. Miller. Yes, I think I can. And, you know, this is an issue that the commission has pursued for several years, and so it shows up in several reports. And a couple things to keep in mind and then I will get you to what we have said about it.

You know, one of the phenomenon is if you are a proceduralist you have greater ability to create new codes because things are more likely to be new there. They get priced at a certain level, and then if they, over time, come down because people become more efficient, spend less time doing it, they don't necessarily always come back down. And also as a proceduralist you generally have more opportunities to generate volume.

So for many years the commission is saying there has been this problem in the fee schedule and you have tracked on exactly your earnings if Medicare were to pay for everything, but even if you look at it at all-payer, look like this between sort of the procedural versus the primary.

Ms. Sewell. And it often has a bigger effect on rural hospitals and rural communities.

Mr. Miller. Right, that is correct, because in rural areas there are more primary care physicians. So we have made recommendations over time to rebalance

those dollars and increase the payments to the primary care side of the fee schedule.

The Congress actually did take action on that, but then it sunset, and so that issue is out there. You are exactly right. I was going to say this, but you said it first, which is that does have an indirect effect on rural areas because they tend to have more primary care.

And then the other thing that we have been talking about lately, this isn't a hard and fast recommendation -- or actually we did make this recommendation at one point, I think. Where you might begin to say for the primary care physician if you make that add-on payment instead of making it service-by-service you make it per patient, and that way the provider has flexibility.

It doesn't have to keep seeing patients to generate revenue but can use that revenue to do things like spend the afternoon on the phone doing care coordination, hire a nurse practitioner to help with the coordination in the office or whatever the case may be. So there has been thinking like that along those lines.

Ms. Sewell. You know, since my home State of Alabama has one of the lowest wage index I have introduced a bipartisan bill with my colleague Diane Black, I want to thank you for that, which would provide more equity in the area of wage index formulas by creating a floor of .876.

Many argue that hospitals in rural and low cost areas should simply raise their wages. What reforms need to be made to the formula to provide more equity to the current reimbursement structure?

Chairman Tiberi. The gentlelady's time has expired. Could you and your staff reply to her in writing?

Mr. Miller. Can I say five words?

Chairman Tiberi. Five words.

Mr. Miller. We have a recommendation on that. I don't know how many words that was.

Chairman Tiberi. That was pretty impressive, Dr. Miller.

Mr. Miller. So we can help you.

Chairman Tiberi. Mr. Reed, you are recognized for the final 5 minutes as the vote has begun.

Mr. Reed. Well, thank you, Mr. Chairman. And I am way over here, and it is good to see you way over there.

Thank you, Dr. Miller. I wanted to follow up on my colleague from Oregon Earl Blumenauer's comments about hospice and the hospice recommendations in your bill. I also am very committed to hospice and palliative care across America and work with my colleague quite a bit on it.

So as you looked at the hospice update and not recommend any update in the MedPAC recommendation, my understanding you also looked at quality of care in coming at that determination, and could you give me any feedback as to what you are seeing in the quality of care in the hospice environment that you saw in the report?

Mr. Miller. Okay. This has been very difficult to track because there hasn't been until recently a lot of good measures of quality and recently CMS has begun to collect up measures. And so I am not exactly, you know, prepared to tell you how the quality profile looks these days because it is sort of just coming online. It might be actually measurable, but at this particular moment I am not able to pull it up.

But I will say this, one of the things that we have been thinking about beyond what has been being collected is looking at things like this, live discharges. We think live discharges if you have a lot of those are an example of potential quality issues and other issues, quite frankly.

And then also there are issues around the skilled, when the presence of a hospice provider in a patient's home in the late stages and whether there is an enough of that going on when the patient enters their late stages.

Those are a couple of areas that we have been looking at, and then as I am trying to say not very articulately there is a new set of measures that were put in place and are starting to come in now, I think, although I may need to double check exactly where all that stands.

Mr. Reed. I would appreciate it if you get that information if you could share with our office.

Mr. Miller. Absolutely.

Mr. Reed. I am very interested in looking at those impacts because I am a firm believer, not only does this hospice and palliative care make good fiscal sense for the purposes it serves, but also, the quality of care to patients. Being a hospice volunteer myself here in DC I can attest anecdotally to the benefit I have seen in patients of hospice and palliative care.

So on another topic, another issue, I come from Western New York. It is a rural section of New York where the Finger Lakes, Corning, is my home town, and one of the things that I worked down here extensively since 2010 is on the Medicare Dependent Low Volume Reimbursement Policy. Peter Welch on the other side and I have teamed up, Peter Welch off this committee, but teamed up on this issue.

Can you give me any indications as to why that reimbursement policy makes sense especially in a rural environment, and what do you see on the horizon, the pros and cons of extending that permanently?

Mr. Miller. And the "it" in this sentence is the low volume and the Medicare dependent?

Mr. Reed. Medicare dependent and the two different reimbursement policies.

Mr. Miller. Okay. Yeah. Two quick comments, and I realize we are time limited here.

We are the people who actually recommended a low-volume adjustment. We support that in concept. Unfortunately, the way it was implemented was not the way to implement it. So here is the way to think about it. Let's say you and I both have a -- you have a thousand-person admit hospital, and I have a thousand admit hospital. That is low volume, and that means we probably are struggling with covering our fixed cost.

But the way it was implemented it said Medicare admissions, and so that means that most of your admissions are Medicare but only some of mine are Medicare. I get help, you don't. And yet we both might be in the same boat. So we are thinking reset the metrics so it ties to total admissions, and we have some ideas of where that cutoff should occur.

The other thing I would say on the Medicare dependent and the low volume is they are often aimed at the same objective, you know, helping a hospital that is

struggling with fixed costs. We are concerned about some duplication. Some hospitals are pulling both, and maybe that's not an exact great use of a Federal dollar.

And then on the Medicare dependent hospital issue there is this notion, you know, it may make sense as an adjustor, but all of these rural adjustors be conscious of the fact that you are not giving it to hospitals that are 10 miles away from each other, then you may be propping up two, you know, operations that just aren't going to economically ever be efficient and maybe it needs to be some consolidation and then a subsidy there.

Mr. Reed. Okay. I appreciate that.

Mr. Miller. That is the two thoughts.

Mr. Reed. Well done. With that I yield back.

Chairman Tiberi. Thank you, Mr. Reed, for your leadership on this issue, as well.

Dr. Miller, thank you for your time --

Mr. Miller. No problem.

Chairman Tiberi. -- your incredible patience, and your expertise in sharing that with us today. These are important issues. Ensuring the efficiency of Medicare for future generations is something that we should be in a bipartisan way all working together on, not just in this Congress but in future Congresses, and we look forward to having you back in the future.

Mr. Miller. I appreciate it.

Chairman Tiberi. Thank you. Please be advised that members will have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that this hearing is adjourned.

[Whereupon, at 4:00 p.m., the subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

Answers to Questions for the Record
Following a Hearing on the Current Status of the Medicare Program
Conducted by the Committee on Ways and Means
in the U.S. House of Representatives
May 18, 2017

Representative Sewell

Question: As noted in the March 2017 report, the nature of FFS payment leads to an "undervaluing of primary care." Dr. Miller, can you expound upon the salary disparity between primary care and specialty care and its impact on the primary care physician shortage?

Answer: Using data from a physician compensation survey conducted by the Medical Group Management Association in 2015, we found that average compensation for certain specialties was more than double the compensation for primary care physicians.[1] For example, radiologists averaged $560,000 in annual compensation and physicians in nonsurgical, procedural specialties (such as cardiology and dermatology) averaged $545,000 in compensation, compared with $264,000 in average compensation for primary care physicians. Such disparities could deter medical students from choosing primary care specialties and discourage current practitioners from remaining in primary care practice. Although Medicare beneficiaries generally have good access to care, access to primary care could become more difficult in the future as the baby boom generation ages into retirement.

In addition, we simulated compensation as if all services provided by physicians were paid under Medicare's fee schedule. We found that simulated compensation for radiologists and physicians in nonsurgical, procedural specialties was still more than double the compensation for primary care physicians. This finding suggests that Medicare's fee schedule for physician and other health professional services is an important source of compensation disparities among specialties. We have observed this disparity in payments among other payers as well.

The fee schedule and the nature of fee-for-service (FFS) payment leads to an undervaluing of primary care and overvaluing of procedures. The undervaluation of primary care stems from two problems with the fee schedule: first, payment rates for primary care services are undervalued relative to payment rates for procedural services and tests; and second, FFS payment allows some specialties to more easily increase the volume of services they provide than others.

Question: What commonalities are there between states with the greatest primary care physicians shortages?

Answer: While the Commission has not estimated shortages in primary care physicians, we have long observed that the current Medicare physician fee schedule overvalues procedures and

[1] Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. MedPAC: Washington, DC.

undervalues primary care. This imbalance contributes to a disparity in compensation between primary care and specialist physicians.

Question: Specifically, what incentives does the Commission believe would help address the primary care physician shortage, particularly in places where profit margins are more likely to be negative and unappealing to young physicians?

Answer: The Commission has made several recommendations over the years to rebalance the fee schedule and bolster support for primary care. The Commission has recommended identifying overpriced services and pricing them accurately, replacing the sustainable growth rate system with payment updates that are higher for primary care than specialty care, creating a budget-neutral primary care bonus, and establishing a per beneficiary payment for primary care practitioners.

Specifically, the Commission recommended in 2008 that the Congress establish a budget-neutral payment adjustment under the fee schedule for primary care services furnished by primary care practitioners. In 2010, the Congress created such a payment adjustment, called the Primary Care Incentive Payment program (PCIP). In our March 2015 report, the Commission recommended that the Congress establish a per-beneficiary payment for primary care to replace the PCIP, which expired at the end of 2015. Such a per-beneficiary payment would provide funds to support the investment in infrastructure and systems that facilitate care management and give providers more flexibility to optimize the delivery of care. A per beneficiary payment would also be a first step in moving Medicare's payments for primary care from a service-oriented approach toward a beneficiary-centered approach that encourages care coordination. To fund this payment in a budget neutral manner, the Commission recommended reducing fees for all fee schedule services other than primary care visits furnished by any provider. This funding method would help rebalance the fee schedule between specialty care and primary care.

Question: Dr. Miller, in the 2017 Report, the commission writes that readmission rates fell for all conditions and for conditions included in the Hospital Readmission Reduction Program in 2015, which ultimately means that care, not just coding, is improving, right? Unfortunately, however, the Commission also notes that a larger share of major teaching hospitals and hospitals serving large shares of poor patients will receive a readmission penalty this year. The Commission recommends a change to evaluate hospitals' readmissions rates against rates for peer hospitals with similar shares of poor patients as a way to adjust penalties in recognition of the impact of socioeconomic status on a system. Dr. Miller, can you talk about some of the challenges hospitals who care for higher low-income populations face and why they may need to be compared to similarly situated hospitals rather than those in more wealthy areas?

Answer: The Commission found that hospital readmission rates declined from 2011 to 2015. These improvements reflect efforts that hospitals have made to improve readmission rates.[2]

In 2017, a larger share of major teaching hospitals and hospitals serving large shares of poor patients will receive a readmission penalty through the Hospital Readmission Reduction (HRR) program.[3] The Commission has recommended an improvement to the HRR, which was adopted in the 21st Century Cures Act. The policy will compare hospitals' readmission rates against rates for peer hospitals with similar patient populations as a way to adjust penalties for the effects of socioeconomic status on hospitals' readmission rates, and improve equity in the program. Also, hospitals' unadjusted performance is shown to beneficiaries so that they have full information on hospital quality.

The Commission has expressed concern that when payment policies penalize providers serving poor or minority populations—those providers have fewer resources that they can use to improve care. Medicare can aid providers serving poor or minority populations by reprogramming resources from the quality improvement organizations (QIOs), granting technical assistance, and other resources to beneficiaries getting care from those providers. One of the Commission's goals is that all beneficiaries should have access to high quality care, regardless of health status, income, and race.

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[2] Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. MedPAC: Washington, DC.

[3] Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. MedPAC: Washington, DC.

PUBLIC SUBMISSIONS FOR THE RECORD

Rep. Devin Nunes
Statements for the Record
May 18, 2017
Hearing on Preserving and Strengthening Medicare
Staff Contact: Ruth Hazdovac

The Medicare ambulance add-ons are important to the ambulance service agencies in my district, which comprises urban areas such as Visalia as well as rural and even super rural or wilderness areas near Sequoia National Park. To ensure my constituents have access to vital and often life-saving ambulance services, it is crucial that the temporary increases remain in effect.

As you know, ensuring that Medicare beneficiaries have access to quality health care choices that meet their needs has been a long-standing priority for me. As we discuss ways in which the committee can strengthen Medicare for current and future beneficiaries, it's important that Special Needs Plans, which are designed with the specific needs of the chronically ill in mind, be part of that conversation. I would like to work with you moving forward as we determine the role of these innovative plans within our Medicare system.

Where Health Care Won't Go – Harper's Magazine

A tuberculosis crisis in the Black Belt

By Helen Ouyang

It was a miserable January morning in Marion, Alabama, last year, with temperatures twenty degrees below average and freezing rain that sliced sideways. But that did not dissuade the people lining up outside the Perry County Health Department. The first appeared at the door when the sun had barely risen, then a couple more arrived, and soon they came by the hundreds. Some brought their children, others showed up with cousins; there were families four generations deep. By nine o'clock, the line had lassoed around the building, with its tail pitching into the parking lot. People held umbrellas in one hand and with the other gripped handkerchiefs or scarves tightly across their mouths. Many were from the same neighborhood, and most were black. All of them had come to collect twenty dollars in exchange for getting tested for tuberculosis.

Shane Lee, Marion's town doctor for the past quarter-century, pulled his taupe pickup truck into the parking lot. His clinic was kitty-corner to the health department, and he was having trouble finding a spot. It was Lee who had discovered the community's first severe case of TB, a little more than a year earlier. In October 2014, a nurse practitioner tore into his office with a fresh medical mask over her mouth, frantically waving an X-ray film. The mask, a tight-fitting turquoise respirator, was unusual. And then he looked at the radiography, which showed that the patient's lungs were nearly completely whited out. It was the worst case of tuberculosis that he had ever seen.

The road from Marion to Greensboro, Alabama, the site of the closest hospital. All photographs by Nina Robinson

Since then, Marion, a town of 3,500 and the seat of Perry County, has been grappling with a historic outbreak of a disease that has vanished from worry in much of the United States. Thirty-four active cases have been found; if that doesn't seem like a lot, consider that the rate of infection — what the World Health Organization uses to determine severity — is almost a hundred times the national average, and higher than the rates in India, Kenya, and Haiti. Nearly 200 more in Marion were discovered to have latent tuberculosis, meaning that they were infected but had not developed active symptoms — which include bloody coughing, shortness of breath, night sweats, and weight loss.

There is no hospital in town. The nearest one, twenty minutes away in Greensboro, has minimal resources. The road to get there is narrow, unlit at night, and littered with roadkill. Perry County has only two ambulances, one of which is on standby for the local nursing home. Life expectancy here is seven years lower than the U.S. average, and the percentage of obese adults is almost a third higher; by the latest count, more than a quarter of births take place without adequate prenatal care. Lee's clinic is Marion's only place for X-rays.

When he saw the image of the infected lungs, he called Pam Barrett, the tuberculosis controller for the state of Alabama, in Montgomery. She conferred with her team, and as Lee alerted them to signs of infection in more patients, they realized that all the cases originated from the same place — an impoverished African-American neighborhood called the Hill. While encounters at the grocery store or the hair salon can, on rare occasions, transmit TB through the air, repeated and extended exposure — living in the same apartment, for instance — puts someone at the greatest risk. This was how the disease was spreading in Marion. "We knew all the cases

were coming from the Hill," Barrett told me recently. "Nobody else needed to be tested unless they were close contacts."

The case Lee saw in that first X-ray was at an advanced stage, and the patient died. Though the health department's staff tried to track those who might be vulnerable to infection — they traced the patient's immediate contacts until they found someone positive, then traced that person's contacts, working outward — most people declined to speak about others in their midst, even when they came for screenings at Lee's clinic.

If the team wanted any chance of containing the outbreak, they needed to connect with the Hill's residents quickly. Barrett came up with an idea: a health fair to test them, an event planned not as "a tuberculosis thing" but as a fun community gathering with free pizza and soda, token giveaways, and raffles for cash. In addition to TB screenings, the fair would offer blood pressure monitoring, finger pricks to check glucose levels, nutrition counseling, and sexual-health education materials. To get local buy-in, her staff partnered with Sowing Seeds of Hope, a Christian community-development organization in Marion, which loaned its logo for flyers and helped post them around town. While location scouting, Barrett personally passed word on to the guys who frequented the Hill's basketball court.

Early one Saturday morning that November, Barrett and her colleagues drove several hours from Montgomery to the Hill. They convened at the basketball court and began setting up tables and supplies. But shortly after they got started, a group of young men appeared and threw beer bottles at them, which whipped past their heads and crashed near their feet. The health workers ducked for cover. The men shouted expletives, then ran off. Barrett called the police. Soon, two sheriffs stationed their car conspicuously out front. Eventually the testing began, and the health workers kept on until the afternoon. But turnout was low, and no active cases of TB were found.

"I've done health fairs all over this community, and I've never had that kind of reception," Frances Ford, a native of Marion and the director of Sowing Seeds of Hope, told me. The health department ran into trouble, she said, by popping in as outsiders and declaring their intention to concentrate solely on this neighborhood. Barrett, unlike the people she was trying to reach, is white, and though some members of her team are black, they didn't know the town. "They targeted African-American people — they referred to them as 'the people on the Hill,' " Ford explained. "The way things were said, the wording. It was stereotyping. That's what I heard."

Over the next year, the outbreak continued to rage. Desperate, Barrett decided to try something that the health department had never done before: a cash reward. Twenty dollars to get tested; twenty more if patients returned to pick up their results. If those results were positive and patients followed up for chest X-rays, another twenty would be disbursed.

On that January morning in 2016, as the financial-incentives program began, Barrett's team finally made some headway. One by one, people from the line around the health department were let in, and during the next three weeks, the state's nurses and doctors managed to test more than 2,500 people. All told, the project cost the state of Alabama $235,000.

Shane Lee on his way to a house call

"No public health department has money lying around to pay people to look after their health," Richard Chaisson, the director of the Johns Hopkins Center for Tuberculosis Research, told me. I asked the health workers why they didn't consider simply going door-to-door around the Hill instead. It would have been less expensive, more personal, and easier to trace members of a household. One of the nurses, a white woman, replied: "If we wanted to get shot."

Ford was aware that the Hill had a reputation for being dangerous, but she wanted me to know that she didn't share this view. "I've never seen anything that I feel uncomfortable around," she said.

When a disease outbreak occurs, Chaisson explained, "the norm is panic, for people to demand testing from the health department, and you can't do it fast enough." But the Hill has never been much for demands. The town of Marion sits in the belly of the Black Belt — historically, a ribbon of seventeen counties in central Alabama and parts of northeastern Mississippi, where whites enslaved black people to farm cotton in the dark, fertile soil; the term has come to refer broadly to predominantly African-American areas in the rural South. Across the Black Belt, there is grave poverty; Alabama is the fourth-most-impoverished state in the nation, and Perry is its worst-off county — 47 percent of residents live below the poverty line. The burden is shouldered unequally, as the poverty rate in Perry County is three times higher for black people than for whites. Jim Crow is gone, yet segregation lingers, along with its associated injustices. While Black Belt districts typically go blue, the rest of their states are deep red; last year, after the state of Alabama enacted a law requiring photo identification to vote and then promptly closed D.M.V. offices in Black Belt counties, a federal investigation confirmed that this targeting amounted to discrimination.

Lee's clinic, near downtown Marion

History feels present in this part of the country, and the past has provided good reason for people to be wary of the medical establishment. In 1932, the Tuskegee Study of Untreated Syphilis in the Negro Male was conducted only two hours away from Marion. Scientists rounded up a group of uneducated sharecroppers, many of whom had syphilis, for long-term research. In the 1940s, when penicillin proved curative, the researchers left the group untreated; many subjects suffered severe complications of syphilis and infected their partners and children. Lee told me that during the health department's tuberculosis campaign, his nurse saw a Facebook post circulating among people in town that compared the testing to the Tuskegee study.

There are similar stories throughout the Black Belt. Beginning in the 1920s, doctors performed hysterectomies and tubal ligations on black women without their consent; this practice, the "Mississippi appendectomy," continued for decades. In 1933, North Carolina assembled a five-person eugenics board, which included physicians, that launched a sterilization campaign of "unfit individuals" — mostly poor African Americans — for the sake of their "best interest and welfare." The program wasn't dismantled until the late 1970s.

In 2010, after the Affordable Care Act went into effect, Alabama chose not to expand Medicaid. Governor Robert Bentley, a doctor who recently resigned following reports that he used state funds on an extramarital affair with an aide (the one who proposed the D.M.V. closings), argued that it would cost too much and make "able-bodied individuals" dependent. "We will not expand on a flawed and broken system that encourages greater reliance, not on self, but on government," he said, declining federal dollars that would have extended health insurance coverage to anyone earning less than $16,394 a year. In Perry County, where the average

income is just under $15,000 and about 20 percent of residents are uninsured, that expansion would have been transformative.

When Donald Trump entered the presidency, Republicans proposed a replacement plan that threatened to make matters worse: the American Health Care Act, which took aim at Medicaid, out-of-pocket cost assistance, and tax credits. It also required people who lacked coverage for more than two months to pay a 30 percent surcharge when they finally bought it again — an especially burdensome policy in Marion, where employment frequently comes and goes. The bill failed to garner adequate support in Congress and many members of the G.O.P. backed off. But Trump has said that he expects to see a new deal by next year, and the far-right-leaning Freedom Caucus has clung to its mission of dismantling the A.C.A.

That prospect looms darkly over Perry County. When I asked Frances Ford about coverage, she told me, "It's an impossibility for people. And these people are trying to work. Some people here are going to say it's not *worth* working." She went on, "You're working, and all your money is going to health insurance."
Several months after the state's paid testing, I drove into Marion. I passed a residential area with beautifully restored antebellum mansions, and the town's courthouse, a gracious building with magnificent columns. But as I wandered around the commercial strip of Washington Street, which runs two miles between the health department and the Hill, the sights revealed themselves gloomily. The door of a red building on a corner had years ago opened to the Ole Theater Cafe. There had been a clothing store, a stationery store, an auto-body shop, a restaurant or two. Now their storefronts were closed and battered-looking.
When I reached the Hill, I turned left at a weather-beaten USED CARS sign, parked, and made my way toward the site of the health department's ill-fated fair. An old Buick was parked there; four men sat inside drinking beers and bobbing their heads to Michael Jackson's "Black or White." I went up to the window. The man sitting in the front passenger seat kept his hand firmly planted on a rifle resting against his left thigh.

Left: The Hill neighborhood. Center: Washington Street in downtown Marion. Right: The Hill's basketball court

I was there, I said, to see Orlando Moore, who lived in the neighborhood. We'd met before, and had made arrangements to discuss the TB testing. The man wasn't sure where Moore was, but eventually I spotted him — a short, scrawny guy with a fade and a gold hoop in his left ear — sitting in a white car nearby. Moore, who was thirty-one, used to drive a truck and mow lawns. Now he had no job, and was expecting his first child — a boy — with his girlfriend, Charnissa, who was in the driver's seat. He nodded as I approached the window. "Hey, you found me," he said. There was a woman in the back, who introduced herself as his cousin.

Moore invited me over to his apartment. In the kitchen, he pulled a bottle of juice from the refrigerator and sat down. The women hovered around us, quiet at first. I asked about the testing. "The Hill's used to being

targeted," he said. "Have you ever had to deal with white people? They look at us as one of the lowest families in Marion." The Moores had been there for generations. He told me that he got tested when the health department offered a cash reward, but added quickly that the results were negative and that he didn't know anyone who had the disease. His cousin, wearing a rainbow-striped dress, chimed in to agree.

Charnissa was incensed over the way the health workers had zeroed in on their neighborhood. "They're singling us out," she said, her voice rising. "Just because we're around! Nobody here had it!" Exasperated, she stormed outside.

I took that as my cue to go. As I headed off, I bumped into Marsha White, a middle-aged woman in a pink-and-white summer dress and knee-high boots, sitting on a kitchen chair outside her apartment. I asked her about the outbreak, and she told me candidly that she had been diagnosed with TB and had gone through treatment. "I'm not ashamed of it," she said, which she acknowledged was unusual on the Hill. She'd discovered that she was infected when her sister pointed out that she appeared to have lost a lot of weight. "I took all my clothes off, looked in the mirror, and I started crying," she recalled. "And every time I walked or talked, I got short of breath." She was a patient in Lee's clinic, and she praised the health department workers for looking after her. Without them, she said, "I think I would've died."

We talked for a while, and after a few minutes, Moore's car appeared on the block. He and Charnissa half-waved at me. His cousin jumped out of the back seat and greeted White with a kiss on the cheek, grabbing some cigarettes from her pocket before dashing off again. "That's my baby girl," White explained.

I hadn't realized that they were family. Lowering my voice to a whisper, I asked if she had kept her TB diagnosis from her daughter.

She chuckled and slapped her thigh. "My daughter? She knew I had it! Her boyfriend also had it!"

I was confused — I told her that, moments earlier, they'd all said that they were healthy, and so was everyone they knew.

"Them folk don't want you to know what's going on with them," she said. "She just told you a lie."

The apprehension I encountered in Marion was so well founded that I wondered if any outsider could surmount it. "I think they trust me as a person," Shane Lee told me. "Because I've been here forever. But there's an inherent distrust of the system in general by the black community."

At fifty-five, Lee — a "blue-collar doctor," as he called himself — had the build of a former football player, with light, ruddy skin and a sandy-brown mustache. He was serious and a bit gruff, reserving his dimpled smiles for the very old and the very young. When I met him at his clinic, he greeted me with a brisk "Good morning, ma'am," and brought me over to his truck to set off for the homes of patients who were too ill or immobile to travel. He usually did this once a week, on Thursdays. With his radio station tuned to Fox News, we rumbled along Washington Street up to the Hill. Hannah Zahedi, a second-year medical student who was shadowing him, rode with us.

Lee treating patients during house calls

Lee is originally from Hueytown, near Birmingham. He's a major general in the Army Reserve, a flight surgeon; for his family medicine residency, he trained not far from Marion, and started seeing patients here when the reigning town doctor made moves to leave. "I was recruited by the town banker and the pharmacist," Lee said. "The town banker took me quail hunting. I like to hunt and fish and shoot ducks." He and his wife settled on a 600-acre farm a few miles from the clinic. "This morning, as I drank my coffee, I saw two bald eagles," he told me. "You don't get that in the city, do you?"

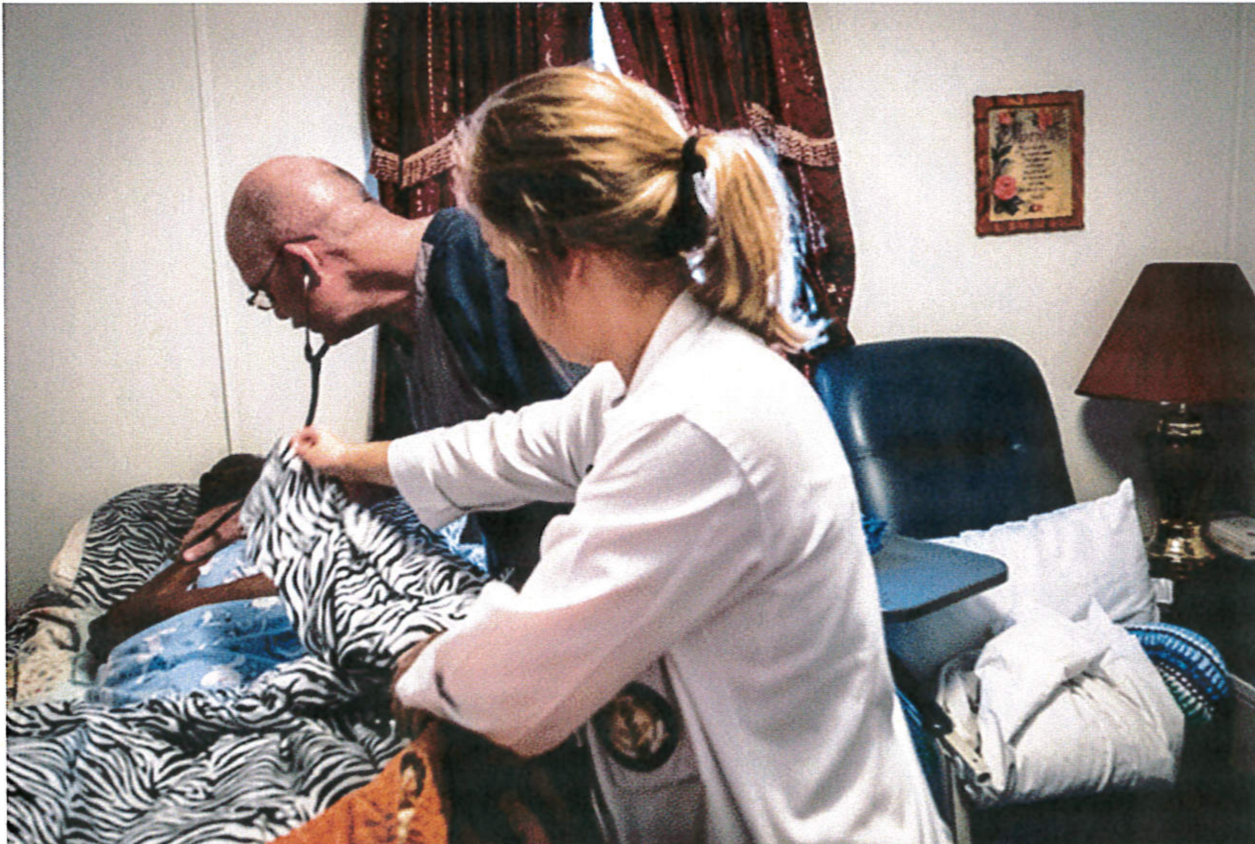
We passed by Marion's nursing home, where Lee serves as director. The building had housed a hospital until the late Nineties, when it could no longer pay its bills; the county remained more than $1 million in debt since the closure. Lee had been on its board. "Yeah, somebody's going to have a heart attack at three A.M., but you can't run a multimillion-dollar facility for one person having a heart attack at three A.M. every now and then," he said. "That's when you need good ambulance service and nine-one-one." Since 2000, eighteen additional hospitals in Alabama have been shuttered, many of them in rural areas. Lee said that he and some Perry County officials would like to make emergency services more reliable, but there is never enough money in the budget. Approaching another street, Lee pointed to a redbrick house that had been the home of Spencer Hogue, one of the original three people targeted in 1984 by Jeff Sessions — then the U.S. attorney for southern Alabama — for voter fraud. Hogue had been a patient of Lee's, and he was diagnosed with latent tuberculosis before he died from other health problems, in September. "He was a no-kidding civil rights warrior," Lee said.

Turning off Washington, we stopped in front of a one-story clapboard house. Thick weeds had overtaken the front lawn. Lee rapped on the door and roared, "Dr. Lee here!" We entered, following a woman's voice to a room in the back, where she was mostly confined to bed because of polio. On her nightstand was a toothbrush, a

tube of hand cream, and a bottle of hot sauce. Lee had already tested her for tuberculosis, and she was negative, but he continued to check up on her frequently. That morning, he wanted to confirm that she had gotten her annual flu and pneumonia vaccines.

"No colds in three or four years," she said proudly.

On rounds, Lee doesn't consult his phone or a notebook, and he knows the social situations of his patients as well as their ailments. He asked how she planned to get by now that her nephew, who had come from up north to help her for a few months, had returned home. "Oh, I'll make do," she said.



Lee treating patients during house calls

Lee seemed unconvinced. As we made our way out, he remarked, "It looks like you need new crutches." He thought for a minute, then said, "I've got mine left over from my knee surgery. I'll have Hannah here run back down and drop them off in the next couple of days."

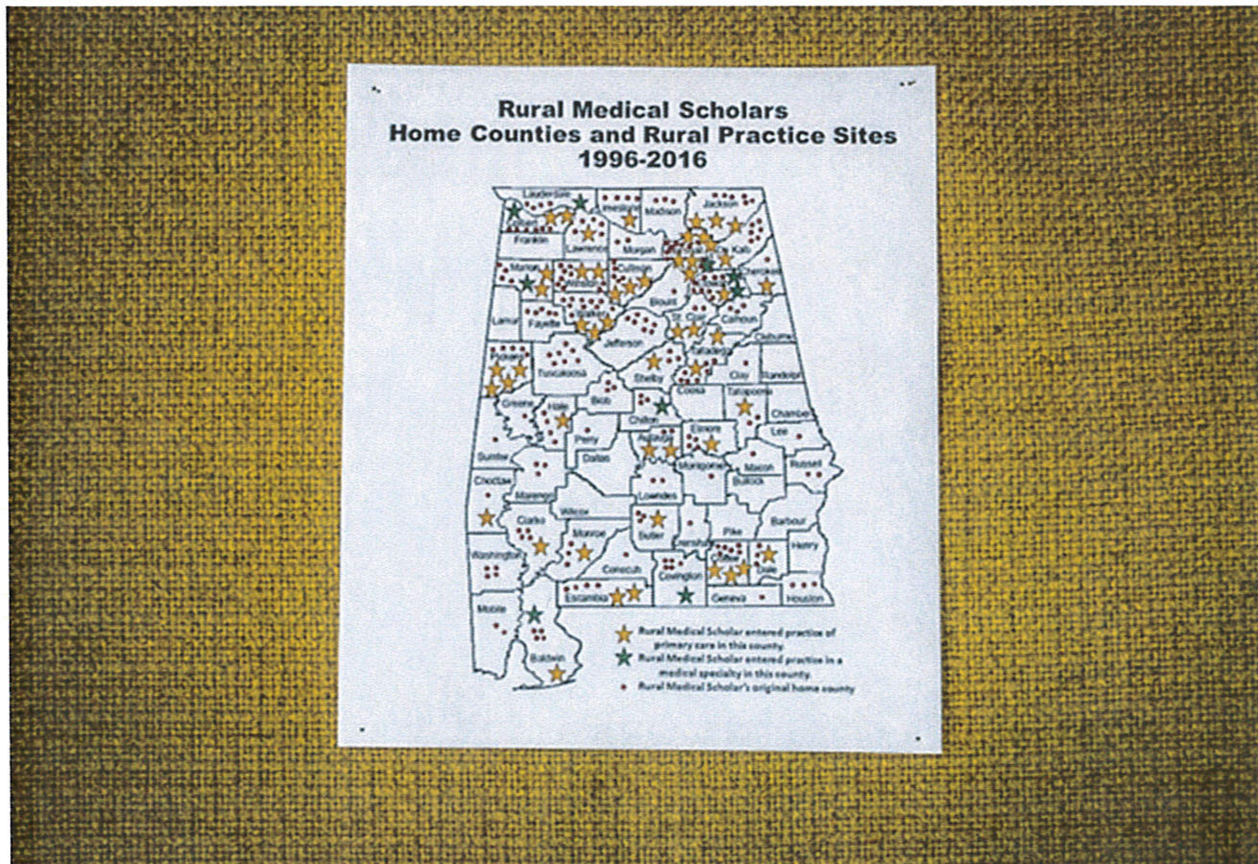
Then we drove off — Lee and Zahedi were seeing more than half a dozen patients before lunchtime. "He's the only doctor I've ever been with that actually does home visits," Zahedi told me. "It's pretty cool. You never know who a patient is until you see them in their own environment. It really helps to see how they live."

Zahedi, I learned, had family roots in Perry County. She was accompanying Lee as part of the Rural Health Leaders Pipeline, a medical education program that aims to build patient-doctor trust by recruiting and training students from communities like Marion, in the hope that they will return home and spend their careers providing primary care where it's desperately needed. It's predicted that America will be short as many as 30,000 primary care doctors by 2025. And though around 20 percent of the U.S. population lives in rural areas, only 10 percent

of physicians do. The pipeline was developed twenty-five years ago by John Wheat, a professor at the University of Alabama in Tuscaloosa. One evening, I joined Lee and Wheat for dinner at a seafood restaurant near campus as they discussed the depressing state of health care in the Black Belt over gumbo and fish tacos. Wheat, who is sixty-five, is tall and grandfatherly. He sipped on sweet tea. He's white — not born in the Black Belt, but his family moved there when he was young. He took to his rural surroundings — clearing the land, hunting rabbit, tending to horses and chickens — and eventually "married into a farm family." He attended the University of Alabama School of Medicine, and worked in cities for a while, but he felt compelled to go back to the countryside.

Lee slurped a spoonful of gumbo. "We need doctors," he said.

"Doctors from the community," Wheat replied. "The uniform testimony from rural Alabama is: 'We're tired of missionaries and mercenaries. We need *our* kids in medical school.' "



A map showing the home counties and practice sites of physicians who went through John Wheat's pipeline program

Of the few physicians who pass through the Black Belt, most stay for only a few years, to do their good deed or satisfy recruitment packages that forgive school loans in exchange for working in an underserved area. There is another doctor providing care in Marion, who came from Pakistan, originally to fulfill a visa requirement, but he doesn't live in town or conduct home visits. Lee had been trying relentlessly to recruit another doctor so that he could extend his clinic hours, but nobody was willing to make the commitment. "By their third year here, they're interviewing every other weekend to go somewhere else," he said.

When Wheat started the pipeline, in 1993, it was a summer program for high-school seniors from Alabama's rural towns. They lived on campus in Tuscaloosa and took college-level chemistry and a writing seminar. The students met physicians, received support from peers and mentors, and were exposed to the steps for admission to medical school — all the advantages a child growing up in a city would have. "The farm kid who's so rural he gets dizzy when he merges onto a four-lane highway? That's the kid I want," Wheat said. Several years in, to increase the number of black participants, he added an extra curriculum for the summer after high school that was aimed at minority students.

As the kids got older, Wheat made arrangements to secure their path in becoming physicians. If a student continued successfully in the pipeline and earned a minimum score on the Medical College Admission Test — lower than that required of other applicants — he or she would be guaranteed admission to the University of Alabama School of Medicine. Other rural students could apply to enter the pipeline for medical school by meeting the same academic standards. Wheat couldn't secure free tuition, but these students were prioritized by the state for scholarships.

Since the program began, about 120 pipeline students have graduated from Alabama's medical school. The first doctors entered into practice in 2004, and more than half have gone on to work in rural areas, compared with only 7 percent of their classmates. Studies have found that the addition of a single primary care physician to a community causes the local economy to grow by at least a million dollars per year; Wheat estimates that his program has delivered $320 million to poor rural towns — by generating medical revenue, creating employment, and revitalizing businesses.

But as we finished our dinner, my thoughts returned to Perry County, which hadn't seen any of those gains. Recruiting from the area could be difficult, Wheat said, even when kids desperately wanted to sign up. I'd witnessed this obstacle when I'd attended a pipeline event at a school in Tuskegee. A bespectacled boy raised his hand to ask, "If we get into the program, how are we supposed to get to campus?" He didn't know anyone with a car who would be willing to drive him to Tuscaloosa.

Customers at a gas station in Marion

Several years ago, when many of Wheat's first students — only teenagers at the time they entered his orbit — had just finished their residency training, he drew up a map. He'd plotted red dots on their home counties and gold stars where they went on to practice. Looking at the results, he could see that there was a strip in the middle that was virtually blank. "They go around the Black Belt or cross over the Black Belt, but they don't go *into* the Black Belt," he said. For years, he realized, he'd been inadvertently omitting the very place he'd started from.

Many people in Marion wanted their hospital back, I said — would that help?

"They think the cure-all is to open another hospital," Lee replied. "That's the worst thing you can do! You've got to get physicians first."

Wheat agreed. "The old theory of 'Build a hospital, and they will come.' Well, they don't come!" The Black Belt, he had found, was a place where health care never seemed eager to go.

The standard treatment for tuberculosis is directly observed therapy — nurses watch over patients and give them each dose of medication, which can be upwards of two dozen pills at a time. Some of the drugs are as large as almonds. Early on, pills must be taken daily, and then they're spaced out to twice a week, usually for another six to nine months. The treatment can make people feel awful, like they have the flu, and it can harm the liver, so patients are not allowed to drink alcohol.

Once Marion's test results came in, the state health workers arduously tracked down people around the Hill. Barrett told me what this entailed: "You have to pick them up at the dumpster behind Hardee's, and then drive them in your car with their head in your lap so no one would see them, and drop them off twenty yards away."

The health department bought a cell phone for a man who didn't have one, so that his nurse could find him to give him his medication. Patients without cars were taken for rides where they wanted to go. Others received fresh groceries. On completion of their treatment, to increase compliance, they earned a hundred dollars. If they were desperate, health workers would try to hand them extra money. "Any scenario, any way we could get people to take their medicines," Barrett said.

The state health workers left their homes in Montgomery for long stretches in order to work all hours on the Hill. They stayed at an inn in Marion and subsisted on takeout. "They care more about the patients than the patients care about themselves," Barrett told me. But even if it seemed that way, all the health department's efforts couldn't fill the underlying void of care within the community. "Everything was reactive, not proactive," Frances Ford said.

Wheat sees the spread of tuberculosis as the ultimate manifestation of an ongoing health care crisis in the region, characterized by mistreatment and neglect. "If we don't respond, these are the things that happen," he said. If a physician raised around Perry County had been working in Marion, he suggested, the outbreak would never have become so dire.

Last summer, as the state dispensed pills on the Hill, Wheat proposed to the University of Alabama a Black Belt Health Professional Scholars Program, in order to make it easier to bring students from the area into his pipeline. He hopes to further lower score requirements for their admission to medical school and to recruit students for a master's in rural health — a one-year degree that can be stretched out to two years, for extra MCAT prep time. Courses would be open to anyone interested in working as a physician assistant, dentist, or physical therapist, which would deliver more people home to provide valuable medical services. "Over the long haul, this is the best way I can see to make a dent in this social circumstance that we've allowed to smolder here for two hundred years," he said.

Wheat's pipeline is paid for mostly by the state, which provides about $875,000 on a year-to-year basis; he also occasionally gets money from philanthropic foundations and federal grants. The school is committed to sustaining the program, but the fate of Wheat's new proposal is less clear. His vision — $10 million spent over ten years and coordination across fifteen schools and campuses — may be too ambitious. "The idea of having physicians target the Black Belt, I think that's tremendously timely and admirable," Selwyn Vickers, the dean of the medical school, who was born in the Black Belt, told me. "But it's not just getting individuals who want to go back. It requires broader infrastructure changes in the Black Belt. The state has to make the place attractive and build infrastructure so people want to go back. Otherwise, you're not treating the cycle of poverty."

In the meantime, Wheat has become ever more solicitous toward Black Belt students. He leaves his door open for advising sessions. "I keep a box of Kleenex," he said. "Many tears have been shed in my office." He has purchased textbooks for kids who couldn't afford them and covered the costs of test fees. To beef up résumés, he has offered students jobs doing administrative work and postgraduate research.

One afternoon, I met Deanah Maxwell, a graduate of the program who is now thirty-seven. She entered the pipeline in its early years, as a teenager from Booker T. Washington High School in Tuskegee. (The current principal summed up her students' circumstances to me: "Ninety-nine percent get free or reduced lunch." She added, "They may have seen a shooting and stayed up late.") When Maxwell arrived at the University of Alabama that first summer, she saw the possibility of a new life. "I'm a junior in high school, about to be a senior," she recalled. "We didn't do a lot of chemistry labs. This is a full-fledged lab! Folks are lighting Bunsen burners, and I was like, 'What am I supposed to be doing?' "

She was enthralled, and persisted with premedical courses through college. She struggled with the MCAT — she took it twice before graduation, and both times failed to meet the pipeline's minimum score requirement for rural students — so Wheat found her a job as a research assistant, which gave her access to prep courses and study materials. On her third try, she passed. When she finished medical school, she worked in southern Alabama for a while before returning two years ago to Tuskegee, where she intends to stay.

Tuskegee, due east of Marion, is flat with green and yellow fields; in the center of town, near the site of the infamous syphilis study, is Maxwell's clinic. When I visited, she introduced me to one of her patients, Roberta Crenshaw, who sat in the exam room wearing a colorful floral shirt and bright red pants. I asked what she remembered of Maxwell's return. "I was so happy to see her!" she told me. "A *home* person. Somebody that grew up here. I know her father, I know her mother." Beaming, Crenshaw turned to Maxwell. "I'd been waiting fifteen years for you to come home!"

Where a doctor comes from matters to the place she works. Yet results of the MCAT — a grueling, eight-hour exam — can be entered into admissions algorithms such that applicants to medical school are axed before a human being even considers their background. When I asked Wheat whether any of his doctors-in-training resented his helicoptering or were irked that he was lowering the score bar for them, he replied, "No, the minority population that comes to us have found it a relief that someone understands that these quantitative measures are not measures of their potential." He continued, "Now, I've certainly had the *Caucasian* population question lowering the quality. And I say, 'Quality of *what*?' " Black Belt students, he went on, "bring an intention and an identity with an underserved population that it is a mission of our medical school to serve."

The purpose of doctors, after all, is to tend to patients' ultimate needs. Increasing the supply of primary care physicians is linked to lower mortality rates; after compiling data from studies across different parts of the country, a group of public health researchers found that by adding one more doctor for every 10,000 people, as many as 160,000 deaths per year could be averted. When the same researchers considered race as a factor, this benefit was found to be four times greater in the African-American population than among white people. Studies have also observed that the availability of primary care significantly reduces health disparities that result from income inequality.

Outside Alabama, a handful of other programs have tried to correct the distribution imbalance of physicians in the United States. At Thomas Jefferson University, in Philadelphia, a rural health pipeline has been targeting poor, mostly white areas of Pennsylvania and Delaware for forty years. The University of Missouri and the University of Louisville run similar initiatives. Last year, the City University of New York welcomed its first

class of medical students; the school intends to train doctors to care for communities in the Bronx and Harlem — which, in health care terms, have more in common with Perry County than with most of Manhattan.

Yet for the most part, medical schools are focused on selecting high achievers rather than grappling with inequality. While this has been an effective strategy in advancing American medicine, large swaths of the population perpetually go without proper health care, and it's hard not to see — as Lee, Wheat, and Ford do — that the lack of attention to places like the Black Belt creates the conditions for an outbreak of tuberculosis, along with scores of other diseases.

When I posed this dilemma to Robert Alpern, the dean of Yale Medical School, he conceded that interest in diversity doesn't always serve its true purpose. "We all offer scholarships to steal students from other schools, to save our own skin, but in fact we don't do anything for the country," Alpern told me. "All we do is shuffle these students around." A more comprehensive solution, he said, would be beyond the university's capacity.

George Daley, who became the dean of Harvard Medical School in January, spent his first month on the job creating a diversity task force to address gaps in racial and socioeconomic representation, at a moment when only about 5 percent of America's medical school graduates are black. But he won't be lowering academic standards to bring in applicants who wouldn't otherwise be accepted. "We're in a position of taking absolutely stellar students and aspire to train the best doctors," he told me. And while Harvard has a center devoted to primary care, he said, "I'm not sure our role is to prespecify where you should go. We try to inspire them to go into public service and try to encourage people to work in diverse communities." He added, "Harvard can't be all things to all people."

The state health department's efforts in Marion were astounding, and they seemed to be effective. For a while Barrett believed that the spread of tuberculosis had been controlled. But when I checked in with her again in the spring, she told me that four cases had been discovered since I'd been to town, and that she wasn't sure when the outbreak would be over. "It's not looking good," she said.
Lee is still on the lookout for symptoms. He has yet to find another doctor to join his practice, but he is hoping that his son, who just finished medical school, will take the job. "I'm getting old," Lee said. "If my son doesn't come back to take over the clinic, I'm going to work until I'm sixty, and I'm done."

One evening, I drove along the route that leads from Marion to the hospital in Greensboro. A doctor there named Dana Todd had invited me to visit her house. The night was foggy and the road curved; even with my high beams on, I couldn't see more than a foot or two ahead. The thought of an ambulance trying to navigate the blind turns was terrifying.

When I arrived, Todd greeted me at her front door wearing a sleek red dress and magenta lipstick that popped against her dark skin. She was tall with short hair. "This feels really weird," she said as she invited me inside. I saw what she meant: the whole house was empty. "The movers came while I was at work," she explained. As it happened, it was her last night in Greensboro. The next morning she was moving to Durham, North Carolina, to start a new job at a primary care clinic affiliated with Duke University.

Wheat had told me that Todd was "the poster child" of the Rural Health Leaders Pipeline. She flew through the high school program into the minority summer course and then earned a master's degree in rural community health as well as a spot in medical school. She also returned as a counselor. After finishing her training, she came back to live and work in her hometown as a family doctor — exactly as Wheat had hoped. Yet she couldn't stay. "I did three and a half years here," Todd said. "But my intent was to do thirty."

She decided to take me to a Mexican restaurant, since she had no furniture for us to sit on. I hopped in her car, and as she took off and started talking at a fast clip, she struck me as more of a city person than someone who grew up in the rural South. Passing the town's private school, she said, "It's ninety-nine percent white. I've never known a single black person to go to that private school." In Marion too, the public schools are filled almost entirely with black children from poor families, and the white kids attend a private school in town. This is the default scenario throughout the Black Belt counties of Alabama, leaving the public schools homogeneously black and severely underfunded.

Todd has a son, who is seven, and he had been going to the same public elementary school that she attended. She was worried that his prospects would be limited if they remained. As he gets older, she wants him to meet a more diverse group of people — a different group — and have access to greater opportunities, the ones that had yet to come to the Black Belt. "That's the most unfortunate part about living here," she told me. "We're not progressing at the same rate as everything else around us." She sighed. "We're just kind of stuck."

At the restaurant, we slid into a booth. "This is one of the few places in town I can come and not see eight people I know," Todd said. People have come up to her at church and asked for medication refills, stopped her in the grocery store for their test results, knocked on her door at night with medical queries. Being the only doctor in town, she felt like she was at work all the time.

And in her personal life, she was isolated. Most of her peers lived in cities with greater employment potential. Few of her childhood friends with professional degrees had returned to Greensboro. Her mother had worked in a sewing factory and her dad was a truck driver; she was the first in her immediate family to graduate from college. "People think you are a millionaire," she told me. "To make six figures in a town where people don't earn that sort of living."

Now she was discouraged by a forsaken quality of her hometown. "One person just can't do it," she said. "It sounds very nice, but one person cannot change everything."

I thought of Marion, still in jeopardy. Later, I called Marsha White to find out how she was doing. When she answered, she sounded stressed, and said that she was taking care of her grandson. I could hear the baby crying in the background. But as we talked, I learned the real reason for the strain in her voice. She told me that, months after she thought the town had come out of its sickness, she had been reinfected with tuberculosis.

https://harpers.org/archive/2017/06/where-health-care-wont-go/?single=1

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Statement

of the

American Hospital Association

to the

Committee on Ways and Means, Subcommittee on Health

of the

United States House of Representatives

"The Current Status of the Medicare Program, Payment Systems, and Extenders"

May 18, 2017

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment for the record regarding expiring Medicare provisions of importance and other Medicare payment issues.

A number of critical Medicare payment policies that were extended in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) face expiration this year. We appreciate the Committee's attention to these important matters and their impact on millions of Americans.

LOW-VOLUME ADJUSTMENT AND MEDICARE-DEPENDENT HOSPITAL PROGRAM

Low-volume Adjustment

Medicare seeks to pay efficient providers their costs for furnishing services. However, certain factors beyond providers' control can affect these costs. Patient volume is one such factor and is particularly relevant in small and isolated communities, where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment existed in the inpatient prospective payment system (PPS) prior to fiscal year (FY) 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year.

The Affordable Care Act (ACA) improved the low-volume adjustment for FYs 2011 and 2012, and MACRA extended the adjustment through the end of FY 2017. For these years, a low-volume hospital is defined as one that is more than 15 road miles (rather than 35 miles) from another comparable hospital and has up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment is given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. About 500 hospitals currently receive the low-volume adjustment. This improved low-volume adjustment better accounts for the relationship between cost and volume and helps level the playing field for low-volume providers and also sustains and improves access to care in rural areas. If it were to expire, these providers would once again be put at a disadvantage and have severe challenges serving their communities.

Medicare-dependent Hospital Program

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. In addition, rural residents, on average, tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment.

To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the Medicare-dependent hospital (MDH) program in 1987; MACRA extended this program until Oct. 1, 2017. The approximately 200 MDHs are paid for inpatient services the sum of their PPS payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities.

The AHA supports the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955), which would make permanent both the MDH program and the enhanced low-volume Medicare adjustment for PPS hospitals, which are vital programs for rural hospitals and the patients and communities they serve. We appreciate the leadership of Congressman Tom Reed of the Committee in introducing this legislation.

AMBULANCE ADD-ON PAYMENTS

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulance services for patients in rural areas, the Medicare Prescription Drug, Improvement, and Modernization Act increased payments by 2 percent for rural ground ambulance services and also included a “super” rural payment for counties that are in the lowest 25 percent in terms of population density. Congress, in the Medicare Improvements for Patients and Providers Act (MIPPA), raised this adjustment to 3 percent for rural ambulance providers, and MACRA extended this policy until Dec. 31, 2017. Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs due to longer travel distances and fewer transports of patients.

The AHA supports the Medicare Ambulance Access, Fraud Prevention and Reform Act of 2017 (S. 967), which would provide for a permanent increase in Medicare payment rates for ground ambulance services. In addition to protecting access to ambulance services through adequate payment, this legislation directs the Secretary of Health and Human Services to study how the additional payments should be modified (if at all) to account for the costs of providing ambulance services in urban, rural and super rural areas. This would ensure that federal payments are aligned with appropriate data and utilization patterns.

IMPACT ACT IMPLEMENTATION

Standardization and Interoperability of Measures

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires that CMS adopt the same measurement domains for all post-acute care Quality Reporting Programs, and that the measures be "standardized and interoperable" across post-acute care facilities. However, the statute does not provide specific operational definitions of these two terms. We believe how CMS interprets these terms will have significant implications for post-acute care providers.

The AHA cautions that "complete" standardization and interoperability of measures – i.e., using the exact same measure specifications, data definitions and data collection tools across all post-acute care settings – may not always be possible, as some measures do not work well across all four settings. CMS could instead focus on achieving "topical" standardization in which all four post-acute care provider types report on the same measure topics, but using data collection instruments and definitions (e.g., rating scales) that may vary. To fulfill the requirement of "interoperability," CMS could develop mechanisms to ensure the data are routinely shared across post-acute settings with crosswalks or other explanations of how the data from each setting are defined.

We urge Congress to help us minimize the burden of collection and reporting requirements. Post-acute care providers must balance numerous reporting requirements from CMS, private payers and others. CMS should ensure any new requirements add value and are not unnecessarily duplicative with existing reporting requirements.

The AHA believes it is time to streamline and focus the measures used in national quality measurement programs on those that truly matter for driving better outcomes and health for the patients we serve. As we progress through implementation of the IMPACT Act, we hope that CMS and Congress will be mindful of what truly matters to patients and not abandon these tenets in service of statutory compliance.

Mandate for a New Post-acute Care Payment System

The IMPACT Act also authorized the implementation of a common Medicare payment system for post-acute care (PAC) provider types: home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).

This policy development process is presently underway through a collaboration by the Medicare Payment Advisory Commission (MedPAC), CMS and the Assistant Secretary for Planning & Evaluation. The first stage of work was completed with MedPAC's submission of a June 2016 report to Congress, which presented a prototype of the new PAC PPS. More recently, MedPAC approved a recommendation for Congress to implement the PAC PPS by 2021, which would accelerate the current timeline by more than four years.

While we appreciate the thoughtful work MedPAC has completed thus far on PAC PPS development, it remains unclear how policymakers could eliminate four to five years from the IMPACT Act's timeline to build a PAC PPS and still produce an accurate and reliable payment system. Specifically, considering MedPAC's estimate that their truncated timeline would require the introduction of a proposal to Congress in 2018 or 2019, MedPAC staff should be called upon to articulate the currently planned policy development steps that could be eliminated to meet their truncated deadline, and explain how, in their view, the shorter process is feasible and would not affect the quality of the resulting PAC PPS policy. As a point of reference, CMS recently spent five years to develop a re-tooled payment system for the SNF PPS – a process that is still underway. In other words, building complex payment systems requires extensive and thoughtful analyses and stakeholder input – and rushing through building a PAC PPS would likely threaten the dependability of the resulting policy.

Post-acute Care Value-based Purchasing

During the previous Congress, the House introduced, H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015, which would repeal the FY 2018 market-basket update cap for post-acute care providers mandated by MACRA and replace it with a PAC VBP program. **In concept, the AHA agrees with the potential for pay-for-performance to accelerate improvements in post-acute care. However, we urged a number of improvements to the PAC VBP legislation due to concerns the bill too narrowly focuses on reducing provider payment rather than promoting "value" – that is, the delivery of consistently high-quality care at a lower cost.**

Should the Ways and Means Committee consider similar legislation this Congress, we urge that any PAC VBP proposal be budget neutral within each PAC setting. Subsequent versions of the PAC VBP bill released for comment in 2016 included budget-neutral language across all PAC settings. Individual providers could earn back some or all of the withheld funds – but not within PAC settings. In other words, the ranking methodology may result in the withheld being earned back only by IRFs, for example. This holds the clear potential to pit PAC providers against each other, when the bill purports to drive collaboration across setting types.

Moreover, we urge that any new PAC VBP effort use quality and resource use measures that are fully developed and found to be valid. AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. The AHA believes pay-for-performance programs should include both cost and quality measures to ensure that the reward system encourages both high-quality care and lower costs. While the 2016 discussion draft of the legislation amended the 2015 bill by adding discharge to community and all-condition risk-adjusted potentially preventable hospital readmissions, the specifications of these measures must

undergo further development before they incur significant payment adjustments.

The 2016 discussion draft proposed a ranking methodology that would have inherently resulted in comparisons between post-acute care setting types, which is inappropriate given the vastly different environments in these settings. The language in the draft attempted to assuage these concerns by emphasizing that scores for these providers would be based solely on their performance in setting-specific standards, but the AHA is troubled that the draft suggested ranking all providers against each other. This is imprecise and would mislead consumers looking for the best providers; just because a SNF is ranked higher than an IRF does not mean that the SNF is the appropriate setting for a particular patient. The AHA urges Congress to consider a different manner of determining comparative value across PAC settings that would avoid these unintended consequences.

Current Pause of the Home Health Pre-claim Review Demonstration

The AHA supports CMS's current pause of its five-state demonstration, through which the agency implemented Medicare pre-claim review in August 2016, which applied to every home health agency and home health claim in Illinois. While the demonstration had not expanded to the remaining states (FL, MA, MI and TX) prior to the recent pause, because of its misguided and excessive scope, we are confident that, based on the Illinois experience, a better approach exists to address CMS's goal for the demonstration, which is to reduce Medicare payment errors and fraud and abuse.

To raise awareness of our Illinois members' grave concerns over the demonstration, the AHA has weighed in at length with the Government Accountability Office's Senate Finance Committee-initiated examination of the demonstration experience in their state. Based on this member feedback, we are confident that CMS's goals would be more effectively and fairly achieved through targeted education interventions that focus on agencies and/or types of claims experiencing payment errors – especially errors associated with the statutorily mandated face-to-face encounter requirement. Despite extensive efforts by both CMS and the field, compliance with this policy remains very time consuming and, in some cases, seemingly impossible given the policy's design and structural limitations associated with hospital and home health transitions. Further, HHAs that demonstrate no problems with either payment accuracy or fraud should not be subject to extra compliance interventions.

Long-term Care Hospital '25% Rule'

The AHA supports the current statutory relief from full implementation of the LTCH "25% Rule" that was provided by Congress in MACRA. The relief extends through Sept. 30, 2017. We have long viewed the 25% Rule as a misguided and arbitrary policy that reduces access to care for clinically appropriate patients – including those deemed appropriate for the LTCH setting by the Bipartisan Budget Act of 2013 (BiBA). However, with the implementation of LTCH site-neutral payment in October 2015, as mandated by BiBA, the purpose of the 25% Rule diminished even further. The LTCH site-neutral policy, unlike the 25% Rule, categorizes LTCH patients based on their medical complexity and reduces payment for only those with lower medical acuity. As such, we have called for the 25% Rule, with its non-clinical criteria, to be

withdrawn by CMS under its own authority. **With this in mind, we strongly endorse the agency's recent proposal for an additional 12-month pause on the full 25% Rule, from October 2017 through September 2018, and again urge the agency to permanently rescind the 25% Rule.**

CONCLUSION

The AHA and the hospital field appreciate your recognition of the need to examine and extend the Medicare payment systems that are the topic of this hearing, and to continue to improve these payment policies. We look forward to working with the Committee this year on legislation to accomplish these goals and urge Congress and the Administration to act on legislation in a timely manner to provide certainty for patients and the hospitals who treat them.

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STATEMENT FOR THE RECORD

Submitted to the
House Ways and Means Committee
Subcommittee on Health

The Medicare Advantage and Part D Prescription Drug Programs
May 18, 2017

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
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Washington, D.C. 20004

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate the committee's interest in strengthening the Medicare program and we welcome this opportunity to offer our comments on issues surrounding the Medicare Advantage (MA) and Medicare Part D prescription drug programs. Through their participation in the MA program, our members have a long track record in emphasizing prevention, providing access to disease management services for chronic conditions, implementing value-based care, and offering systems of coordinated care for ensuring that beneficiaries receive the health care services they need. Similarly, as sponsors of Part D plans, our members have demonstrated strong leadership in reducing medication errors, promoting clinically sound drug usage, and holding down costs for beneficiaries.

We appreciate the committee's support for the MA and Part D programs, including the leadership demonstrated by many members – both Republicans and Democrats – who signed letters earlier this year, urging the Centers for Medicare & Medicaid Services (CMS) to avoid further MA payment cuts and maintain stable coverage options for beneficiaries in the 2018 rate setting process. Overall, more than 320 members of Congress addressed letters to CMS, expressing support for the MA program, in the weeks leading up to the April 3 announcement of 2018 MA payment rates.

Our statement focuses on two topics: (1) the value offered to beneficiaries by the MA and Part D programs; and (2) legislative recommendations for strengthening the MA and Part D programs.

Value of Medicare Advantage (MA) and Medicare Part D Programs

AHIP's members are strongly committed to serving Medicare beneficiaries under the MA and Part D programs and continuing to provide cost-effective, high quality, and accessible health care. Plans are implementing patient-centered innovations that include:

- Integrating and coordinating care for beneficiaries;
- Mitigating the harm of chronic diseases by focusing on prevention, early detection, and care management;
- Reducing beneficiary costs;
- Addressing the needs of vulnerable individuals, including low-income beneficiaries; and
- Applying clinical best practices to increase patient safety and to limit unnecessary utilization of services.

Today more than 18.5 million Americans – about 32 percent of all Medicare beneficiaries – have chosen to enroll in the MA program, and 16.6 million of them receive drug benefits through their plan.[1] An additional 25 million Americans receive drug coverage through a stand-alone Prescription Drug Plan (PDP). Since 2010, MA enrollment has increased by 60 percent, and Part D enrollment has increased from 24 million in 2007 to over 42 million today. While the average payment to MA plans is equivalent to fee-for-service (FFS) costs, MA bids are 10 percent below FFS costs and MA plans often offer additional benefits to enrollees for no additional premium. Ninety percent of beneficiaries can choose from at least five MA plans.

Moreover, MA plans have proven to be more efficient than FFS in delivering access to care in an impactful manner. For example, in one study, post-acute care utilization in MA after hospital discharge was lower than FFS.[2] Readmission rates for MA enrollees also were found to be about 13 percent to 20 percent lower than FFS.[3] Another study found that MA plans had higher rates of annual preventive care visits (53 percent vs. 33 percent in FFS).[4] Part D coverage also has been shown to reduce spending: one study found that enrollees with Part D coverage had 8

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[1] CMS monthly enrollment files, April 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/mcradvpartdenroldata/

[2] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, Karaca-Mandic, Pinar, Sood, Neeraj. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

[3] Lemieux, Jeff, Sennett, Cary, Wang, Ray, Mulligan, Teresa, Bumbaugh, Jon. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96-104. February 2012.

[4] Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S. et al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11-20. January 2015.

percent fewer hospital admissions, incurred 7 percent lower Medicare expenditures, and used 12 percent fewer total resources than beneficiaries without Part D coverage.[5]

Legislative Recommendations for Strengthening MA and Part D Programs

Even with the demonstrated success of the MA and Part D programs, there are several areas where Congress can take action to further strengthen these programs and enhance the value they provide to our nation's Medicare beneficiaries.

Allow MA Plans to Include Telehealth Services in Basic Benefits Package

Health plans have embraced telehealth through the widespread use of nurse hotlines, remote monitoring services, electronic office visits, and other innovative ways of providing value to enrollees. However, current law limits MA plans from incorporating telehealth benefits into their basic benefit package that go beyond the scope of services included in the FFS benefit. As a result, MA plans must use supplemental benefits funded by rebates or premiums to offer expanded coverage of remote access technologies, which has reduced flexibility in plan financing and limited the availability of other additional benefits or buy-downs of Medicare cost sharing. Permitting MA plans to broaden the use of telehealth in delivering basic benefits would be more consistent with modern medical practices and should enhance value and reduce premiums for enrollees.

Allow MA Plans to Offer Non-Medical Benefits as Supplemental Benefits

MA plans should be permitted to offer non-medical benefits as part of the supplemental benefits they provide to their enrollees. This includes housing and nutrition-related services as well as other social services that can help improve the overall well-being and health status of beneficiaries with chronic conditions. Allowing MA plans to offer non-medical benefits would be consistent with the goals of CMS' Accountable Health Communities Model, which is funding bridge organizations to screen Medicare beneficiaries for health-related social needs and refer them to, or provide them with, services that meet these needs. Moreover, this additional

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[5] Kaestner, Robert et al. Effects of prescription drug insurance on hospitalization and mortality: Evidence from Medicare Part D. *National Bureau of Economic Research* Working Paper 19948. February 2014. http://www.nber.org/papers/w19948.

flexibility would allow health plans to apply lessons learned from participating in state Medicaid programs or in the Social HMO demonstration to coordinate medical and non-medical benefits, including long-term services and supports for Medicare beneficiaries.

Establish Unified Grievances and Appeals Process for Individuals Enrolled in D-SNPs

Currently, grievance and appeals procedures for beneficiaries in dual eligible Special Needs Plans (D-SNPs) are governed by separate state and federal requirements. These redundancies create confusion for beneficiaries and caregivers, and result in decreased efficiency and increased administrative burdens for plans. Enrollees in D-SNP plans would be better served by a unified grievance and appeals process.

Eliminate the MA Benchmark Cap

To the extent that CMS is unable to identify statutory authority to do so, we urge Congress to repeal the benchmark cap that currently prohibits some MA plans from receiving the full bonus payments they have earned under the program's Star Ratings System. This existing policy continues to be problematic for beneficiaries enrolling in these plans, who are likely to experience additional costs or reduced supplemental benefits as a result, and is inconsistent with the broader health system goals of incentivizing high quality performance. Removing this cap is an important step toward preserving and rewarding the innovative programs and strategies through which MA plans are working to provide value to seniors and individuals with disabilities.

Allow for Non-Uniform Benefits by Expanding Value-Based Insurance Design

Our members have pioneered innovative benefit designs that use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. These types of value-based insurance design (VBID) features can improve quality of care by encouraging individuals to access critically needed, high-value services and health improvement activities including preventive care. These strategies align with the national goals of providing patient-centered care, improving patients' overall health status, and changing financial incentives in a way that drives quality in health care delivery. We urge Congress to expand the use of VBID in the MA program nationally to permit more beneficiaries with chronic conditions to receive customized benefits through these models and to support participation by all MA organizations.

Permanently Reauthorize Special Needs Plans

We encourage Congress to permanently reauthorize all Special Needs Plans (SNPs) including D-SNPs, plans for beneficiaries with specified chronic conditions (C-SNPs), and those for beneficiaries who require an institutional level of care (I-SNPs). Plans have made substantial investments to develop and operate these products, which are demonstrating success in improving beneficiary outcomes in comparison to the FFS program.[6] Short-term reauthorizations create uncertainty and are inconsistent with the continued development of these innovative programs. Permanent reauthorization would alleviate this uncertainty and further our members' commitment to creating programs tailored to enrollees with special needs.

Allow MA Plans to be Considered Alternative Payment Models

The Medicare Access and CHIP Reauthorization Act (MACRA) defines an Alternative Payment Model (APM) as a CMS Innovation Center model, the Shared Savings Program, the Health Care Quality Demonstration, or a federally-required demonstration. MA plans have partnered with providers in developing APMs that contribute to the delivery of care that is of higher quality and lower cost than care delivered through FFS coverage.[7] Accordingly, we believe that the statute should be modified to allow MA plans to be defined as APMs. This step would level the playing field by providing risk arrangements in MA the same treatment as risk arrangements in traditional Medicare, resulting in more equitable opportunities for physicians.

Improve Part D Flexibility to Use Effective Management Tools

The expansion of robust utilization management tools in the Part D program would create more value for beneficiaries and the Medicare program. Namely, we support steps that would increase plan sponsor flexibility around the tools used to manage effective and efficient medication use, including: removal of Part D protected classes; requiring coverage of one drug per class; applying the coverage gap discount program to biosimilars; relaxing the meaningful difference

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[6] Cohen, Robb. Lemieux, Jeff. Mulligan, Teresa. Schoenborn, Jeff. Medicare Advantage Chronic Special Needs Plan boosted primary care, reduced hospital use among diabetes patients. *Health Affairs* 31(1): 110-119. January 2012.

[7] Mandal, Aloke K. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

standards; and allowing more flexibility for formulary design (e.g., preferred and non-preferred specialty drug tiers).

Thank you for considering our recommendations for strengthening the MA and Part D programs. We look forward to working with the committee as you consider legislation addressing these important issues.