MEDPAC'S ANNUAL MARCH REPORT TO THE CONGRESS ON MEDICARE PAYMENT POLICY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

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MEDPAC'S ANNUAL MARCH REPORT TO THE CONGRESS ON MEDICARE PAYMENT POLICY

Tuesday, March 17, 2009

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:07 a.m. in 1100 Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 10, 2009
HL–1

CONTACT: (202) 225–3943

Chairman Stark Announces a Hearing on MedPAC's Annual March Report to the Congress on Medicare Payment Policy

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) annual March Report to the Congress on Medicare Payment Policy. **The hearing will take place at 10:00 a.m. on Tuesday, March 17, 2009, in the main Committee hearing room, 1100 Longworth House Office Building.**

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

BACKGROUND:

MedPAC advises Congress on Medicare payment policies. MedPAC is required by law to submit its annual advice and recommendations on Medicare payment policies by March 1, and an additional report on issues facing Medicare by June 15. In its reports to the Congress, MedPAC is required to review and make recommendations on payment policies for specific provider groups, including Medicare Advantage plans, hospitals, skilled nursing facilities, physicians, and other sectors, and to examine other issues regarding access, quality, and delivery of health care.

In announcing the hearing, Chairman Stark said, **"MedPAC's recommendations help us keep Medicare working well for providers, beneficiaries, and taxpayers. MedPAC's guidance is critically important to Congress as we craft legislation to strengthen and improve Medicare and consider comprehensive health care reform."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March 2009 Report to the Congress on Medicare Payment Policy.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee Web site and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select *"Committee Hearings".* Select the hearing for which you would like to submit, and click on the link entitled, *"Click here to provide a submission for the record."* Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting

requirements listed below, by close of business **Tuesday, March 31, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman STARK. Good morning. First of all, I hope you will forgive my coughing and wheezing here. It sounds worse than it is.

First of all, I would like to welcome the new Members of the Subcommittee, but the only ones I can find are Mr. Herger and Ms. Brown-Waite. Welcome. Our new Members have yet to arrive.

Thank you for attending today and join me in welcoming Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission, affectionately known as MedPAC.

Glenn's tenure as Chairman is coming to a close later this year, although we are hopeful there may be an opportunity to extend his tenure at least for another year because I gather the plans to find a replacement have kind of fallen apart. We could do a lot worse than having Glenn stay with us for a while.

Also, the staff of MedPac and the Commission, I am not sure all of you know, but the Commission is broadly representative of providers of all types, regions, rural, inner city, profit, not for profit.

It is as representative a board, I think, as we could find in looking at our health delivery system.

We have a busy year ahead of us. In order to reach those goals, we are going to have to get through some tough issues, and a lot of sacred cows are going to be on the table.

Many in the provider community will balk at some of MedPAC's recommendations, but too often, we get twisted up in provider complaints saying they cannot possibly sustain a market basket shave or refinement in their payment systems.

That is why it is good to have MedPAC remind us of how high some of the margins get or how out of kilter the payment system is, and that your job is to ensure that Medicare maintains access and is a prudent purchaser of medical care.

Improvements to Medicare and reforms to the program must be and will be part of this year's larger health reform agenda, and if we are to improve the value of our health care dollar, we need to be smarter purchasers, and the delivery system reform begins here with the public health insurance program like Medicare.

Medicare cannot do the job on its own. We will not get widespread delivery system changes if the private sector is not pushed to modernize as well, which is another reason we need a public health insurance plan to compete with the private options in a reformed system.

We have no system, no mechanism, really no authority to directly push the private sector to make delivery system changes or reforms, and to address the rising costs other than to lead by example in the public health insurance programs and require the private plans to compete.

We can draw some lessons from the need for a public health insurance system with our experience from Medicare Part D, which has no public option and is generally a mess.

I look forward to working with my colleagues here on the dias and getting input and advice from Mr. Hackbarth and the MedPAC staff.

I would yield to Mr. Herger for any comments he would like to make.

Mr. HERGER. Thank you, Mr. Chairman. I join in welcoming you back. Good to see you back here in the chair. We certainly all wish you the very best and continuing recovery.

Mr. Chairman, MedPAC's March report to Congress illustrates why we must approach health care reform very carefully and thoughtfully.

We do not need to look any further than the Medicare Program to see that the Federal Government has often shown itself to be incapable of accurately and appropriately administering health care programs.

MedPAC has once again identified a number of areas where the Medicare Program is significantly over paying for services. MedPAC describes Medicare's $10 billion a year hospice benefit as "lacking the data vital to the effective management of the benefit."

According to MedPAC, Medicare over payments to home health agencies have averaged 16.5 percent since 2002. MedPAC also found that Medicare has over paid free-standing skilled nursing facilities by more than ten percent for the last seven years.

MedPAC states that indirect medical education payments are set at twice the amount of the costs they are intended to cover.

Similarly, MedPAC feels that the key factors determining reimbursement rates for diagnostic imaging services are nearly twice as high as they should be, leading to incentives for over use.

Let us not forget that the chief counsel at HHS, Office of Inspector General, recently said "A lot of career criminals and organized crime officials have decided that building a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars and is far more lucrative. Right now, it is a good bet that you can take millions from us and chances are you are not going to get caught."

We will hear Mr. Hackbarth talk a lot today about efficiency. I think it is abundantly clear that the Medicare Program is far from being efficient.

Then there is the other side of the coin, the side that we explored at last week's hearing, how Medicare significantly under pays physicians and hospitals.

Over the last 10 years, MedPAC reports that the Medicare has paid physicians just 80 percent of private insurance rates. Similarly, MedPAC predicts that hospitals' Medicare margins will be negative 6.9 percent this year.

It is not rocket science to figure out that somebody else is carrying Medicare's water and subsidizing these drastic under payments. This somebody else is 160 million Americans with private health insurance.

Because of Medicare's under payments to hospitals and physicians, those with private health insurance are paying $49 billion more each year.

Medicare is not alone. The Government's other large health program, Medicaid, under pays physicians and hospitals by $40 billion annually. Hospitals and physicians have to turn to those with private health insurance to fill the $89 billion hole left by Medicare and Medicaid.

As a result, a recent report by Milliman found that the average private health insurance policy for a family of four cost $1,800 more than it should.

If you are still not convinced that Medicare's reimbursement system is broken, The Lewin Group found that if the Democrats' proposed Government run health plan paid its providers Medicare rates, 120 million Americans would lose their current health insurance and be forced into the Government run health plan.

I would strongly urge my friends on the other side to consider the evidence we will hear today about the significant problems in the Medicare Program before trying to force 120 million Americans who currently have private health insurance into another Government run health plan.

Mr. Chairman, I and my colleagues await your call to improve our Nation's health care system. We all agree that we must make health insurance more affordable for all Americans.

Let us focus on areas where we can find agreement from expanding preventive care and chronic disease management to eliminating waste, fraud and abuse.

Who knows. This may build the goodwill that could lead to a truly bipartisan health reform proposal.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Herger.

Glenn, why do you not go ahead? We will let you run over the 5 minutes as you are our only witness. I know you have some slides and some things that you would like to present to us.

Why do you not go ahead however you would like.

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

Mr. HACKBARTH. Thank you, Chairman Stark and Ranking Member Herger, and Members of the Subcommittee.

I am pleased to be here to present and discuss MedPAC's March 2009 Report on Medicare Payment Policy.

Our report includes recommendations for payment updates for fiscal year 2010, updated information on Medicare Advantage and Medicare Part D, recommendations on public reporting of financial relationships among drug and device manufacturers, health care organizations, and physicians, and recommendations for reform of Medicare's hospice payment system.

To very quickly summarize, MedPAC recommends rate increases for hospitals, physicians, ambulatory surgery centers, dialysis facilities, and long term care hospitals.

We recommend rate freezes for skilled nursing facilities and inpatient rehab facilities. We recommend a rate reduction for home health agencies in Medicare Advantage plans, and a significant redistribution of payments for physicians and hospices.

In total, our March report contains 22 recommendations. On those 22 recommendations, there were roughly 350 votes cast by Commissioners. Of those roughly 350 votes, only four were no votes and three were abstentions.

As Chairman Stark indicated, MedPAC has 17 Commissioners. Eleven of us have experience in health care delivery as clinicians, executives, or board members, including six MedPAC Commissioners who are trained as either physicians or as RNs.

Five MedPAC Commissioners have experience in the management of private health plans. Four have experience in the Federal Government, and some of us have experience in all three.

In addition to that, we have several Commissioners who have distinguished records in academia who contribute to the intellectual rigor of our work, and last, but certainly not least, we have an exceptional staff led by Mark Miller.

Why do I emphasize the credentials of the Commissioners? The point I want to make is that for the most part, we are from the health care system. As such, we recognize the talent and commitment of the professionals who serve within that system. We are not outsiders, critics who have no appreciation of the challenges of being on the frontline.

That is not to say that our recommendations are necessarily correct. We are fallible like everybody else. We may be right in some cases and wrong in others.

What is clear is that if we are wrong, it is not because we are inexperienced or lack a stake in a successful health care system.

Medicare is an indispensable part of American health care, not only has it financed care for many millions of senior and disabled Americans, it has helped finance investments in health care delivery that have benefited all Americans.

Medicare, however, is unsustainable in its current form. To make it sustainable, we must slow the increase in costs while maintaining or even improving quality and access.

That in turn will require both restraint on payment increases under Medicare's current payment systems, as well as a significant overhaul of those systems.

In particular, MedPAC believes we must invest in rebuilding the nation's deteriorating system of primary care. Abundant research shows that a strong system of primary care is essential for a high performing health care system.

In addition, we must move beyond Medicare's largely fee-for-service payment system to one that better rewards both efficiency in the use of limited resources and better coordination of care.

Our current system is not only expensive, it can be dangerous, especially for patients with multiple chronic illnesses of which there are many in the Medicare program.

Having spent 15 years in Government service, as well as ten years in private health plan and medical group management, I know that changing payment systems is complex, and it takes time and resources to develop, test, implement and refine new payment methods.

Moreover, as you well know, the process is controversial because changing payment systems, reforming payment systems, inevitably entails a redistribution of resources and income across physician specialties, across provider types, and even across geographic regions.

This complexity and difficulty must not deter us from the task. After all, the only alternatives will be higher taxes and premiums, including a growing burden on the next generation, fewer benefits, and unnecessary pain and suffering for beneficiaries who depend upon us.

As always, Mr. Chairman, MedPAC stands ready to assist the Committee in any way that we can.

With that, I am happy to talk about our specific recommendations.

[The prepared statement of Glenn M. Hackbarth follows:]

Statement of Glenn M. Hackbarth, Chairman,
Medicare Payment Advisory Commission, Bend, Oregon

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Report to the Congress: Medicare Payment Policy

March 17, 2009

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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

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

As required by the Congress, each March the Medicare Payment Advisory Commission reviews and makes recommendations for Medicare fee-for-service (FFS) payment systems and the Medicare Advantage (MA) program. In our March report, we:

- Consider the context of the Medicare program in terms of its spending and the federal budget and national GDP.
- Consider Medicare FFS payment policy in 2010 for: inpatient and outpatient hospitals, physicians, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.
- Review the status of the MA plans beneficiaries can join as an alternative to traditional FFS Medicare and our MA recommendations.
- Review the status of the plans that provide prescription drug coverage.
- Make recommendations on public reporting of financial relationships among pharmaceutical and device manufacturers, physicians, and health care organizations.
- Make recommendations on reforming Medicare's hospice payment system.

MedPAC's report offers a set of recommendations for Medicare payments that balance the need to assure beneficiaries' access to care with the need to spend the dollars wisely. These recommendations are driven in part by the Commission's and other researchers' conclusions that providers' costs are not immutable, but instead are influenced by how providers are paid. The recommendations contained in the report exert fiscal pressure—in the form of limited Medicare updates—to help constrain costs both in the short and long run. The recommended actions are one part of a broader array of recommendations aimed at more fundamentally reforming Medicare's delivery system, most recently discussed in our June 2008 report, including ideas for example to reward better coordination of care and efficiency over time and invest in information about comparative effectiveness.

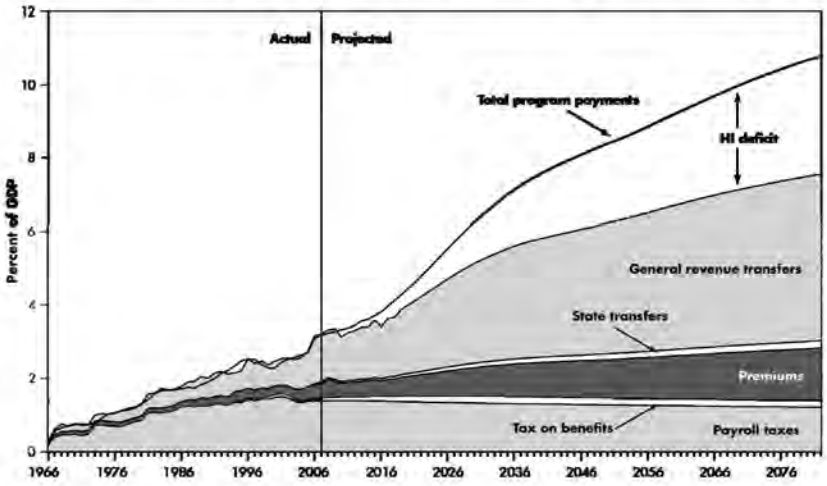
Context for Medicare payment policy

Medicare and other purchasers of health care in our nation face enormous challenges. Health care costs are increasing for individuals and private and public payers, while quality frequently falls short of patients' needs. The Commission has recommended a number of measures to increase the accountability of providers and the value of care, such as pay for performance, measuring resource use, penalizing high readmission rates, and research comparing the effectiveness of medical treatments. The marked variation in both service use and quality of care across the nation, suggest that opportunities exist for reducing spending while improving quality for beneficiaries.

Health care spending—including Medicare spending—has been growing much faster than the economy. The growth in national income, the availability of newer medical technologies, and the cost-increasing effects of health insurance are thought to account for much of this long-term growth, and some of those forces will likely push future spending even higher. Medicare will have the additional challenge of higher enrollment associated with retiring baby boomers. Technological and demographic factors notwithstanding, the current structure and functioning of our health care system that encourages service volume rather than quality and coordination also contributes to the significant expenditure levels. Medicare payment policy is an important tool for encouraging greater efficiency and effectiveness in the delivery of care.

The Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. If Medicare benefits and payment systems remain as they are today, the Medicare trustees note that over time the program will require major new sources of financing for Part A and will automatically require increasing shares of general tax revenues for Part B and Part D. The trustees project that dedicated payroll taxes will make up a smaller share of Medicare's total revenue and that a large deficit between spending for Part A (HI) and revenue from dedicated payroll taxes will develop (Figure 1).

Figure 1. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2008 annual report of the Boards of Trustees of the Medicare Trust Funds.

To finance the projected deficit through 2080, the trustees estimate that Medicare's payroll tax would need to increase immediately from 2.9 percent to 6.44 percent of earned income, or HI spending would need to decrease immediately by 51 percent. Delays in addressing the HI deficit would eventually require even larger increases in the tax rate or even more dramatic cuts in spending. The premiums and general revenues required to finance projected spending for Part B and Part D (SMI) services could impose a significant financial liability on Medicare beneficiaries and on resources for other priorities. If income taxes remain at the historical average share of the economy, the Medicare trustees estimate that the SMI program's share of personal and corporate income tax revenue would rise from 11.1 percent today to 24 percent by 2030. For beneficiaries, even though Part D now covers a portion of their spending on prescription drugs, growth in Medicare premiums and cost sharing for SMI services will require more of their incomes, which could lead to financial hardship for some

individuals. In 2004, roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level.

Analysts across the political spectrum have raised concerns that the Medicare program—in its current form—may become too heavy a fiscal burden and squeeze the funding for other federal priorities. The Congressional Budget Office (CBO) finds that any feasible set of policy solutions will require a slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation's economy.

Changes in Medicare payment systems are complex to develop and implement. Delaying action constrains the options for addressing Medicare's problems. In the short run, while changes are being formulated, MedPAC recommends payment updates designed to exert fiscal pressure to encourage providers to improve their efficiency.

Assessing payment adequacy and updating payments in fee-for-service Medicare

Each year, in accordance with our mandate, the Commission makes payment update recommendations annually for fee-for-service (FFS) Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. For each sector, we first assess the adequacy of Medicare payments for providers in the current year (2009), taking into account factors affecting the efficient provision of services and policy changes (other than the update) that are scheduled to take effect in the policy year (2010) under current law. Next, we assess how those providers' costs are likely to change in 2010, the year the update will take effect. In addition to these provider-specific factors, the Commission also considers the payment update from the perspective of the economy-wide gains achieved by the firms and workers who pay taxes that fund Medicare. Competitive markets demand continual improvements in processes and quality from those workers and firms. Medicare's payment systems should exert the same pressure on providers of health care services.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospital services are positive. Access to hospital services continues to be good with more hospitals opening than closing. In fact, the overall level of hospital construction was at a record high in 2007 and many hospitals are expanding the services they offer their communities. MedPAC and others have expressed concern about the degree to which these capital investments add value to clinical care. For example, the Center for Studying Health Systems Change has raised the possibility of a return to the "medical arms race," as hospitals compete on amenities and new technology (Berenson, 2006). Despite increasing competition from independent diagnostic testing facilities and ambulatory surgery centers, the volume of hospital outpatient services furnished to Medicare beneficiaries has grown, indicating that access is strong. Quality of care measures are generally improving.

Access to capital has been erratic in 2008. Bond offerings and construction started off at a record pace in January but froze in September 2008 due to an economy-wide freeze of the credit markets. The difficulties in accessing capital resulted from a sudden economy-wide breakdown of the credit markets rather than any change in the level of Medicare hospital payments. Recently, hospitals with robust fundamentals have been able to issue debt, but even financially sound hospitals face higher interest rates.

While most payment adequacy indicators are positive, hospitals' Medicare margins remain negative. Average Medicare margins, which were -5.9 percent in 2007, are projected to be -6.9 percent in 2009 (after accounting for the effects of payment policy changes scheduled for 2010 under current law).

Factors influencing cost growth and financial performance

Several observations inform our assessment of payment adequacy in light of these negative Medicare margins. First, hospitals' costs are not immutable. MedPAC research shows that hospitals under financial pressure are able to constrain their costs. The hypothesis is that hospitals with high margins on non-Medicare patients face less pressure to constrain costs, as a result their costs increase and their Medicare margins tend to be low. Consistent with the

hypothesis, hospitals facing lower financial pressure (i.e. high non-Medicare margins and growing net worth) in recent years (2002 through 2006) tended to have higher costs and hence lower Medicare margins in 2007 than hospitals under greater financial pressure (Table 1). In 2007, hospitals under low financial pressure in the prior years had higher standardized costs per discharge ($6,400) than hospitals under high financial pressure ($5,800).

Table 1. High financial pressure leads hospitals to constrain costs

	Level of financial pressure 2002 to 2006	
2007 Financial characteristics (medians)	High pressure	Low pressure
Standardized cost per discharge		
All hospitals	$5,800	$6,400
Non-profit hospitals	5,700	6,500
For-profit hospitals	5,900	6,000
Annual growth in cost per discharge 2004 to 2007	4.8%	5.0%
Non-Medicare margin (private, Medicaid, uninsured)	-2.4%	13.5%
Overall Medicare margin	4.2	-11.7

Note: High pressure hospitals had median non-Medicare profit margins of 1 percent or less from 2002 to 2006 and net worth would have grown by less than 1 percent per year from 2002 to 2006 if the hospital's Medicare profits had been zero. Low pressure hospitals had median non-Medicare margins were greater than 5 percent from 2002 to 2006 and a net worth that would have grown by more than 1 percent per year if its Medicare profits were zero. Standardized costs are adjusted for case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on costs per discharge.
Source: MedPAC analysis of Medicare Cost Report and claims files from CMS available as of August, 2008.

Over time, aggregate hospital cost growth has moved in parallel with margins on private-payer patients. Due to managed care restraining private-payer payment rates in the 1990s, hospitals' rate of cost growth in that period was below input price inflation. However, from 2001 through 2007, after profits from private payers increased, hospitals' rate of cost growth was higher than the rate of increase in the market basket of input prices (MedPAC, 2009). This has resulted in lower Medicare margins. Hospitals with the highest private payments and most robust non-Medicare sources of revenues have lower Medicare margins (-11.7 percent) than hospitals under greater fiscal pressure (4.2 percent).

While Medicare margins for hospitals may be negative in aggregate, Medicare payments are still adequate to cover the costs of efficient hospitals. As shown in Table 2, MedPAC analysis has identified a set of low-cost hospitals that consistently out-perform other hospitals on a series of quality measures, including mortality and readmissions. Among this set of hospitals, we found that Medicare payments on average roughly equaled the hospitals' costs.

Table 2. Characteristics of traditionally high performing hospitals

	Relatively efficient during 2004-2006	Other hospitals
Number of hospitals	338 (12%)	2535 (88%)
Historical performance 2004-2006		
Relative risk-adjusted composite 30-day mortality (AHRQ)	87%	106%
Relative standardized cost per discharge 2004-2006	90	102
Relative risk-adjusted readmission rates (2005)	97	101
Quality metrics in 2007		
Relative risk-adjusted composite 30-day mortality (AHRQ)	86%	103%
Relative risk-adjusted 30-day AMI mortality (CMS)	98	100
Relative risk-adjusted 30-day CHF mortality (CMS)	97	101
Relative risk-adjusted 30-day pneumonia mortality (CMS)	94	101
Relative risk-adjusted all-condition in-hospital mortality (3M)	83	102
Relative percent of patients highly satisfied (H-CAHPS)	100	100
Relative standardized costs	89	102
Median Medicare margin in 2007	0.5%	-7.4%

Note: AHRQ (Agency for Healthcare Research and Quality); H-CAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems); AMI (Acute myocardial infarction); CHF (Congestive heart failure).
Relatives are the median for the group as a percentage of the median of all hospitals. Per case costs are standardized for area wage rates, case-mix, severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computing using AHRQ methodology to compute risk-adjusted mortality for eight conditions (AMI, CHF, Pneumonia, gastrointestinal hemorrhage, stroke, craniotomy, coronary artery bypass graph, and abdominal aortic aneurysm repair). We then weighted the scores for each type of discharge by the share of discharges in that particular hospital.

Hospital update

The Commission recommends an update equal to the projected increase in the market basket for inpatient and outpatient services (projected to be 2.7% in 2010), with this update implemented concurrently with a quality improvement program. Given the mixed payment adequacy indicators, the Commission believes a hospital's quality performance should determine whether its payments increase more or less than the market basket – a recommendation we have made in previous years. We find that the combination of fiscal pressure and rewards for quality can result in the provision of more efficient and better

patient care. A quality improvement, or pay-for-performance, payment pool would be funded by setting aside 1 to 2 percent of overall payments. Put differently, although the sector as a whole would get a full market basket increase, the Commission is not saying that each hospital deserves a full update. The net effect of our update policy and a 1 to 2 percent set-aside for pay-for-performance is that only hospitals with poor quality rankings will get less than a full market basket update. To be explicit, dollars would be redistributed from lower performing hospitals to high performing hospitals.

Medicare as a public payer funds medical education programs through both direct and indirect payments. In 2007, Medicare's indirect medication education (IME) payments to teaching hospitals totaled $6 billion. As we have in prior years, we recommend a reduction in the IME adjustment equivalent to 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. These dollars would be used to help fund in part the quality improvement program recommended above. There are two reasons for this recommendation. First, we find that these payments are set at a level more than twice the costs associated with teaching residents (MedPAC, 2007, 2009). Second, the new MS-DRG severity adjustment increases payments to teaching hospitals to the extent they treat more severe cases.

Physician services and ambulatory surgical centers

We assess overall payment adequacy for physician services in fee-for-service (FFS) Medicare, examine payments for expensive imaging services, and assess payment adequacy for ambulatory surgical centers (ASCs)—facilities that are typically owned wholly or in part by physicians.

Physician update and primary care

Our analysis of physician services provided in fee-for-service (FFS) Medicare finds that, overall, most indicators of payment adequacy are positive and stable, suggesting that most beneficiaries can obtain physician care when they need it.

- Our 2008 survey of beneficiaries indicates that beneficiary access to physicians is generally good, and by most measures, better than that reported by privately insured patients age 50 to 64. Among the small share of beneficiaries (6 percent) who reported

that they looked for a new primary care physician, we did see some access problems, with 28 percent reporting problems finding one.

- Our survey shows that Medicare beneficiaries are less likely than privately insured individuals to report problems getting timely illness or injury appointments. Among those who scheduled an illness or injury appointment, 84 percent of Medicare beneficiaries and 79 percent of privately insured individuals said they "never" experienced a delay, while 12 percent of Medicare beneficiaries reported "sometimes" having to wait longer than they wanted, compared with 16 percent for privately insured individuals.
- Physicians continue to accept and treat Medicare patients: 92 percent of office-based physicians who receive 10 percent or more of their practice revenue from Medicare were accepting new Medicare patients in 2007, and the share of physicians who have participation agreements with Medicare was 95 percent in 2008.
- MedPAC's 2008 beneficiary survey also examined differences in access to physician services between white and minority beneficiaries. In general, minorities were more likely than whites to experience access problems. This does not appear to be unique to Medicare; privately insured minorities were also more likely than privately insured whites to have access problems.
- Medicare payment rates continue to be about 80 percent of private insurance payment rates as they have for the past decade.
- In 2007, the volume of physician services provided per beneficiary grew almost 3 percent.

In light of these findings, the Commission recommends that for 2010, the Congress update payments for physician services by 1.1 percent.

The Commission remains concerned that primary care services are undervalued and at a significant risk of being underprovided, despite some recent increases in payments for primary care services. To underscore the urgency of this issue, the Commission voted to reiterate its previous recommendation that Congress increase payments for primary care services when provided by practitioners who focus on primary care (MedPAC 2008a). This adjustment would be budget neutral within the fee schedule.

Changing payments for expensive imaging services

The Commission recognizes that there has been rapid technological progress in diagnostic imaging over the past several years, which has enabled physicians to diagnose and treat illness with greater speed and precision. However, the rapid volume growth of costly imaging services may be driven, at least in part, by prices that are too high. Further, high payment rates for imaging services means that payment rates for primary care and other services are lower.

CMS's method for setting practice expense relative value units (a key factor that determines payment rates) for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. This assumption has led to higher payments for these services. Higher payments encourage providers with low expected volumes to purchase expensive imaging machines. Once providers purchase machines, they have an incentive to use them as frequently as possible. Indeed, there is evidence that MRI and computed tomography (CT) machines are used much more frequently than Medicare assumes.

The Commission recommends that Medicare adopt a normative standard in which providers are assumed to use costly imaging machines at close to full capacity (45 hours per week, or 90 percent of the time that providers are assumed to be open). Such a normative standard would discourage providers from purchasing expensive imaging equipment unless they had sufficient volume to justify the purchase. The Secretary should start by adopting a standard of 45 hours per week for all diagnostic imaging machines that cost at least $1 million and should explore applying this standard to imaging equipment that costs less. This change would reduce payment rates for costly imaging services and increase rates for other physician services like evaluation and management and major procedures.

Payment adequacy in ambulatory surgical centers

Physicians furnish outpatient surgical services in their offices, hospital outpatient departments, and increasingly, ambulatory surgical centers (ASCs). ASCs are a source of revenue for many physicians, as over 90 percent of ASCs have at least one physician owner.

ASCs offer several advantages to physicians and patients over hospital outpatient departments. Physicians have greater control and may be able to perform more surgeries per day in ASCs because they often have customized surgical environments and specialized staffing. Patients may be able to schedule surgery more quickly, experience shorter waiting times, and find ASCs that are more conveniently located. Whether ASCs provide less costly or higher quality care than other settings is hard to say, because ASCs do not submit data to the Medicare program on their costs or the quality of the care they provide.

Indicators suggest that ASC Medicare payment rates are adequate. From 2002 to 2007, the number of ASCs grew by an average of 6.7 percent per year, volume per beneficiary grew by 9.8 percent per year, and the number of Medicare beneficiaries served in ASCs increased by 7.5 percent per year.

CMS made substantial changes to the ASC payment system in 2008. The most significant changes include a different method for setting payment rates, allowing separate payment for certain ancillary services, and a 32 percent increase in the number of procedures covered under the ASC payment system. Under the revised payment system, 86 percent of all procedures have a higher payment rate than under the old system. However, the highest-volume procedures have lower payment rates. If ASCs diversify the procedures they provide to Medicare beneficiaries over the four-year transition period to the new payment system, they should be able to maintain or increase their Medicare revenue.

Weighing our findings on payment adequacy and the revised payment system, the Commission recommends that ASCs receive a payment update of 0.6 percent in calendar year 2010. The Commission also recommends that ASCs be required to submit cost and quality data to the Secretary. Current law requires that ASC payment rates be increased by the full amount of the consumer price index for all urban consumers (CPI–U) in 2010. However, the Commission plans to examine how well the CPI–U measures input price changes for ASCs and explores alternative price indexes.

Dialysis services

Most of our indicators of payment adequacy for outpatient dialysis services are positive. The growth in the number of dialysis facilities and treatment stations has kept pace with the growth in the number of dialysis patients, suggesting continued access to care for most dialysis beneficiaries. MedPAC specifically considered whether African-American beneficiaries and beneficiaries eligible for Medicare and Medicaid had more difficulty than other beneficiaries accessing dialysis services and found that in 2006, facilities that closed did not treat a higher proportion of these patients compared with those that remained in business.

The growth in the number of dialysis treatments has kept pace with patient growth between 2006 and 2007. The total volume of most dialysis drugs administered grew between 2004 and 2007 but more slowly than in the past because of statutory and regulatory changes that lowered the payment rate for most dialysis drugs. In addition, the decline in the use of erythropoietin, the leading dialysis drug, may also be linked to a warning by the Food and Drug Administration and recent studies reporting side effects with the use of this drug class.

Some measures of quality of care are improving. Use of the recommended type of vascular access—the site on the patient's body where blood is removed and returned during hemodialysis—has improved since 2000. More patients receive adequate dialysis and have their anemia under control. However, improvements in quality are still needed.

Recent evidence about trends in the increase in the number of dialysis facilities suggests that providers have sufficient access to capital. Both the large dialysis organizations and smaller chains have obtained private capital to fund acquisitions.

The Medicare margin for composite rate services and dialysis drugs for freestanding dialysis facilities was 4.8 percent in 2007. The two largest dialysis chains (which may benefit from economies of scale) realized a higher Medicare margin than other providers (6.9 percent versus 0.2 percent). We project the overall Medicare margin for freestanding dialysis facilities will be 1.2 percent in 2009.

The sum of these indicators suggests that a moderate update of the composite rate is in order. Therefore, the Commission recommends that the Congress maintain current law and update the composite rate by 1 percent for calendar year 2010.

Skilled nursing facility services

Our indicators of the adequacy of Medicare payments for skilled nursing facility (SNF) services are generally positive. These indicators include a stable supply of providers, a slight increase in service volume, and growth in Medicare margins. Quality indicators were mixed. Access to capital is tight, reflecting general uncertainty in the financial markets, not the adequacy of Medicare payments. Most beneficiaries continue to have good access to services, especially rehabilitation services. However, patients seeking medically complex care may experience delays in placement. Since 2002, admissions for medically complex patients have been increasingly concentrated in fewer facilities. The growing concentration of medically complex cases in fewer SNFs, the continued growth and intensity of rehabilitation days, and the wide variation in Medicare margins underscore the inequities and poor incentives of the current PPS design. Previously recommended revisions to the PPS—which we reiterate in this report—would more accurately reflect providers' costs to treat different types of cases, thereby reducing the incentive to admit certain patients over others and producing a more equitable distribution of Medicare margins across facilities. The commission also recommends the adoption of a pay-for-performance program to improve quality (March 2008).

Between 2006 and 2007, Medicare costs for freestanding SNFs grew faster than in the two previous years. However, Medicare payments continued to outpace SNF costs, in part because of the increase in the days classified into the highest-payment case-mix groups. As a result, the aggregate Medicare margin for freestanding SNFs was 14.5 percent in 2007, making this the seventh consecutive year that the aggregate Medicare margin was above 10 percent. The aggregate margin for 2009 is projected to be 12.6 percent. Because indicators are generally positive and SNF payments are more than adequate to accommodate anticipated cost growth, the Commission recommends a zero update for SNFs in 2010.

Home health services

Indicators of payment adequacy for home health services are positive. Access, volume, and the supply of agencies remained stable or increased, suggesting that Medicare beneficiaries have adequate access to care. Quality continued to improve, and the turmoil in the financial markets does not appear to have significantly impaired access to capital for this industry. Home health agencies continued to be paid significantly more than cost, with average margins of 16.6 percent in 2007. The home health industry has maintained average Medicare margins of about 16.5 percent a year since 2002. At the same time, the mix of visit types has changed and the average number of visits per episode has dropped 30 percent from 1998 to 2007.

In 2007, volume and average payment per episode continued to rise, with total payments growing 12 percent to $16 billion. The number of home health users also rose, even as the number of traditional fee-for-service enrollees declined due to greater enrollment in Medicare Advantage plans. The type of episodes provided continued to shift to higher-paying services. At the same time, home health agency costs have remained low. We estimate home health margins to be 12.2 percent for 2009. The 2009 margin is expected to decline because administrative adjustments to take back coding increases offset the market basket increase.

Because of the consistently high margins and other positive indicators, the Commission has concluded that home health payments should be significantly reduced in 2010 and 2011 to ensure that Medicare does not continue to overpay home health providers. Therefore, the Commission recommends that the Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments in 2011 to 2010, so that payments in 2010 are reduced by 5.5 percent from 2009 levels.

The reduction in 2010 will begin the process of reducing payments to appropriate levels, but further reductions might be necessary. The package of service delivered under the home health benefit has changed substantially since the PPS was established, and the current rates are well in excess of the efficient provider's cost. The Commission recommends the Congress direct the Secretary to re-base rates for home health care services in 2011 to reflect

the average cost of providing care.

However, the Commission is concerned that quality of care be maintained when the rebasing is implemented. Thus, the Commission also recommends that the Congress should direct the Secretary to develop payment measures that ensure adequate beneficiary care. Two types of safeguards need to be developed: financial safeguards that can be proposed concurrently with the rebasing recommended for 2011 (e.g., risk sharing, blending prospective payment with a per-visit payment), and quality of care safeguards linking payment to avoidance of adverse events, which can be implemented as soon as practicable.

Inpatient rehabilitation facility services

Our assessment of payment adequacy for inpatient rehabilitation facilities (IRFs), which provide intensive rehabilitation services in an inpatient setting, reflects recent changes in Medicare policy that significantly affect the volume of IRF services. In 2004, CMS renewed enforcement of the 75 percent rule, which required IRFs to have a certain percentage of admissions with one or more of a specified list of conditions. The compliance threshold was to be phased in from 50 percent to 75 percent over several years. Before the phase-in to 75 percent was complete, the Congress set the compliance threshold permanently at 60 percent from July 2007 going forward, in one of several provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) related to IRF services. The overall policy goal of the rule is to direct the most clinically appropriate cases to this intensive, costly setting. The renewed implementation of this rule was expected to result in a decline in IRF volume for certain types of cases and an increase in IRF average patient complexity.

Our indicators of Medicare payment adequacy are on net positive. From 2004 to 2007, Medicare IRF discharges declined as was expected, but the number of IRF beds did not decline as much—suggesting that capacity remains adequate to meet demand. With the decline in IRF volume, there has been a corresponding increase in the volume of patients in home health and SNFs, suggesting that beneficiaries who would have received care in an IRF are receiving care in other settings. Access to capital has tightened in 2008 due to the economy-wide credit crisis. However, the changes in the credit markets are not related to

Medicare payment changes. Measures of quality (functional gain between admission and discharge) continue to show improvement. However, changes over time in the mix of IRF patients make it difficult to draw definitive conclusions about quality trends.

The actual 2007 margin for IRFs is 11.7 percent and our projected 2009 Medicare margin is 4.5 percent. The projected decrease in the margin is the result of a MMSEA provision that eliminated the IRF payment update for the second half of 2008 and all of 2009. The margin projection for 2009 does not assume increased cost control efforts by IRFs in response to the MMSEA's elimination of the IRF update or the decline in discharges in recent years. To the extent that IRFs restrain their cost growth in response to these changes, the projected 2009 margin would be higher than we have estimated. Based on our analysis of payment adequacy, the Commission recommends eliminating the update to payment rates for inpatient rehabilitation services for fiscal year 2010.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with clinically complex problems who need hospital-level care for relatively extended periods (average length of stay for Medicare patients must be greater than 25 days). Medicare is the dominant payer for LTCH services, accounting for about 70 percent of LTCH discharges. This sector has been marked by rapid growth and geographic concentration. Concerns about this growth and the appropriateness and necessity of some admissions prompted CMS to impose the 25 percent rule, under which Medicare generally pays less if more than a specified percentage of a hospitals-within-hospitals (HWHs) or satellite LTCH's patients is referred from its host hospital. The MMSEA delayed the full implementation of this rule and its extension to freestanding LTCHs.

Growth in the number of LTCHs has remained relatively flat between 2005 and 2007 and the number of HWHs has fallen an average of 2 percent per year as the 25% rule takes effect. Beneficiaries' use of services suggests that access has not been a problem. We found that LTCH use per FFS beneficiary increased slightly between 2005 and 2007. The evidence on quality is mostly positive. Readmission rates for the top 15 LTCH diagnoses have been stable or declining. Rates of death in the LTCH and death within 30 days of discharge also have

been declining for most diagnoses. LTCH patients appear to have experienced fewer infections due to medical care and fewer cases of postoperative sepsis. However, patients appear to have experienced more decubitus ulcers and more cases of postoperative pulmonary embolisms and deep vein thrombosis.

As with other sectors, LTCHs' access to capital in the current economy-wide credit crisis does not reflect Medicare payment adequacy. LTCH's need for major capital will be mitigated in the short term by the three-year moratorium on new beds and facilities imposed by the MMSEA.

LTCHs' Medicare margin for 2007 is 4.7 percent. Although implementation of the MMSEA somewhat improved the financial outlook for LTCHs, growth in facilities' costs is still likely to outweigh payment increases over the next few years. As a result, we estimate LTCHs' aggregate Medicare margin will be 0.5 percent in 2009.

On balance, our indicators of payment adequacy are positive and the Commission recommends that the Secretary update payment rates for LTCH services by the market basket index less an adjustment of 1.3 percent, with this adjustment designed to provide an incentive to control costs while maintaining quality. Under the current forecast of the rehabilitation, psychiatric, and LTCH market basket, the Commission's recommendation would update the LTCH payment rates by about 1.6 percent in 2010.

The Medicare Advantage program

The Medicare Advantage (MA) program provides Medicare beneficiaries with an alternative to the fee-for-service (FFS) Medicare program. It enables them to choose a private plan to provide their health care. Those private plans can use alternative delivery systems and care management techniques, and they have the flexibility to innovate. The Commission supports private plans in the Medicare program, but has consistently expressed concerns about the current MA payment system.

In our analyses of data on enrollment, availability, payments, benefits, and quality we find:

- About 22 percent of Medicare beneficiaries were enrolled in MA plans in 2008 and all beneficiaries have access to an MA plan in 2009.
- Plans provide enhanced benefits to enrollees and overwhelmingly these benefits are not financed out of plan efficiency, but rather by the Medicare program and other beneficiaries, and at a high cost. For example, each dollar's worth of enhanced benefits in private FFS (PFFS) plans costs the Medicare program over three dollars.
- Quality is not uniform among MA plans or plan types. High quality plans tend to be established HMOs; more recent plans have lower rankings on many measures.

As shown in Table 2, in 2009, payments to MA plans continue to exceed what Medicare would spend for similar beneficiaries in FFS. MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009. In the aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package are 102 percent of FFS in 2009, an increase from 101 percent in 2008, which means that plans in aggregate continue to be less efficient than FFS Medicare. As an exception, HMOs continue to bid below FFS, bidding 98 percent of FFS.

Table 3. Payments exceed FFS spending for all plan types in 2009

Plan type	Enrollment as of November 2008 (in millions)	Benchmarks (percent of FFS spending in 2009)	Bids	Payments
All MA plans	**9.9**	**118%**	**102%**	**114%**
HMO	6.6	118	98	113
Local PPO	0.7	121	108	118
Regional PPO	0.3	114	106	112
PFFS	2.3	120	113	118

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. We estimate FFS spending by county using the 2009 MA rate book. We removed spending related to the double payment for indirect medical education payments made to teaching hospitals. Totals may not add due to rounding.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

To be clear, even though we use the FFS Medicare spending level as a measure of parity for the MA program, this should not be taken as a conclusion that the Commission believes that FFS Medicare is an efficient delivery system in most markets.

High MA payments provide a signal to plans that the Medicare program is willing to pay more for the same services in MA than it does in FFS. Similarly, these higher payments signal to beneficiaries that they should join MA plans because they offer richer, benefits, albeit financed by taxpayer dollars. This is inconsistent with MedPAC's position supporting financial neutrality between FFS and MA. To encourage efficiency across the Medicare program, Medicare needs to exert comparable and consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance (P4P) programs, to maximize the value it receives for the dollars it spends. The Commission has made recommendations in previous years to further these aims in the MA program, and those recommendations are reiterated in this report.

Part D Prescription Drug Benefit

Part D uses competing private plans to deliver outpatient prescription drug benefits. Each year, sponsors submit plan bids for providing Part D benefits. Part D sponsors may change plans' benefit designs, formularies, and cost-sharing requirements. Policymakers need to stay informed about changes to ensure that Part D meets the broader goal of giving beneficiaries access to appropriate drug therapies. Year-to-year changes in bids and enrollee premiums give policymakers information about how well sponsors are managing drug benefit costs for beneficiaries and for taxpayers.

In the report, we describe Part D enrollment in 2008 and plan offerings for 2009. We also report on one aspect of Part D intended to promote quality: medication therapy management programs. We find:

- Ninety percent of Medicare beneficiaries received some form of drug coverage in 2008. Fifty-eight percent of all Medicare beneficiaries enrolled in Part D plans; 32 percent had drug coverage at least as generous as Part D through employer-sponsored plans or other sources. Twenty-one percent of Medicare beneficiaries had lower premiums and cost sharing via the low-income subsidy (LIS). CMS estimates that 2.6 million were eligible for the LIS but were not enrolled.
- In 2009, the number of stand-alone prescription drug plan (PDP) options declined by

7 percent, but a typical beneficiary still has about 49 PDPs among which to choose. Sponsors are offering 6 percent more Medicare Advantage–Prescription Drug plans (MA–PDs) than in 2008.

- For 2009, Part D premiums are higher than in 2008. If enrollees stayed in the same plan, they saw premiums rise by an average of $6 above 2008 levels to nearly $31 per month (an increase of 24 percent).
- For 2009, we estimate that more than 80 percent of enrollees are in plans that use one generic tier and separate tiers for preferred and nonpreferred brand-name drugs in their formulary. (The formulary includes the list of drugs a plan may cover, cost-sharing tiers, and information on whether a drug is subject to tools such as prior authorization.)
- Cost sharing tended to rise among PDPs for 2009. Copays for the typical enrollee in a PDP rose to $7 per 30-day supply of a generic drug, $38 for a preferred brand-name drug, and $75 for a nonpreferred brand. MA–PD cost sharing was more likely to remain at 2008 levels, with the exception of increased coinsurance for specialty-tier drugs.
- For 2009, fewer premium-free PDPs are available to enrollees who receive the LIS: 308 plans qualified, compared with 495 in 2008. CMS estimated that it needed to reassign about 1.6 million LIS enrollees to new plans for individuals to avoid paying some of the premium.
- A small percentage of beneficiaries are enrolled in Medication Therapy Management Programs (MTMPs). While all plans are required by Medicare to offer MTMPs to beneficiaries enrolled in their drug plans, MTMPs differ in the number and type of chronic conditions and prescriptions a beneficiary must have to be eligible, the kinds of interventions provided to enrollees, and the outcomes sponsors measure. More standardized collection and reporting of outcome measures could be used to determine whether programs are meeting their goals of improving the quality of pharmaceutical care, what patient populations benefit from these programs, and what interventions are most successful.

Public reporting of physicians' financial relationships

Drug and device manufacturers have extensive financial relationships with physicians, academic medical centers, and other health care entities. These financial ties have led to many advances in medical research, technology, and patient care. However, they may also create conflicts between the commercial interests of manufacturers and physicians' obligation to do what is best for their patients. The line between appropriate and inappropriate interactions may not always be clear, but there is no doubt that the interactions should be transparent. Transparency does not imply that all—or even most—of these financial ties undermine physician–patient relationships.

Requiring manufacturers to publicly report their financial relationships with physicians and other health care entities should have several important benefits. For example, it could discourage physicians from accepting gifts or payments that violate professional guidelines. It would also help CMS and other payers determine whether physicians' practice patterns are influenced by their interactions with industry. The Commission recommends that the Congress require manufacturers to report their financial relationships with physicians and other health care entities and that the Secretary post this information on a public, searchable website.

In 2005, pharmaceutical manufacturers provided free samples with a retail value of more than $18 billion to physicians and other providers. While free samples may benefit patients, there are concerns that they may influence physicians' prescribing decisions and lead physicians and patients to rely on more expensive drugs when less expensive medications might be equally effective. More information about the distribution of samples would enable researchers to study their impact on prescribing patterns and overall drug costs and could help payers and health plans target education to providers about alternative drug options. The Commission recommends that the Congress require pharmaceutical manufacturers to report information about drug samples and their recipients. The Secretary would make this information available for research and legitimate business purposes through data use agreements.

In addition to financial relationships with drug and device manufacturers, physicians may also have financial ties to health care facilities. There has been rapid growth in physician investment in hospitals and ambulatory surgical centers, for example. Although physician ownership of facilities may improve access and convenience for patients, evidence suggests that physician-owned hospitals are associated with a higher volume of services within a market. The Commission recommends that the Secretary collect information on physician investment in hospitals and other health care providers and make it available in a public database, which would facilitate research on how physician ownership might influence patient referrals, quality of care, volume, and overall spending.

Physicians have a wide variety of financial relationships with hospitals besides investment interests, yet we know very little about their prevalence. If information on these relationships were publicly available, payers and researchers could use it to examine their impact on referral patterns, volume, quality, and cost. Through the Disclosure of Financial Relationships Report, CMS plans to collect detailed data from a sample of hospitals on their ownership, investment, and compensation arrangements with physicians. We recommend that the Secretary use data from this survey to report to the Congress on the prevalence of various arrangements. This report could help guide future decisions on what types of physician–hospital relationships—in addition to ownership—should be publicly reported.

Reforming Medicare's hospice benefit

The Medicare hospice benefit was established in 1983 to allow beneficiaries to choose palliative care and other benefits consistent with their personal preferences for end-of-life care as an alternative to conventional medical interventions. The creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package; it was a statement recognizing and respecting social values and patient preferences at the end of life. Since Medicare began covering hospice care, the share of beneficiaries electing hospice has grown, as there has been increased recognition that hospice can appropriately care for patients with non-cancer diagnoses.

Along with this expansion, hospice stays have grown longer, with especially rapid growth occurring since 2000. Medicare hospice spending also rose rapidly, more than tripling between 2000 and 2007, when it reached $10 billion. Over this time, the number of Medicare-participating hospices increased by more than 1,000 providers, nearly all of which were for-profit entities. The Commission's analysis of the hospice benefit in our June 2008 report shows that Medicare's hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices. We also find that the benefit lacks adequate administrative and other controls to check the incentives for long stays in hospice, and that CMS lacks data vital to the effective management of the benefit.

To address these problems, we make recommendations to reform the payment system, to ensure greater accountability within the hospice benefit, and to improve data collection and accuracy. In making these recommendations, the Commission recognizes the importance of the hospice benefit and its substantial contribution to end-of-life care for beneficiaries. The goal of these recommendations is to strengthen the hospice payment system and deter program abuse. It is not to discourage enrollment in hospice. Thus, the Commission's recommendations are intended to encourage hospices to admit patients at a point in their terminal disease that provides the most benefit for the patient. The Commission recommends:

- A revised hospice payment system under which per-diem payments begin at a relatively higher rate, decline as length of stay increases, and provide an additional payment at the end of the episode. This model would better reflect hospices' level of effort in providing care throughout the course of a hospice episode and promote stays of a length consistent with hospice as an end-of-life benefit. Without a change in the payment system, there is a risk that hospice in Medicare will become a de facto long-term care benefit, inconsistent with the statutory intent of the program. At the same time, it should be noted that the new payment system would affect the length of stay by ensuring decisions regarding admissions to the benefit would be made at the appropriate time in the patient's disease progression. Changes would be made in a budget neutral manner in the first year.

- More oversight of hospices' compliance with Medicare eligibility criteria and greater physician engagement in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. One contributor to increasing length of stay may be insufficient attention to the patient's clinical indicators on the part of the physician certifying the patient's continued eligibility for hospice. Requiring additional documentation, coupled with focused medical case reviews of hospices with a greater share of very long stays would help ensure that hospice is used to provide the most appropriate care for eligible patients. We envision the Medicare case reviews to be targeted to the hospices with high average lengths of stay, not all hospices. In addition, potential conflicts of interest among hospices and other providers caring for hospice patients should be addressed and we have recommended that the HHS Inspector General investigate nursing home and hospice referrals.

- Additional data be collected on hospice claims and cost reports. Hospice claims should contain information on the kind and duration of visits provided to a patient to better understand care provided and to differentiate patterns of care among different types of patients and hospices. Hospice cost reports should include additional information on revenues and be subject to additional reviews to ensure they serve as accurate fiscal documents.

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Chairman STARK. Thank you. The health insurance industry has commissioned a variety of reports that reference a cost shift to private health plans from Medicare and Medicaid.

I notice that nowhere do they ever suggest that perhaps the private plans are paid too much, rather than Medicare paying too little. I can understand why they would not want to raise that issue.

Last week, we heard the argument from an actuary whose report was paid for by AHIP and Blue Cross, and you mentioned this so-called cost shift in your March report.

Can you explain MedPAC's view of this argument and whether it is supported by your research? When others do this analysis, are they analyzing what is the right price for Medicare?

Mr. HACKBARTH. Our concern, Mr. Chairman, is that overly generous private payments drive up costs and that flows through and affects the Medicare system.

We see evidence of that in two types of data. If you look over time at the relationship between hospital margins from private payers and Medicare costs, if you look at that as a time series, looking back a couple of decades, you see era's where the payment from private plans are high, that has a negative effect on Medicare margins. Medicare margins turn out to be low.

The other look at it that we did was to look among existing hospitals and look at those that are under financial pressure and those that are not.

By being "under financial pressure" we mean institutions that do not have the luxury of having generous payment from private insurers, who feel a lot of pressure to control costs. Their costs are significantly lower than institutions who have generous private insurance payment to support their operations.

It is about a 10 or 11 percent difference. The ones under financial pressure are able in fact to control their costs and reduce their costs when they need to.

Of course, the next logical question to ask is is that lower level of costs consistent with providing a high quality of care to Medicare beneficiaries.

What we did was look at hospitals and identify a group of efficient hospitals that have both low cost and high quality scores on issues like mortality and re-admissions, and we found that in fact, there are institutions that are able to combine low cost with high quality.

Our statutory charge, assignment that the Congress has given to the Commission, is to identify payment rates for the Medicare Program that are consistent with the efficient delivery of health care services.

Looking at all these different types of evidence, we conclude that the problem is not that Medicare rates are too low and we think they are consistent with the efficient delivery of services.

One last point on the cost shifting issue. In order to be able to shift costs to increase charges to private insurers, a hospital would need to have market power. It would need to have some leverage to say oh, we are not getting enough from Medicare, we are going to charge you more.

If an institution has that sort of market power, it raises the question of well, what if Medicare increased its rates, would they automatically reduce the rates for private insurers? If they have substantial market power, sufficient market power to shift costs, as

is alleged, it is not at all clear to me that higher Medicare rates would result in lower rates to private insurers.

For profit hospitals will seek to maximize their profits. Not for profit hospitals will seek to maximize their revenues so they can do good things with it.

Higher Medicare rates, it is not at all clear to me that leads to lower private insurance rates.

Chairman STARK. In your first chapter of the March report, you pointed out that while public and private programs have both seen rapid growth in spending, Medicare's spending per enrollee has historically grown more slowly than the private insurers' spending per enrollee.

What accounts for Medicare's better cost containment or slowing of its rate of spending growth, and do you think some of Medicare's innovations such as prospective payment, have contributed to this?

Can we solve the problem of rising health care costs by looking at Medicare in isolation, or do we have to combine the whole thing, look at Medicare and the private plans?

Mr. HACKBARTH. If you are referring to a graph that is in our report, as I recall, it looks at the rate of increase in Medicare costs compared to private insurance costs, going back for 30 or 40 years.

If you study that graph, what you see is that in particular, since the 1980s, the Medicare rate of growth has tended to be lower than the rate of growth in insurance costs in the private system.

Of course, the significance of the 1980s was the advent of the prospective payment system for hospitals, and then ensued from that a series of other changes as well, prospective payment systems and the like.

The one exception to that general trend is in the mid-1990s, when in fact the growth in private insurance costs were lower than Medicare's. You will recall, of course, that was the period of managed care and active management of health costs by private insurers.

If you look at the whole picture on average, as you say, Mr. Chairman, the Medicare rate of increase is somewhat lower.

There is some disagreement. You can find experts on both sides. Some are saying well, it is really not an apples to apples' comparison because of differences in the benefit structure, and then others say well, even if you account for that, it is still true.

I am not sufficiently expert on the technical things to judge those two. The data do show a lower rate of increase in Medicare.

Chairman STARK. Thank you. Mr. Herger, would you like to inquire, sir?

Mr. HERGER. Thank you, Mr. Chairman.

Mr. Hackbarth, last week, you sent the Committee a statement questioning the findings of a Milliman report. This report concluded that because Medicare and Medicaid under paid physicians and hospitals, these providers charged those with private health insurance more for their services.

As a result, the annual cost of private health insurance for the average family of your is nearly $1,800 more expensive.

Your statement did not question the cost shift resulting from Medicare's $14.1 billion under payment to physicians, nor did it

analyze the Medicaid's $40 billion under payment to the physicians and hospitals.

You stated that Medicare reimbursements to physicians have been 20 percent below market rate for the last decade. Reports show that Medicaid pays physicians just 44 percent below private insurance rates, and pays hospitals 33 percent below the market rate.

Nearly 60 percent of hospital discharges are Medicare and Medicaid patients.

Surely, you cannot believe that these significant under payments are not affecting the private insurance rates.

Mr. HACKBARTH. Let me just start by clarifying that the statement that was submitted for the record last week was not a specific rebuttal of the Milliman report. That analysis was done in advance of the publication of the Milliman report.

Indeed, this argument that I just described a few minutes ago about cost shifting is one that we have been making for the last three or 4 years. This is not a new issue for us.

In fact, this argument goes way back. Back in the 1980s, I worked at what was then HCFA, now CMS, and cost shifting was a huge debate.

I just wanted to be clear that the material that was submitted last week was not a rebuttal of Milliman. It was material that is in our March report. It is based on analysis that we have been doing for several years.

Mr. Herger, as you said, our analysis focuses on hospitals and the reason for that is on hospitals, we have cost data to do the sort of analysis that I described a minute ago. For physicians, we do not have cost data.

We cannot do the efficient physician analysis in the same way that we just did the efficient hospital analysis that I described earlier. That was the reason for not focusing on physicians.

As you point out, we find that Medicare rates for physician services overall are about 80 percent of those of the private carriers that we used as benchmarks. That figure has been relatively stable in recent years. It is actually higher than the number was back in the 1990s.

Medicare rates have increased relative to private insurance rates since the 1990s.

I would also point out that 80 percent is the overall average, that it varies by type of service. For evaluation and management services, the ratio is more like 88 percent, not 80 percent.

It still raises the question are Medicare rates too low or are private insurance rates too high. We think the Medicare rates are adequate and consistent with the efficient delivery of services. We do think there is a mal-distribution of the payments. We do think the payments for primary care ought to be higher and payments for some other services should be lower.

We do not see the need for an across the board large increase in Medicare payments to physicians.

Mr. HERGER. Again, it is hard for me to understand how you come to this with such a huge disparity, 33 percent below market rate for hospitals and physicians, 44 percent.

This is a huge disparity. You mentioned yourself—you do not see cost shifting because of this?

Mr. HACKBARTH. The analysis that we focused on is whether the Medicare rates are sufficient for the efficient delivery of services. We believe they are, both for hospitals and for physicians.

Mr. HERGER. Is that because they are getting their money some place else? You are giving this much. The services are being completed, but they are not being completed because of what you are paying them. They are being completed because the shift is going to the hospitals and the physicians.

Mr. HACKBARTH. We believe that the Medicare rates are sufficient for the efficient delivery of services. Clearly, it is beyond dispute that private insurers pay higher rates.

Mr. HERGER. What if we took private insurers out of the picture and it was only the money coming from Medicare/Medicaid, would you still think that would be enough to keep——

Mr. HACKBARTH. Yes, we would.

Mr. HERGER. You do?

Mr. HACKBARTH. Yes. We think health care costs in the United States are too high.

Mr. HERGER. I do, too. I think it is because of fraud and abuse. I think it is because of lack of torte reform. I think there is enough other areas there why it is too high.

I respectfully strongly disagree with you, but thank you. Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Herger.

Mr. Doggett, would you like to inquire?

Mr. DOGGETT. We can base our health care policies on methodology and on ideology or we can base them on facts. I appreciate, Mr. Hackbarth, the work that you and your Commission do. I think your work by its very nature never makes those most directly affected happy because we cannot assure coverage for more people unless we address the issue of cost containment, and you do that, and I do not always agree with every single recommendation, but I do appreciate the way you approach this issue.

Mr. HACKBARTH. Thank you.

Mr. DOGGETT. Let me ask you to focus on a couple of specifics. One of those is long term care hospital patient criteria. As you know, Congress mandated CMS to produce some patient criteria and facility criteria regarding when it is appropriate to use long term care hospitals.

I know there are some at CMS that are skeptical that it is feasible because of the difficulty of setting the criteria that would identify a patient uniquely qualified.

It seems to me the real question is which patients are appropriate for care. Which patients would benefit from the level of care that is higher and more expensive at a long term care hospital.

I would just ask you to react to whether it should be feasible to establish criteria that will help define which patients will benefit from care at long term care hospitals.

Mr. HACKBARTH. We believe the answer is yes, that not only is it feasible but necessary. We fully support the Congressional mandate to CMS that they develop such criteria.

Let me just describe our reasoning for a second. The challenge in post-acute care, the broad category that we use to describe home health care, skilled nursing, facility care, long term care hospitals, in-patient rehab, these are all types of care that patients generally get after a hospital admission.

They are out of the acute hospital and they need some additional care. Where do we get it best? The overall problem that we have in post-acute care is that we fear too many patients are going to very expensive sorts of institutions, like long term care hospitals or in-patient rehab hospitals, when in fact they could get equally good care, equally good results at lower cost institutions, a combination of skilled nursing facilities and home health.

When we look at long term care hospitals, which are very expensive institutions, we want to make sure that the only patients who use that resource are the ones that absolutely need it.

Hence, we think it is important to define eligibility for that service based on specific criteria, not just for the patients, but then also criteria on what the institutions need to be able to provide.

It is not an easy task but it is an essential task. Otherwise, we run the risk of spending a lot of money on patients who could be served equally well some place else.

Mr. DOGGETT. You believe CMS can and should undertake that task of defining those criteria for individuals and for the facilities?

Mr. HACKBARTH. We do.

Mr. DOGGETT. Let me turn to another area of what I personally think is waste and abuse within the Medicare system to which some of our colleagues seem to be totally blind.

That is in the pharmaceutical industry. The pharmaceutical companies are not doing enough, in my opinion, to reveal their financial relationships with physicians. I know several of them have been turning their public relations' effort toward new codes of ethics in an effort to preempt Congressional action.

Why are not those voluntary actions sufficient? Why is some further action here necessary?

Mr. HACKBARTH. As you know, there are close and in some cases complex relationships between physicians and pharmaceutical manufacturers, device manufacturers and others.

We want to be clear that we do not think those are necessarily inappropriate. Involving physicians in the development of new drugs and devices is an entirely appropriate and natural thing to do.

Mr. DOGGETT. You just believe they are insufficient?

Mr. HACKBARTH. We believe it needs to be transparent, and the connection, Mr. Doggett, to the voluntary guidelines is without data systematically collected, we cannot monitor adherence to voluntary guidelines.

Mr. DOGGETT. Exactly. You have to have them both.

In that regard, if you look at Part D and our experience with it as reflected in your work, excluding the people that get extra help, looking at the rest of the Part D population, as I understand it, 93 percent of the people covered by Part D have had a premium increase. They are paying more for drug coverage this year than for last year.

In theory, competition was supposed to provide those folks more choices and they would be able to switch to lower cost plans. That has not worked in fact, has it?

Mr. HACKBARTH. There have been generalized increases, if that is what you mean. Premiums in general are going up.

Mr. DOGGETT. They are going up. I think we can learn from the experience of Part D in recognizing how vital it is to have a public plan option in any broader health care reform we do, because we see that relying exclusively on competition among private plans and Part D has not held premiums down. They continue to increase.

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

Chairman STARK. Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Hackbarth, thank you for being here. I want to just pick up where my colleague left off on the Medicare Part D, and specifically on the issue of specialty tier drugs, the idea that these companies can move certain drugs into a higher tier which requires a huge co-pay provision.

From where I sit, it looks to me as though it is an effort to cherry pick the healthier patients and at the expense of those who really need a more expensive drug, not a choice that they are making, but they have whatever type of ailment/disease that requires these more expensive drugs, and they are being shut out and they are being precluded from being able to get the medicine that they need.

It seems terribly dishonest, and I thought there was a 25 percent co-pay provision, and it looks like they have figured out a way to skirt that.

I would like to hear your opinion of what is going on.

Mr. HACKBARTH. Clearly, the high co-pays on specialty tier drugs represent a significant financial burden on patients with serious illnesses and who need those drugs.

That burden, of course, is limited by the availability of the catastrophic coverage under Part D, so cost sharing is capped after some limit. They must incur significant out of pocket costs until they get to that cap.

As to whether this is an effort to cherry pick, it well could have been that, although it has become so generalized now, almost all the plans are doing it. Its effectiveness as a way of cherry picking has been diminished by its pretty much universal use.

This sort of high cost sharing, cost sharing can be an useful tool potentially if people have a choice. If they have a choice of another drug that is equally effective and lower cost, you might say well, there ought to be high cost sharing on something that is unproven but much more expensive.

That is not what is happening here. This is high cost across the board for people that are dependent on high cost drugs.

Mr. THOMPSON. Do you have any recommendation on this?

Mr. HACKBARTH. We have not looked at that issue specifically, Mr. Thompson, to make recommendations.

Mr. THOMPSON. Can you? Would you? Will you?

Mr. HACKBARTH. We exist to serve you folks. We would be happy to look at it.

Mr. THOMPSON. Thank you. At the risk of sounding like a broken record, I want to return to something that I have talked to you about in the past and just about everybody else with an oar in the water on this, and that is the gypsy.

As you know, I represent part of one county, Sonoma County in California, that is at an incredible disadvantage, and they find themselves competing against the San Francisco market because of the inadequate rate that they get. It is very difficult for them to operate.

GAO and CMS have both made recommendations as to how to deal with this. I wonder if you have recommendations or you could comment on the ones that have already been made.

Mr. HACKBARTH. I believe it was 2007, we sent a letter with CMS suggesting that they look at two possible alternatives. As I understand it, they are looking at those alternatives as well as some others.

The basic challenge, as you know, Mr. Thompson, in this area is you have these geographic adjustment factors, and in some cases in the past——

Mr. THOMPSON. It is not just California.

Mr. HACKBARTH. It is not just California.

Mr. THOMPSON. Across the country.

Mr. HACKBARTH. To varying degrees, it is an issue across the country. The troublesome situation is where one locality has high cost and low cost areas within it, so there is a lot of diversity within the existing locality.

The payment level is an average of the high cost and the low cost, so the high cost people feel disadvantaged and the low cost people are relatively advantaged.

You can address that be redefining the boundaries, but these are geographic indexes which means that they need to add up to one, it is a zero sum game. When you redefine the boundaries, you can create new winners and losers.

The impact of any particular proposal on your counties, for example, is very much a function of the specifics of the recommendation.

Mr. THOMPSON. You do not have any silver bullet?

Mr. HACKBARTH. We do not have a silver bullet for sure. We did make two proposals back in 2007, and I would be happy to follow up with you on exactly what our proposals were and how they would affect your counties.

Mr. THOMPSON. You had mentioned earlier the issue of low cost/high quality institutions. Are there not other outside factors that contribute? How are you going to measure for that and how can you use one model and try to duplicate that in another area?

For instance, some of us were at a breakfast today where we heard that hospitals are looking at—hospital planners are looking at obesity rates and then deciding that is where they are going to build hospitals because they see that as a future growth area for medical problems.

If you are dealing with an area that has a community that has poor health indicators, you are not going to be able to flip a low cost/high quality model into that area and be successful.

Mr. HACKBARTH. Yes. The analysis that I referred to is looking specifically at hospital costs per admission. It is not looking at the

overall rate of obesity or other illnesses or other health issues in the community.

It is looking at once a patient is admitted, what are the resources required to treat that patient successfully.

As I said, we found on a per admission basis, there are institutions that do very well on quality scores using far fewer resources than average.

Mr. THOMPSON. Thank you.

Chairman STARK. Thank you. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. Appreciate it.

You said you had 17 members on your panel. Do they represent all sections of the country?

Mr. HACKBARTH. As well as you can with 17 members. We cannot represent every constituency, but as Mr. Stark said, we have a range of people from urban areas and rural areas and the like.

Mr. JOHNSON. Do you have some Texas guys on there?

Mr. HACKBARTH. No, but we have——

Mr. JOHNSON. That is enough.

Mr. HACKBARTH. We have South Dakota and we have a member, George Miller, who for many years ran small rural hospitals in Texas. He keeps us filled in on Texas.

Mr. JOHNSON. Are you in favor of free enterprise?

Mr. HACKBARTH. I am, absolutely.

Mr. JOHNSON. In Medicare Part D, as I recall, the option for a while was to have the Government dictate the cost of prescription drugs. I recall it was about $32 or something like that. Those rates have gone down now in Medicare Part D, which would suggest to me that free enterprise is working in that particular program.

Would you agree or did you all discuss that?

Mr. HACKBARTH. We think the jury is still out overall on Part D. Certainly, there have been very important successes. As you say, we have covered a lot of people and at a cost significantly lower than initially estimated. That is very good news, indeed.

As was indicated earlier, the prices have started to go up. That could be the result of a lack of power in the competitive forces, or it could be that more Medicare beneficiaries are getting the drugs that they need to treat serious chronic illness.

One of the areas that we know drugs can help is in reducing hospital admissions and more expensive care for patients with chronic illness.

To the extent that we are more successful in getting more Medicare beneficiaries on those drugs, prices are going to rise.

I would say the single biggest thing that I worry about, Mr. Johnson, in the context of Part D is what we do about sole source drugs that are very, very expensive, of which there are more and more.

It is not clear to me how private insurers are going to cope with that problem with the amount of bargaining leverage that they have.

That is the single biggest concern I have about Part D.

Mr. JOHNSON. Thank you. When you all consider the question of increases, how do you discuss it among yourselves so that you know that you are coming up with the right decision?

You told me you believed in free enterprise, yet here we are as a government trying to dictate what the pricing is going to be.

Do you all discuss that among yourselves?

Mr. HACKBARTH. Are you talking about Part D now or other Medicare services?

Mr. JOHNSON. Overall Medicare.

Mr. HACKBARTH. The analysis that we go through, we look at a variety of factors. Where available, we look at cost information. We look at access to care. We look at access to capital for the institutions affected. We look at quality of care. We do not base our decisions or recommendations to the Congress on any one factor, but it is a series of factors.

Mr. JOHNSON. It seems to me that there are not any two hospitals alike. I do not know how you find a glove that fits them all. The various parts of the country are different. That is why I asked you if you had somebody representing every part of the country. No two parts of the country are alike as far as medicine is concerned, from a doctor, hospital or prescription standpoint.

I think you would agree with that. Do you not?

Mr. HACKBARTH. In fact, Medicare makes many adjustments to reflect the different circumstances of hospitals. We do not pay a fixed flat rate. We pay one that reflects not just the diagnosis of the patient but also the severity of their illness. We make a lot of geographic adjustments. We have a series of special payment systems to meet the needs of small isolated institutions.

It really is not an one flavor, fits all.

Mr. JOHNSON. You indicated to me you did not have anybody from Texas. Do you have anybody from Alaska on your board?

Mr. HACKBARTH. No, we do not.

Mr. JOHNSON. It seems to me those are the two largest states in the country and you do not even represent them on your board. I cannot see how you can be a positive influence toward the system without that representation.

Thank you very much, Mr. Chairman.

Chairman STARK. I might suggest that if you need any information on Baylor Medical School, Mr. Johnson is an expert, and he would be glad to counsel you at any time that you need help in understanding anything there is to understand about Baylor.

Mr. HACKBARTH. I will keep that in mind.

Chairman STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. I would. Thank you, Mr. Chairman. Thank you for being with us today.

You have indicated that—I am terribly concerned about our inability to get a hold of costs, which the increases have been inexorable.

When I was an insurance commissioner in the 1980s, it was 12.4 percent of GDP. We were fearful of it turning to 15 percent by the turn of the century. Here we are at 16.7 and heading due north.

Your report, I believe, indicates that some of the strategies on cost containment would involve elevated roles of the primary care physician, that some of the best value achieved across the systems

is based on the evidence presently available to MedPAC is primary care centered integrated systems, meaning better outcomes at lower costs.

Would you care to elaborate on that?

Mr. HACKBARTH. Yes. We absolutely do believe, Mr. Pomeroy, that a strong primary care system is essential. As I said in my opening statement, there is lots of research that demonstrates that fact. I would be happy to discuss it.

In order to increase payment for primary care, we have made several different types of recommendations. First, we have recommended a change in how the relative value units are calculated. I would be happy to discuss that in more detail.

Second, we recommended basically a bonus payment for primary care physicians. It would be an add-on payment.

Third, we have advocated a large scale pilot of the medical home idea, which as you know, is a key element of which is to say in addition to making fee-for-service payments to primary care physicians, we also ought to make a lump sum per patient payment that they can use to finance staff, information systems and the like, to better coordinate the care for Medicare beneficiaries.

We think we need to change payment on all three of those levels.

Mr. POMEROY. Even in the medical school at the University of North Dakota, with a residency geared at family practice, we have something like one of five students selecting that option.

Are we educating too many specialists at the expense of an insufficient number of primary care physicians?

Mr. HACKBARTH. The numbers of medical students electing to go into primary care has dropped alarmingly, at a very rapid rate in recent years.

The fact is we are producing way too few primary care physicians for our future needs.

The factors behind that decline, more than one thing is at work, we think the income level for primary care is certainly one of those things, and that is why we have recommended these changes.

Mr. POMEROY. Adjusting those relative values?

Mr. HACKBARTH. Yes. It would be too simplistic to say that oh, we do these things and that is going to solve the problem.

Mr. POMEROY. I do accept that, although without getting at the reimbursement question or maybe even medical education cost issues in more dramatic ways, you are not going to make much headway. What has happened has been dramatic. We need something dramatic to turn it around.

Mr. HACKBARTH. Right. This sort of payment change is a necessary condition to get more primary care. It is not a sufficient condition.

Mr. POMEROY. Some of the places where we are seeing the greatest achievements of integrated systems with primary care emphasis are in some of the areas of lowest reimbursement in the country, compared to for example, Rapid City, $5,281, to Miami, Florida, per capita expenditure per enrollee, $14,359, almost triple.

Would it make sense by way of updates to basically enhance the update for lower cost systems relying on this kind of modeling and begin to penalize the updates on high cost systems that do not re-

flect this type of care and are not achieving adequate outcomes for their people?

Mr. HACKBARTH. Yes. There has been considerable discussion recently of the notion of accountable care organizations, which are the sort of organizations you describe, organizations that integrate primary care with specialty and hospital services and could assume responsibility for both clinical outcomes and financial responsibility for defined patient population.

Medicare's current payment systems do not recognize accountable care organizations. There are no special payment provisions for them.

MedPAC is in the process of analyzing how we might alter Medicare's payment systems to support that sort of organization that you describe. For a variety of reasons, it is not as simple as you or I would like it to be. We are looking for the right payment mechanism to reward that sort of activity.

Mr. POMEROY. Thank you. I yield back my time, Mr. Chairman.

Chairman STARK. Mr. Kind, would you like to inquire?

Mr. KIND. Thank you, Mr. Chairman, I would, and I welcome the Chairman and your testimony here today.

Just to pick up on the line of questioning that Mr. Pomeroy was just on, I truly believe that one of the keys to any health care reform that we do around here is not just dealing with coverage but also linking cost with quality of care that exists out there.

MedPAC has in this report and in previous reports, too, kind of touched upon it, but in a glancing sort of way, when you look at the regional variations with the quality of health care that is being performed out there.

What I want to ask you about is your thoughts on where we go forward with comparative effectiveness research, evidence based research, and the role and the importance that is going to play in any health care reform proposal.

Just today, I think I read a report online that Consumer Reports now will be releasing a list of drugs that they recommend, based on comparative effectiveness research. Medicaid programs from various states have utilized this in order to reduce costs. Private health plans, too, are looking at it.

I wanted to get your reaction or MedPAC's perspective on the role comparative effectiveness is going to play with health care reform and potential cost savings that does not jeopardize the quality of care at the end of the day.

Mr. HACKBARTH. Yes. We think comparative effectiveness research is a critical piece of health care reform. Information about what works is essential for physicians and patients as well as for public and private insurers.

The private marketplace has not and will not produce that research in adequate amounts. A public role in financing that research is essential in our view.

Comparative effectiveness research is one of the few pieces of what has been labeled "health care reform" that has the potential at least to affect the long term rate of increase in costs.

The long term rate of increase is heavily influenced by the way technology, new technology, comes into the system, and how it diffuses through the system.

Too often right now, the door is wide open to new technology. It is not carefully evaluated before the fact or even after the fact, and it just spreads. It is used in cases where it may be very expensive but not all that effective. We need research to make better decisions.

I would make one last point. MedPAC's view is that the use of that information ought to be de-centralized. We do not envision one Federal bureaucracy saying here is the right answer for every question in medical care. We think the use ought to be de-centralized, physicians and patients, private insurers, public insurers, all acting independently, making the best judgments they can.

Mr. KIND. Mr. Hackbarth, let me ask you this. Obviously, there have been some concerns being raised already and we had a little bit of that debate in the context of the recovery in the Investment Act, where $1.1 billion was allotted in that for comparative effectiveness and it will be going to the Health Care Research and Quality Agency, NIH, HHS, to kind of disperse it and get these studies in place.

How do you address the concern that some might have that this is only going to lead to rationing, this is only going to be about costs and not quality outcomes, especially concerns being raised within the pharmaceutical industry and the medical technology manufacturers right now that are apparently very scared on how this information will be used?

Mr. HACKBARTH. Right. What we need is information on effectiveness, set aside cost for a second. We need better information about what works. In our view, we are not going to get that unless we make this sort of public investment in the research.

I can sympathize. I think we call sympathize with people who are concerned about the potential for rationing. We can all envision ourselves as the patient, or a loved one being the patient, and in that case, of course, we want the best possible care, damn the cost. That is how we would all act as individuals.

We are also taxpayers. We are all also premium payers to private health plans. From my perspective, we are also all parents or grandparents, and we have a next generation or two to worry about.

As we think about this sort of investment, we should not just put on the patient hat or potential patient hat and say oh, all decisions ought to reflect that, we need to reflect the patient perspective, the taxpayer perspective, and the parent perspective, protecting the future generations.

Mr. KIND. You think establishing the research that shows the best outcomes, evidence based, presenting that information to patients and doctors, that these are rational actors and they will make decisions accordingly?

Mr. HACKBARTH. Yes. Just to give one example. Tom Dean, a physician on the Commission from South Dakota, as a practicing physician, he wants this information. He wants better information about what works so he can do a better job for his patients.

Mr. KIND. Great. Thank you.

Mr. HACKBARTH. That is the most basic level.

Mr. KIND. Thank you, Mr. Chairman.

Chairman STARK. Thank you. Mr. Nunes, would you like to inquire?

Mr. NUNES. Yes, Mr. Chairman. I appreciate the time.

Mr. Hackbarth, I come from a region, San Joequin Valley of California, where we historically have lower reimbursement rates. We are having trouble recruiting specialists and even doctors. Many of the doctors in my district are becoming older and we are seeing more and more doctors basically coming from foreign countries locating here.

I think that raises several questions in my mind about the rate of Medicare reimbursement levels.

If you look at—the first question is if you look at the 1980s and if you adjust it for inflation, I believe the doc's are making less today than they were inflation adjusted back to the 1980s. Is that accurate?

Mr. HACKBARTH. I do not know whether that is true or not, Mr. Nunes.

Mr. NUNES. I am pretty sure it probably is. If you look at the hospitals that are operating in these low and negative rates for the non-Medicare margins, and the theory that I think you have suggested or MedPAC has suggested is if Medicare simply paid less, that the hospitals would become more efficient at delivering care, it seems kind of crude, it does not seem to me like this is a workable solution, at least in my district. I think we have tried that and what we are seeing is as I stated in my opening, a problem with recruitment and a problem getting specialists.

It seems like the more you cut, the harder it becomes. I guess my question is if we want to improve efficiencies, is cutting these Medicare payments truly the best way to do it, essentially rationing care, which is what you were talking about earlier, and is there a better way that we could provide this care?

Mr. HACKBARTH. Yes. Let me start with a distinction. You began by talking about the particular problems of a rural area and attracting physicians, especially specialty physicians. That is a different sort of issue than the issue of the overall Medicare payment rate.

Let me address them in turn. In terms of having payment rates that are adequate for the special circumstances of a rural area, on the hospital side, Medicare has a series of different payment policies to try to help small institutions, especially those that are isolated, for example, the critical access hospital provision where we pay 106 percent of costs for institutions that quality as critical access. Medicare has tried to address those.

With regard to physician payments in Medicare, there are some special adjustments for rural areas in the physician payment system as well. There is a 10 percent bonus payment for health profession shortage areas. There is a floor—I do not want to get too bogged down on the details—a floor on the work value in the physician payment system that elevates payments in many rural areas.

Mr. NUNES. At the most basic level, Mr. Hackbarth, if you look at—truly, my area is not very rural any more. We have some large places. Fresno is not exactly a rural area any more.

Overall, what you are suggesting or what MedPAC is suggesting is basically lower reimbursement rates, and my example is we have

kind of tried that in my district and it does not appear to be working, so the larger question is where are we headed with all this?

Mr. HACKBARTH. Earlier with Mr. Johnson, we were talking about competitive markets and in fact, I do believe in competitive markets and want to use them where we can.

Competitive markets can be pretty harsh, too. In fact, we all see evidence of that every day. Many Americans losing jobs or having their wages reduced or losing their health benefits because of intense competition in competitive markets.

What we need to do in Medicare's administered price systems is apply the same relentless pressure. It is not always a pretty process. It does not mean that everybody is going to be happy, but we know both in competitive markets and administered price systems, it is that pressure which causes people to make the hard decisions necessary to improve efficiency.

Mr. NUNES. We will see if that works. I do not think it has worked too well in my district. I guess we will find out.

Thank you, Mr. Hackbarth. Thank you, Mr. Chairman.

Chairman STARK. Thank you. Ms. Berkley, would you like to inquire?

Ms. BERKLEY. Yes, and thank you, Mr. Chairman, for holding this hearing. Thank you very much for being here. I appreciate it.

I think we all appreciate that if health care spending in our country continues to rise at the current rate as we baby boomers reach retirement, that the promised benefits under Medicare are unsustainable. I appreciate the efforts of the Administration to move us in a direction of sustainability.

My district has the fastest growing senior population in the United States. I represent the urban core of Las Vegas. We have no option but for Congress to take steps to ensure that seniors are able to see a doctor and receive appropriate care.

I agree with many of the recommendations in the report, but there are some things that I would like to share with you, my experience, and in the interest of full disclosure, I am married to a nephrologist and my daughter is a primary care physician, who just started practicing 6 months ago.

According to the report, Medicare payment rates are about 80 percent of the private insurance payments. What our experience has been in my husband's practice is the private insurance companies are pegging their reimbursement to whatever the rate of Medicare is.

When he and I were dating, I was running for Congress for the first time, so about 12 years ago. He would bring HCFA regulations on our dates, not the most romantic.

Mr. HACKBARTH. Sounds like fun.

[Laughter.]

Ms. BERKLEY. A party every night. I am an attorney by profession, and I could not figure out those HCFA regulations to save my life. I believe that a lot of doctors down code because the computer automatically kicks out the higher codes.

They may have expended a great deal of time and effort and expertise in providing care for their patient, but knowing that it is going to be more trouble than it is worth, they are not doing the

higher codes, they are doing the lower codes, so right away, their reimbursement is less.

I would like to have you answer and I would like to finish my thoughts and then perhaps you could answer, what effect do you think allowing the proposed cuts to the physician fee schedule to go into effect would have on a patient's ability to continue seeing their doctor?

I do believe that some of the recommendations in the report require more scrutiny. For example, I support increasing incentives for primary care physicians. However, I do not agree that these incentives must or should be provided by lowering reimbursement to other providers.

I can tell you from personal experience, my daughter is very conscientious. She is in the first six months of her practice. She works very, very hard. She works 12 hours a day, and deserves to be compensated for her work.

Her 60-year-old father leaves the house by 7:00 every morning and I do not see him until after dinner. He is still on call on the weekends. Did not finish his training until he was in his thirties, and deals with the sickest people in our country, and deserves to be compensated for his work as well.

I know that in the State of Nevada, in my district, we do not have enough nephrologists, we do not have enough gastro guys, we do not have enough surgeons, and we do not have enough cardiac specialists or cancer doctors.

The idea that we have an abundance of specialists and not enough primary care physicians, the reality is we need more primary care physicians, but I can tell you in Las Vegas, we have a serious shortage of nephrologists, and that is why my husband is still taking calls on the weekends.

I also think we need to be careful about unintended consequences in implementing reforms, and let me give you an example.

When Congress took a broad brush approach to lowering spending on imaging in 2005, it led to fewer seniors being screened for osteoporosis during visits to their doctors, simply because the physicians were unable to continue offering the service, it did not pencil out.

I know because I have osteoporosis and if I did not have a doctor that had a bone density machine and said you know, while you are here, I want you to get on this machine, I would not have known until I probably started breaking bones.

Seniors are not going to go to the hospital for a bone density test and they should not because it costs three times as much there than if their doctors get reimbursed adequately for a DEXA test.

The Lewin Group estimated that if we restore payments for DEXA scans to their 2006 levels, it would actually save Medicare more than $1.1 billion over the next five years by preventing costly and devastating fractures.

I cannot believe that does not go across the board to other imaging machines and procedures as well.

I am very supportive of the health IT initiatives. I think it will help eliminate duplicative tests and other wasteful spending, while ensuring that patients receive recommended evidence based care.

I know that my time is up. There are a number of other areas that I would like to discuss with you, but in 30 seconds, can you answer any of these questions that I posed?

[Laughter.]

Mr. HACKBARTH. I will go real fast. Private insurers often do use Medicare's physician payment system, which I think is an indication that sometimes the private sector is following Medicare. Medicare is a leader in payment innovation.

Second, if you were referring to the 21 percent cut in physician fees and what the effect of that would be, very likely it would be a bad effect on access for Medicare beneficiaries, so we do not support that. We have recommended a modest increase for physicians.

Third, you raised the issue of primary care going up at the expense of some specialties. What I would emphasize there is if you look at total Medicare physician expenditures, the share going to primary care has been shrinking, and the share going to specialists, sub-specialists of various types, has been increasing.

You have to look at both the price and the volume and intensity of care provided. We have had a shift in income distributions within Medicare away from primary care toward sub-specialty care.

Fourth, there are some other specialties, for example, general surgery, that we are worried about potential shortages. Those issues are not necessarily Medicare issues only, Medicare payment issues only. They are broad issues that go well beyond Medicare.

I do not know about payment levels for bone densities, specifically. I would say that there are instances where Medicare over pays for equipment. For example, imaging equipment, expensive imaging equipment like MRI and CT.

We make a recommendation in this report for reducing those rates because we think the payment rates are overly generous, and I could explain that if we have time.

Ms. BERKLEY. Perhaps we can get together in my office and talk about these issues. My personal experience does not always track with the recommendations in the report.

Mr. HACKBARTH. I would be happy to, yes.

Ms. BERKLEY. Thank you.

Chairman STARK. Mr. Pascrell, would you like to inquire?

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Chairman, I would like to take a slice out of this issue and speak of the health workforce issues, which I think are a critical part of what we are talking about today.

I believe that the reform that we started to talk about last week will be meaningless without a health workforce that is both adequate in size and competency, competency, to respond to an increased demand and a new focus on efficiency, on outcomes, on prevention, on wellness, on coordination.

Health workforce strength has important implications for health care costs. That is the conclusion I have come to. I do not know if that is the conclusion you come to.

Mr. HACKBARTH. It does.

Mr. PASCRELL. I introduced the Health Workforce Investment Act last year, for a comprehensive national framework for health workforce planning. The legislation provides tools that would allow us to collect the data that we need to identify health workforce

problems, to formulate what we would consider to be comprehensive and effective policies to address these problems, set national goals and objectives for the future, and provide states with the leadership and flexible funding needed to address health workforce needs.

In your report, you briefly mention that a portion of the hospitals' rapid cost growth has risen from fierce competition for nurses and other employees.

Is it fair to say that health workforce shortages have the ability not only to restrict access and actually to affect quality, but also to increase costs?

Is it possible to avoid these shortages along with other health workforce issues through a more comprehensive Federal approach to health workforce tracking and planning?

Would you address that just for a moment?

Mr. HACKBARTH. Mr. Pascrell, we have not looked specifically at the issue of workforce planning, as you describe it. I would agree, as I said at the outset, with your premise that the mix and number of people that we train does have a significant impact on both the cost and quality of the system.

We have concerns about the current mix of people that we are training. We talked earlier about the too few primary care clinicians and too many sub-specialists.

We also have some concerns about what they are taught.

Mr. PASCRELL. Exactly.

Mr. HACKBARTH. The emphasis in resident training is still very much in-patient, hospital, whereas more and more of health care is moving outside the hospital. Residents are not being trained in those locations.

Mr. PASCRELL. It is not hyperbole when I have concluded through the preliminary data that I have seen that there is an essential connection between quantity, the number of people, whether we have enough or not, and the kind of training those people receive, and the cost of health care.

If we do not address that, I think the rest of that reform is meaningless. Would you agree with that conclusion?

Mr. HACKBARTH. Again, I agree that the mix of people that we train has a very important effect on quality and cost.

Mr. PASCRELL. The second issue I want to address is the bundled hospital payments. There is a whole range of experts, including MedPAC, the Obama Administration and The Commonwealth Fund, and they recommended a move toward a payment bundling for episodes of hospital care.

I believe there is room for efficiencies and quality improvement, that is what we are all here about, I guess.

I am concerned that hospitals and particularly post-acute care providers may not be prepared for such a shift in the way we treat payments. Additionally, MedPAC outlines the challenges to placing patients in the most appropriate post-acute setting for their needs.

I have gone through that situation with my own mother, who had an acute stroke last April, was given three weeks to live, and she just turned 95 last Sunday. We are hanging in there.

From the hospital to hospice to acute care to the nursing home is a stretch, and we do not know in between what decisions are best for everybody.

I do not feel comfortable penalizing a hospital without giving them the tools to positively change their delivery and their referral methods, particularly given the fiscal health of the hospitals.

I have had one hospital close in my district just recently, and another one has filed for bankruptcy just last week.

What design do you envision for a bundled payment system that best ensures hospitals and providers have adequate information and resources to avoid re-admissions, very expensive, and improved patient outcomes, and how can a bundled system ensure that the patients are referred to the most appropriate post-acute care setting?

Mr. HACKBARTH. Let me start with a couple of facts about the nature of the problem. About 18 percent of Medicare hospital admissions are followed by a re-admission of the same patient within 30 days.

Mr. PASCRELL. Within 30 days?

Mr. HACKBARTH. Within 30 days, at an aggregate cost of about $15 billion.

Mr. PASCRELL. Why is that?

Mr. HACKBARTH. It happens a lot. In some cases, it is unavoidable, but we think there is evidence that in many cases, it is avoidable.

Take a specific example, patients with chronic obstructive pulmonary disease, a common problem among Medicare beneficiaries. There is roughly a four fold difference between the hospitals with the highest re-admission rates and the hospitals with the lowest re-admission rates.

That is very unlikely to be due to chance or circumstances beyond the hospital's control.

Mr. PASCRELL. What is likely to be due to?

Mr. HACKBARTH. We think that among the potential problems are very poor hand off's between the hospital and the attending physicians in the hospital and the patient's primary care physician, home health providers who are engaged in the care, information about what to do in certain circumstances.

We pay them separately. We pay them in silo's and too often, they act clinically in silo's. They are out the door, it is not my problem any longer, it is somebody else's.

The idea behind bundling is say look, it does not end when the patient is discharged. We need physicians, hospitals and post-acute providers to work together to assure the best care for the patient.

Mr. PASCRELL. Thank you. Mr. Chairman, I think this is very fundamental to the issue of cost that we are struggling with. Now that you brought attention and many others have brought attention, so that we are not just concerned about finding the money to throw at the problems, but we are really trying to essentially reduce the cost of health care, I think these fundamental things are critical, and I would like to go into them further.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Ms. Brown-Waite, would you like to inquire?

Ms. BROWN-WAITE. Certainly. Thank you very much, Mr. Chairman.

Mr. Hackbarth, I have asked the staff to put up a slide. Earlier when you were speaking to Representative Nunes, you made a statement that we would be forcing people to make hard decisions.

Obviously, rural health care, we all know, there had been an accessibility and certainly an affordability issue out there.

If the Medicare Advantage plans pull out, people will be suffering in health care, in health care availability, and certainly cost. Many of them will not any longer have the availability of vision, dental, and Part D inclusion in Medicare Advantage.

On the chart, and I believe there actually are two of them, it carefully shows that what people are going to have to make hard decisions about are going to be where they are going to come up with the additional money.

For example, in one of my counties, it means they are going to be paying $126 more if Medicare Advantage pulls out. Mr. Pomeroy's Billings' folks will be paying $246 more a month, and Mr. Blumenauer has a county where they will be paying $234 a month.

I am sure you did not mean that forcing people to make hard decisions, the people that would be making the hard decisions are the people in areas where those who have joined the Medicare Advantage plans are very happy with the additional services that they get as opposed to traditional fee-for-service Medicare.

When you look at these charts, and there are other Members of the Committee who also will be having their constituents being forced to come up with additional funding, how can you recommend cutting the Medicare Advantage reimbursement rate to fee-for-service when these additional services are provided?

Unless there is a disease of the eye, eye vision coverage is not included in traditional Medicare fee-for-service, and certainly not dental, part B reimbursement, and the availability of drugs so that it is covered through the Medicare Advantage plan.

We are able to quantify the additional cost. I would like to have your reaction to that.

Mr. HACKBARTH. Can I put up a slide of my own?

Ms. BROWN-WAITE. Sure.

Mr. HACKBARTH. I guess this is going to take yours down. Is that okay?

Ms. BROWN-WAITE. No, I would actually prefer mine to stay up.

Mr. HACKBARTH. Then I will tell you what the numbers are. The added benefits that you referred to are benefits paid by the taxpayers. They are not paid out of efficiency of the private plans in question.

Private plans says we are giving you these additional benefits, are we not great. On average, those benefits are not being paid by the private plan, they are being paid by taxpayers and other Medicare beneficiaries who are not in Medicare Advantage.

Ms. BROWN-WAITE. Is it fair to say that they are being paid for by the taxpayers because of the higher reimbursement in order to get to some of these rural areas to have coverage?

Mr. HACKBARTH. As I said earlier, in traditional Medicare, we have a series of payment provisions for both hospitals and physicians whereby we pay more for those providers in rural areas.

Ms. BROWN-WAITE. Because there was no other way to get those services there. Let me ask you another question.

Mr. HACKBARTH. I would like to be able to answer your first one.

Ms. BROWN-WAITE. I certainly hope that the Chairman is going to allow me to continue.

Mr. HACKBARTH. Okay. Go ahead.

Ms. BROWN-WAITE. If the availability of private fee-for-service plans is expected to drop substantially in 2011 when MIPPA provisions become effective, why do we not just wait and see what happens at that point before cutting plans even further?

I would refer to page 268 in your report for that statement.

Mr. HACKBARTH. If I may, Mr. Chairman, I am going to go back and finish my answer to the first question.

Chairman STARK. Yes, by all means, go ahead.

Mr. HACKBARTH. There are added benefits. They are paid for by the taxpayers and the way we are providing them through private plans is a very expensive way for the Congress to provide additional benefits to Medicare beneficiaries.

In private fee-for-service plans, for example, we are paying over $3 for each additional dollar of benefits.

If the Congress wishes to extend added benefits for these sorts of services, it seems to us that is your call, that is the Congress' responsibility, but in the interest of solvency of the Medicare Program and the interest of existing beneficiaries who have to finance this with their part B premiums, we ought to do it in the most efficient way possible, and Medicare Advantage is not doing that. It is providing added benefits paid by the taxpayers at a very high cost.

Chairman STARK. Would the gentlelady yield?

Ms. BROWN-WAITE. Yes, I will yield.

Chairman STARK. Are they providing the benefits or offering them? We get mixed up. They offer benefits. We have no record as to whether they really provide them.

Do people really use the gym or do they get the eyeglasses? They get $50 for a eyeglass. I do not know where you get glasses for $50.

The question about what they actually provide may be different from an offering.

If the gentlelady will continue to yield, 75 percent of the people in your district do not belong to Medicare Advantage, which means they are paying $3 a month more for the 24 percent in your district who do.

Ms. BROWN-WAITE. Mr. Chairman, let me explain to you why so many of them do not belong, because they are public employees and if you belong—for example, I have so many retirees from New York State, from Mr. Pascrell's state, New Jersey, and those retirees—if they leave the retirement plan that they have and they go into a Medicare Advantage, they cannot get back into traditional Medicare.

That is one reason why there is a reluctance. I know my husband considered it and he said well, you know, I just do not know if I

want to be back in traditional Medicare at some time, so that is one of the reasons why there is a hesitancy there.

Mr. Chairman, my husband is no longer with me. I hope that you are not laughing at my analogy of my husband, who was a public retiree. My husband passed away.

There is a hesitancy there to go into a Medicare Advantage plan. In my district, because I have so many retirees from states and so many of them are former public employees, that is one reason why there is not that much utilization of the plan.

Chairman STARK. You have the highest utilization of any of the Republicans.

Ms. BROWN-WAITE. They tell me that. Yes, I know.

My second question is why are we not waiting until your prediction of the private fee-for-service plans will drop substantially because if they drop, what is there?

Mr. HACKBARTH. The reason is that we believe that we need the Medicare, both public and private plans. We support Medicare Advantage, but we need to offer beneficiaries a neutral choice between traditional Medicare and a private plan.

We are now systematically encouraging people to leave traditional Medicare, which in many parts of the country is a low cost/high quality plan, to go into private alternatives that are much more expensive, and to provide additional benefits but only at a very, very high cost.

Low cost areas of the country, I really sympathize. I am from Oregon. I am from one of those low cost/high quality states. I hear a lot from my friends in Oregon about how unjust Medicare is and in Miami, they get all these added benefits. I understand that and I empathize with that.

Looking at the challenges facing the Medicare Program, we cannot afford a policy that takes Oregon and turns it into a high cost state. We need to level Miami down toward Oregon, not level Oregon up toward Miami, or we are doing a severe injustice to our children and grandchildren.

We need a more efficient health care system. Medicare Advantage as currently structured is not moving us in that direction.

Chairman STARK. Thank you. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Mr. Hackbarth, thanks again for coming. Thank you for the report. We will be talking quite a bit more as we move forward on the prospects for health care reform, so we thank you very much for the work that the Commission has done, and please convey to the Commissioners our gratitude for the work they are doing.

A couple of quick questions. First, I think your report points this out as well, that we continue to fall behind when it comes to trying to provide modest income, disadvantaged communities with the health care resources they need to ever have quality health care, to be a healthy community, and whether it is in the rural poor areas of the country or the urban inner city areas of the country, there is just not enough access, especially to primary care physicians.

One of the ways that we can try to tackle this is by trying to provide some type of loan deferment or loan forgiveness program for

someone who is in medical school who decides to practice in one of these disadvantaged communities for a time, so they get some reward for it.

I am wondering if there might be some other ways to try to go about that. My question specifically is do you think there might be something we can do within GME, graduate medical education programs, to try to help provide more incentive to graduate medical students who will go practice in disadvantaged areas and thereby increase, we hope, especially the supply of primary care physicians into these areas, so we can start them off on a healthy foot?

Mr. HACKBARTH. Yes. Congressman Becerra, I want to thank you for raising the issue of disparities. Last year, and I think you will remember, Congresswoman Tubbs-Jones gave me a really hard time on this topic. She was right, that we have not—MedPAC has not in the past given sufficient attention to the issue, so we are beginning to do that. We have a way to go. She was right and I want to acknowledge that.

Mr. BECERRA. In the spirit of her memory, I think we will continue to fight that as well, and I appreciate the words that you have offered in that exchange and subsequently, but please go ahead.

Mr. HACKBARTH. On the issue of GME, in fact, at our meeting last week, we began what I think will probably be a series of discussions about GME and how Medicare supports GME, and how we could possibly use Medicare dollars to leverage changes in medical education.

We are not yet at the point of conclusions, but I would say there are Commissioners who are interested in potentially using this leverage to alter the specialty mix, as discussed earlier, potentially you could use it to subsidize the cost of training for particular specialties or people who agree to locate in particular areas and serve under served populations.

There is a lot of money in the pot, so to speak, and ample reason to question whether we are getting what we want out of the system, what we need out of the system.

Mr. BECERRA. If you just increase payments to primary care physicians, you may increase the pool or the supply of primary care physicians. That does not mean that those primary care physicians will go into the areas that are in most need of their services.

Mr. HACKBARTH. Yes. I would say that when we talk about getting physicians to go into under served areas, whether it is Los Angeles or a rural area, that is an issue that goes way beyond Medicare. Medicare is a very important payer, the largest single payer, but for the typical physician, it is only a fraction of their income.

We would need a more concerted approach to shift the distribution.

Mr. BECERRA. That is right. For the most part, when we talk about the need for primary care physicians, if you are a senior, you are going to have access at one point or another to a physician in a far greater way than if you are a poorer adult or a child and do not have good access through any particular program, even Medicaid.

You are right, but Medicare can help because there is a pot of money there that if we direct it the right way, it might be able to help solve that.

Last question. I am a little stunned and disturbed by the level of increases we are seeing in costs within the Medicare Part D program, the prescription drug program.

I think you point out that the average premium increase was about 24 percent. Part D, the prescription drug program within Medicare, does not have a public health insurance option that people in Medicare can choose from to get their prescription drugs. You go only within the private sector for that, those insurance options to plans that are out there for you for your prescription drugs.

Two good questions and my time has expired. One, is it common for us to see 24-percent increases in premiums on the part A and part B side, on the doctor and hospital side of Medicare, and secondly, at this kind of rate, is that not a perfect example of why we need some kind of competitive model that gives us a chance to make sure that we do try to keep a lid on prices going up for consumers of that health care?

Mr. HACKBARTH. You are right that the Part D premiums have increased substantially. It is not entirely clear why that is. Let me list a number of potential factors.

One could be it is a by-product of pricing strategy that companies decided to low ball, aggressively price at the beginning of the program, to maximize their market share, and now that they have enrollees that are backing off and trying to recoup.

A second potential factor could be that there is inadequate risk adjustment. We have been looking at the risk adjustment, Part D, and see some indications that for the high risk patients, it may be inadequate, and we have sent some data to CMS for them to look at.

A third possibility, as I mentioned earlier, is that more people could be getting drugs. The whole purpose of this was to assure that Medicare beneficiaries had access to needed drugs, and we may be successful at that. More and more are getting on. That does not happen overnight. It takes some time, and that may be good news. It may help us hold down some other costs.

These are mutually exclusive. It could be some combination of all these. It could be that a bigger and bigger share of the drug bill is moving toward very high cost single source drugs, biologics, for example, where private purchasers have great difficulty sitting across the table from a monopolist and negotiating a favorable price.

As I say, it could be some combination of all those and there could be some additional factors as well. We will be looking as we get the claims information at trying to figure out exactly what is going on here.

Mr. BECERRA. Do we seen in part A and part B the same 24 percent increase in premiums?

Mr. HACKBARTH. No, we do not.

Mr. BECERRA. Final comment on whether or not if we had a public option available to Medicare consumers, that they could shop and have a way to try to have a better competitive price to

choose from among the plans, if you had a public plan that was out there?

Mr. HACKBARTH. Yes. We have not looked specifically at the issue of a public drug plan. I would say that in general we think that Medicare benefits from having both a public plan and private alternatives. We think they have different strengths and in some ways complimentary strengths.

A public plan has economies of scale, lower administrative costs, and pricing power. Private plans have greater flexibility in payment methods, the ability to identify efficient providers.

The solution is not one or the other. We need both.

Mr. BECERRA. Right. Thank you so much. Mr. Chairman, thank you. I yield back.

Chairman STARK. Mr. Yarmuth, would you like to inquire?

Mr. YARMUTH. Thank you, Mr. Chairman. I appreciate the courtesy you have extended to a non-Member of the Subcommittee.

I am a non-Member but health care comprises about 25 percent of the economy in my district, in Louisville, Kentucky, so I am very much interested for my district, as well as for my role on the Committee.

I have two quick questions about the bundling recommendations. One is my hospital companies tell me that one of the things that has to be accounted for in any bundling structure would be a difference in diagnosis.

You mentioned COPD. If somebody came in with congestive heart failure, which has just by definition almost a greater incidence of re-admission, that the system should accommodate differences in diagnosis.

Would you agree with that?

Mr. HACKBARTH. Correct; yes. What we would envision is a diagnosis based system with severity adjustment, as we use for the basic Medicare payment system.

Mr. YARMUTH. The second thing, the question of where the admission comes from is something that has also been raised to me, that many admissions are not directly by a physician to a hospital, some come from a skilled nursing facility, some come from home health, and so forth.

How would that logistically work in terms of who would be responsible for administering the bundle in that case?

Mr. HACKBARTH. One of the questions—we have recommended a pilot of bundling. One of the central issues is how to make the payment, to whom we should make the payment, and then it would be divided among participants.

That is one of the questions that we think requires further investigation.

The basic idea though is regardless of the source of admission, whether it is from a nursing home or from the community, that there be a fixed payment that covers physician, hospital, and probably the post-acute services for the admission.

Mr. YARMUTH. Now, I have to make a disclosure similar to my colleague, Ms. Berkley. I worked for several years in the home health care business. My brother is a CEO of a home health care company. As I love my brother, I have been a long time stockholder of that company.

I also am concerned because this is a company that is a significant employer in my district.

The standards that you set in making the report say you want to increase the accountability of providers and the value of care, paper performance, measuring resource use, penalizing high re-admission rates, comparing effectiveness of treatments, all of which I think we would all agree with.

In the case of home health care, it seems, however, that the report relates only to the margin of profit on its costs.

Does margin really have anything to do with the standards that you mentioned in the overall goals of the recommendations?

Mr. HACKBARTH. We think that the margins are important, but we do not think that is the only change that ought to be made in home health payments. In fact, we have advocated that the payments be adjusted for outcomes, for re-admission rates and discharge to the community out of home health altogether.

We think there is a need for some quality adjustment in the payment system as well. Having said that, we think there is abundant evidence that the average rate is far too high.

Mr. YARMUTH. Let me ask you two questions about that. Do you dispute the fact that there would be differences in margins between or among various providing groups, the hospital margins by definition cannot really be compared to home health or to long term acute care facilities and so forth?

Mr. HACKBARTH. I am a lawyer by training and a health care manager. I am not an economist. I think economics would tell you that a low capital industry like home health, probably all other things being equal, would have lower margins in a competitive market than institutions that have substantial capital requirements.

Mr. YARMUTH. I would think it might be exactly the opposite but we can debate that.

Is it not true, that at least according to *USA Today* yesterday, home health care, a total cost expenditure by Medicare for home health was 16.5 or $16.6 billion in 1997 and is actually a little bit less right now, so in terms of a percentage of the overall expenditures, it has actually performed better in terms of a burden on the system?

Mr. HACKBARTH. What has happened is that the product being offered has changed dramatically over that period of time. When the rates were initially set for our current payment system, the average number of visits per episode was about 32, and now we are down at about 22.

What they are offering for the payment has declined.

Mr. YARMUTH. Would there not be an issue of whether they have done a better job and that needs to be assessed in terms of ongoing reimbursement?

Mr. HACKBARTH. Yes, and I agree with that, but I also agree that in a competitive marketplace, as the product changes and costs go down, payment rates follow, so the purchaser's share in those savings, the way the home health payment system is working right now, the product has changed, and all of the benefits of that are accruing to home health agencies and none of it accruing to the Medicare Program.

We need to adjust the rates to reflect the changed product.

Mr. YARMUTH. We can have an extended conversation on that later, but I appreciate the time, Mr. Chairman very much. Thank you, Mr. Hackbarth.

Chairman STARK. Mr. McDermott, would you like to inquire?

Dr. MCDERMOTT. Thank you, Mr. Chairman.

It strikes me in listening to all this testimony that clearly the primary care aspect of health care has fallen into disrepute and it is not paid for and simply, as long as we have that situation, we are going to continue to have costs that run out of sight.

That is why I propose that all medical schools, all state medical schools, be free, and that people be required then to pay back by four years of primary care.

That alone will not fix the problem because there really does need to be some kind of medical home or bundling, as you are describing it.

I brought an example. I think it says what is wrong with Medicare today. A 68 year old woman goes into a hospital with back pain. She stays there for 1 day being treated various different ways and examined, and goes out with a $10,759 bill, plus physician fees of more than $1,000 on top of that, plus laboratory fees.

All she got at the end of the day was a shot for pain and that was the treatment, for which Medicare was billed $10,000. Two CAT scans, one MRI.

My view of that kind of situation says if somebody walks in with a Medicare card and knows they can get it paid for by Medicare at some level, I do not know what Medicare actually pays—the hospital billed for the MRI $3,484. I do not know what your payment is. The CAT scan was $2,497. Again, I do not know what portion of that you pay.

Clearly, when you are paying on a procedure basis, it pays to do procedures.

I would like to hear where you are on the bundling question or the medical home. Mr. Yarmuth asked the question but who do you give it to and how do you give it to them, and where are you in either having pilot projects?

Clearly, seniors mostly have chronic illnesses. They are not acute situations where you go in, do surgery and fix it. Most of what they are dealing with is diabetes, arthritis, back pain.

You have to look at that episode and treat it globally rather than piece by piece by piece, or you get $10,000 in one day.

Mr. HACKBARTH. Yes. The example that you cite, Mr. McDermott, and obviously I do not know the circumstances of the particular patient, but I dare say that a lot of physicians hearing that would raise their eyebrows and wonder what is going on.

Dr. MCDERMOTT. I am a physician.

Mr. HACKBARTH. I know you are. Why would a patient be admitted to a hospital for that sort of treatment?

Dr. MCDERMOTT. Not admitted, kept in the emergency room all day.

Mr. HACKBARTH. Kept in the emergency room. I am sorry. I misunderstood.

In my prior life before becoming Chairman of MedPAC, I was CEO of Harvard Vanguard Medical Associates, a 600 physician

multi-specialty practice in Boston, affiliated with Harvard Medical School.

We were largely a prepaid group practice, and one of the benefits of that system is that our physicians would make sure the patients did not go to the emergency department for this sort of costly treatment if and when there is a better alternative available.

That is an example of where a well structured Medicare Advantage program can create the proper incentive for people like my former colleagues to do the right thing for the patient and for the program.

When we are outside of Medicare Advantage——

Dr. MCDERMOTT. Let me just talk about Medicare Advantage because I can tell you what is going on in Seattle.

Health maintenance organizations are taking the fee, keeping 15 percent for themselves, and giving the rest to doctors who will join the plan.

Mr. HACKBARTH. Yes.

Dr. MCDERMOTT. That is how they are getting them in, saying we will pay you more than Medicare pays you if you join us. If you are an ordinary person walking around looking for a doctor, you have to find a doctor who is in one of those plans because patients will not——

Mr. HACKBARTH. I am not surprised by that example. What I would do is draw a distinction. I do think a well structured Medicare Advantage program has some advantage. The problem with the current system is that it is not well structured. We have payment rates that are far too high and that is what leads to what you are talking about.

In traditional Medicare, one of the weaknesses of traditional Medicare is that nobody is responsible for the continuing care of the patient, which is what leads to examples like the one you cited.

We have all these different payment silo's, one thing for the physician, one thing for the hospital, one thing for the post-acute providers.

We need payment systems that bring them together and provide a mechanism for coordinating care and making sure that patient does not go to the emergency department when an office visit might do better.

Medical home is potentially a vehicle for doing that. If we can get more Medicare beneficiaries connected with a primary care physician who is responsible for their ongoing care, not just 15 minute office visits, but their ongoing care, and pay that physician appropriately for doing that ongoing coordination of care, I think we could reduce the sort of cases that you are talking about.

Dr. MCDERMOTT. Thank you.

Ms. BERKLEY. Mr. Chairman, can I ask a question?

Chairman STARK. Sure.

Ms. BERKLEY. I do not know if it is a question or an observation. Where is the patient responsibility in any of this? You know, I cannot tell you how many times a patient misses a dialysis treatment, they get called, they do not respond to the telephone call, and a day and a half later, they are in the emergency room demanding dialysis, which costs considerably more in the emergency

room than it does if they would have made their bi-weekly or tri-weekly appointment.

When does it become not the doctor's fault that the patient is relapsing or getting re-admitted and more the patient's personal responsibility?

Mr. HACKBARTH. Yes. I think that is a really important issue and the ideal relationship between the physician and the patient is collaborative. The patient has to help. They need to do some things for care to go well.

It is not within Medicare's power to make patients responsible, but I think we can set up circumstances——

Ms. BERKLEY. Sometimes not the doctors either.

Mr. HACKBARTH. I think we can in some ways at least set up circumstances where there is a better opportunity for effective collaboration between physicians and patients.

The medical home would be an example of that. It would allow physicians to spend more time with patients on education issues, and take the example of a patient who is receiving dialysis. If a patient in addition to having a terrific nephrologist has a very good primary care physician, some of that educational responsibility could be done by the primary care physician, supported by the lump sum payment that I referred to earlier, and the nephrologist will benefit from that as well.

Ms. BERKLEY. I can tell you without fear of contradiction because I go on rounds with my husband, I listen to him counsel his patients about smoking, about obesity, about mild exercise, and I have seen these same patients walk out after dialysis and light up a smoke.

If you think it is frustrating for you, you can imagine how it is frustrating for him.

Mr. HACKBARTH. Absolutely.

Ms. BERKLEY. Then when the patient becomes morbidly ill and they are on all sorts of machines, the family's first response is I do not care what you have to do, keep my husband, keep my wife alive, when they have done very little to keep themselves alive.

The cost of providing that care is extraordinary. I do not know what the answer is.

Mr. HACKBARTH. I wish there was a simple answer. I have worked with physicians throughout my professional career and I hear that from them over and over and over. I understand.

Chairman STARK. Thank you. I am going to ask unanimous consent that we keep the record open so that we can send you some written questions, if you will.

Did you have anything?

Mr. HERGER. No, thank you.

Chairman STARK. Thank you all, and again, Glenn, thank you very much for your patience with us.

Mr. HACKBARTH. Thank you.

Chairman STARK. The hearing is adjourned.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

[Questions for the Record follow:]

Questions For the Record
to Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission

March 17, 2009 Hearing on
MedPAC's March 2009 Report to the Congress

QUESTIONS FROM MR. STARK

Including Oral Drugs in the Outpatient Dialysis Bundle

Q1. In discussing the payment bundle for dialysis services, the March report states, "Part D drugs used to treat ESRD-related comorbidities may be another candidate for the expanded bundle. Their inclusion might help ensure that beneficiaries receive appropriate care and that providers do not substitute Part D drugs for drugs that are covered under the broader dialysis bundle." Can you explain further why including these drugs might ensure appropriate care? What are the implications if providers substitute Part D drugs for drugs covered under the bundle?

A1. The Commission has a longstanding recommendation for implementing a broader dialysis payment bundle that include services, products, and items needed and commonly used by dialysis patients. The Commission noted in its March 2009 Report to the Congress that including Part D drugs used to treat ESRD-related comorbidities (such as anemia and bone mineral disorders) may be another candidate for the expanded bundle. We also noted that their inclusion might help ensure that beneficiaries receive appropriate care and that providers do not substitute Part D drugs for drugs that are covered under the broader dialysis bundle.

Bundled payment approaches give providers an incentive to furnish the covered services as efficiently as possible, as they retain the difference if Medicare's payment exceeds the costs they incur to furnish the services. However, if Part D drugs are not included in the dialysis bundle, then providers might have an incentive to reduce their costs to furnish covered services by substituting (to the extent possible) Part D drugs for services covered under the bundle. A dialysis payment bundle that includes Part D drugs used to treat ESRD-related comorbidities would prevent providers from cost shifting by substituting Part D drugs for services covered under the payment bundle.

Including Part D drugs used to treat ESRD-related comorbidities in the dialysis payment bundle might help ensure that beneficiaries receive appropriate care. The decision making process would be based on what is best for the patient. Incentives to substitute a Part D drug for a service covered under the bundle, which might not result in the best care, would be eliminated. Patients' adherence to their drug regimen might be improved by receiving all of their drugs needed to treat ESRD-related comorbidities under Part B. For patients receiving in-center dialysis, providers could furnish all of the drugs that were necessary to treat ESRD-related comorbidities at the facility. Similarly, providers could

deliver the necessary drugs (along with other needed supplies and equipment) to home dialysis patients.

SNF PPS Revisions

Q2. Does MedPAC agree that prospectively revising the parity adjustment so that it reflects actual data, as proposed in the 2009 payment rule, is appropriate to improve payment accuracy?

A2. Yes. A revised estimate of the parity adjustment would improve payment accuracy. When CMS estimated the adjustment required to maintain budget neutrality with the adoption of the new case-mix system, using 2001 data it estimated that 19 percent of cases would be grouped into the new (highest payment) case-mix groups. However, using 2006 data, it found that more than 30 percent of cases were grouped into the new groups. With a larger than expected share of days grouped into the highest-payment case-mix groups, the new case mix system is not budget neutral. Instead, the new groupings generate higher payments for the same set of patients than the old case-mix system. A reduction in the parity adjustment is needed to maintain budget neutrality.

The industry may argue that by using more recent data, CMS does not address the changes in real case mix that have occurred. However, the parity adjustment is not intended to account for changes in case mix—it ensures that the same set of patients (and their days) would be paid the same amounts under different classification systems.

Q3. If that policy is combined with MedPAC's SNF payment recommendations from the June 2008 report, is that sufficient to both resolve MedPAC's earlier concerns that the recalibration policy exacerbates problems with NTA/therapy payments and also fix those payment issues moving forward?

A3. Yes. A separate payment component for NTA services will result in better targeting of payments for these services. Establishing therapy payments based on patient and stay characteristics will dampen the incentive to furnish therapy for financial, rather than clinical reasons. Payments will be higher for patients with high predicted therapy care needs and lower for patients who are predicted to require fewer therapy services.

Establishing the NTA pool based on estimates of the share of nursing costs attributable to NTA services will negate the need for an additional NTA adjustment. The distortions that would have resulted from the proposed revisions to the NTA adjustment would not occur because the NTA adjustment will be eliminated.

Physician Ownership of Ambulatory Surgical Centers

Q4. The March report points out that over 90 percent of ambulatory surgical centers have at least one physician owner. In the past, MedPAC has voiced concerns about physician ownership of hospitals and the effect on utilization of care. Do the same concerns apply to physician ownership of ASCs?

A4. Physician investment in hospitals, ASCs, and other providers serving Medicare patients has grown rapidly in recent years and in the March Report to the Congress, MedPAC has begun to look carefully at provider ownership across all entities that bill Medicare. Although physician ownership of facilities like ASCs may improve access and convenience for patients, there is evidence that the presence of physician-owned hospitals is associated with a higher volume of services in a market. In addition, physician ownership of ASCs may influence referral patterns. Also in our March Report to the Congress, MedPAC recommends that Congress should require all hospitals and other entities, including ASCs, that bill Medicare to annual report the ownership share of each physician who directly or indirectly owns and interest in the entity.

Hospital Readmissions

Q5. The March Report references a recommendation from last year about how we can lower readmissions. Is it appropriate for the hospital to be the only provider at risk here? Don't the other providers, such as the nursing home and the physician, play a role in whether a patient ends up being readmitted to the hospital? How can we build upon the MedPAC hospital readmissions recommendation such that we address other providers that play a role in whether a readmission occurs?

A5. In our June 2008 Report to the Congress, the Commission recommended CMS conduct a pilot for bundling payments, noting also that it is interested in pursuing broader approaches to holding providers accountable for service use around hospitalization episodes. Though the Commission did not make recommendations for including providers beyond the hospital and doctor, the report did note in a text box (p. 98) that the concept of holding providers jointly accountable could be applied even more broadly than recommended. For example, under a virtual bundling system, the hospital and inpatient physicians would be held accountable as well as providers seeing the patient on an outpatient basis or in post-acute settings within the 30 days after discharge.

QUESTIONS FROM MR. HERGER

Q1. CMS recently used its regulatory authority to reduce ASC reimbursement rates for some services. MedPAC recommends that ASCs receive a 0.6 percent update in 2010, the first payment increase ASCs will have received since 2003. MedPAC recommends HOPDs receive a significantly higher payment update.

Are you concerned that, taken together, these recommendations could yield a shift in where these procedures are performed? I see this as a distinct possibility given that reimbursements are higher in the hospital setting, making the HOPD setting more attractive to providers, especially those where both ASCs and hospitals are part of the same system. Have you considered that while this recommendation may yield short-term savings, the end result could be higher overall Medicare costs as patients migrate to more expensive care settings?

A1. MedPAC analysis suggests that currently, providers do not have an incentive to refer to HOPDs over ASCs.

First, the Commission has found robust growth in Medicare revenue to ASCs, the number of ASCs, number of operating rooms, volume of services, and number of beneficiaries receiving care in ASCs. In addition, the growth in the number of ASCs indicates that ASCs have had adequate access to capital. All these factors suggest that payments to ASCs are adequate.

Second, despite the uncertain effect of a substantially restructured payment system that CMS implemented in 2008, early indications suggest that the restructured payment system is not detrimental and may actually be beneficial to ASCs' financial health. These include:

- The number of ASCs has continued to increase into 2008.
- Payment rates for 86 percent of the surgical procedure codes covered under the ASC system in 2007 have higher payment rates under the revised payment system in 2009.
- A survey of ASCs indicates they view the reimbursements under the revised payment system as a positive.
- Market analysts indicate that the earnings per share for the two publicly-traded ASC chains increased by more than 10 percent in 2008 and project the earnings per share to increase by at least 10 percent in 2009.

Third, the robust growth in the number of ASCs and volume of services is likely, in part, related to the convenience and efficiency that ASCs offer both patients and providers. For patients, ASCs offer more convenient locations, shorter waiting times, and easier scheduling; for physicians, they offer more control over their work environment by developing customized surgical environments and hiring specialized staff.

Given these indicators, we do not find sufficient evidence to suggest an incentive to switch from ASC use to HOPD use. However, MedPAC will continue to monitor payment adequacy and make recommendations to ensure beneficiaries access to high quality, efficient providers.

QUESTIONS FROM MRS. BROWN-WAITE

Q1: Does the MA program reduce spending in the Part D program? Do Medicare Advantage Prescription Drug Plans offer enhanced benefits over standard Part D plans, thus reducing seniors' out-of-pocket costs for their prescriptions?

A1: We estimate that Medicare's direct subsidy to Part D plans is about $2 per member per month lower (3 percent) than it would be if program payments were based solely on PDP bids rather than the combination of MA-PD bids and PDP bids. This translates into annual savings of around $0.5 billion in calendar year 2008. Likewise, we estimate that enrollees' base beneficiary premium for basic Part D benefits is lower by about $1 per

month because of MA-PDs' lower average bid. This totals about $0.3 billion across all Part D enrollees.

However, these savings are dwarfed by the significant payments in excess of fee-for-service (FFS) spending levels for Medicare Advantage plan enrollees through the current payment system. Paying MA plans 114 percent of FFS spending amounts to roughly $12 billion more in Medicare program payments for 2009. Similarly, Medicare beneficiaries pay Part B premiums that are about $3 per month higher than they would be if MA plans were paid at FFS spending. Across all Part B beneficiaries, this extra premium amount totals about $1.5 billion in 2009

Q2. If Medicare Advantage is paid at the same rates as fee for service, clearly the additional benefits seniors have grown accustomed to will no longer exist. Who is going to pay for reduced Part B premiums? Who is going to pay the reduced co-pays? How are my low-income constituents going to get the health care they need when Medicare Advantage benefits are taken away from them?

A2. While it is true that some beneficiaries—both low-income beneficiaries and others in MA—currently enjoy extra benefits through Medicare Advantage plans, those benefits are financed by all beneficiaries and taxpayers. This is neither an equitable nor a sustainable mechanism to provide added health care benefits to low-income beneficiaries. In our March 2008 Report to Congress, MedPAC recommended using the Medicare Savings Program to ensure greater access to health care services for low-income beneficiaries, which would be a more efficient and equitable mechanism.

Q3. In last year's report, you stated, "The Commission recognizes that changing MA plan payment rates to achieve financial neutrality too quickly may cause disruptions for beneficiaries and may have other unintended consequences." So we are just going to move ahead anyway, without addressing this? We are just going to disrupt the health care benefits of the elderly and vulnerable, without further consideration?

A3. The Commission is sensitive to the need to minimize disruption for beneficiaries currently enrolled in MA plans, particularly among those in high quality plans. For this reason, in the context of MA payment reform, the Commission has discussed a measured transition process from the current benchmarks to 100% of FFS as the overall level of benchmarks. Transition options were first discussed in MedPAC's June 2007 Report to the Congress and additional transition options will be discussed in detail in MedPAC's mandated report on MA payment, slated to be delivered to the Congress in June. We would be happy to brief you in detail on transition options upon request.

Q4. Page 258 of MedPAC's March report says that Medicare Advantage HMO bids are, on average 98 percent of FFS spending. It is misleading that we hear over and over again from MedPAC how Medicare Advantage plans are less efficient than traditional Medicare. Isn't it true that two-thirds of MA enrollees are enrolled in

plans whose average bid is below traditional Medicare's costs? Why are we fixing what it not broken?

A4. It is correct that Medicare Advantage HMO bids average 98 percent of FFS, but because of the high benchmarks under the current MA payment system they are actually paid at approximately 112 percent of FFS (payment for the Medicare benefit package plus the payment for enhanced that are financed primarily by Medicare dollars).

Also, it is true that across all plan types, the average bid is 102 percent of FFS. Nevertheless, MedPAC has consistently noted that HMOs are able to be more efficient than FFS. While this efficiency is encouraging, even among HMOs, the ratio of the average bid to FFS has risen over time, not fallen.

Q5. Fraud and abuse of the Medicare FFS program is currently running rampant, especially in Florida. What amount of spending in FFS is attributed to fraud? If the enrollees on Medicare Advantage start moving back to FFS, won't the billions of dollars lost to fraud each year just increase, since fraud is practically non existent in the MA program? What kind of payment reform have you proposed to address upcoding and overpayments, especially in the home health area?

A5. Fraud can arise within the Medicare Advantage sector as well as in FFS. That said, fraud in the FFS sector also has an impact on payments to MA plans. Because the Medicare Advantage rates are based on FFS spending levels, FFS fraud and abuse spending is actually passed on to the Medicare Advantage program through the rate setting process that sets MA payments in many counties equal to Medicare FFS expenditure levels.

Across all sectors of Medicare, MedPAC makes recommendations to ensure beneficiary access, while paying accurately for the efficient provision of services. In fact, MedPAC agrees that excessive payments in the home health sector are problematic and for several years has recommended zero updates for the sector. For 2010, MedPAC has recommended no update and a 5.5% rate cut. For 2011, MedPAC has recommended rebasing the home health payment rates in an effort to bring home health payments more in line with provider costs.

Q6. Is it true that MA spending accounts for 15% of the Medicare program's total spending annually?

A6. This figure is not correct. Spending in the Medicare Advantage program accounts for approximately 22% of Medicare's annual program spending.

Q7. With respect to bringing MA payments down to 100% of FFS, how many Medicare beneficiaries who currently have benefits through MA plans would lose it?

A7. This is a complex question because it involves predicting both plan behavior and beneficiary behavior in response to different payment levels. Moreover, it also depends on how financial neutrality with MA is achieved, e.g., 100% of local FFS, national blends, competitive bidding. Our findings will be published in MedPAC's June Report to the Congress.

Q8. What would the impact of President Obama's competitive bidding proposal be in Florida? Would beneficiaries lose access to MA plans? How would their out of pocket costs be affected?

A8. MedPAC is not familiar with the details of the Administration's competitive bidding proposal, so we would not be able to estimate its impact on either access to MA plans or out-of-pocket costs. However, as noted above, MedPAC is preparing a Report to Congress on MA payment, which will include a discussion of potential competitive bidding approaches for the MA program.

Q9. Plans currently compete with each other for the market share of eligible beneficiaries. Does MedPAC believe that in order to have a true competitive bidding system, FFS must be included?

A9. Including FFS in the bidding process is one option for a competitive bidding system in Medicare Advantage. However, the Commission does not think it is the only method for creating an effective competitive program in Medicare.

Q10. Does MedPAC's comparison of MA benchmarks to FFS costs incorporate all administrative costs that the FFS program incurs? What, if any administrative costs, are not included?

A10. This question is addressed in our forthcoming June Report to the Congress. Our estimates incorporate the relevant administrative costs of the FFS program.

Q11. Is it true that MedPAC's comparison of MA benchmarks to FFS costs is based off CMS' projected estimate of what FFS costs will be in the following year? In past years, hasn't this estimate assumed reductions in the physician fee schedule that Congress subsequently addressed that have increased FFS costs over CMS's projections?

A11. Its is correct that MedPAC's 2009 comparison of MA benchmarks to FFS costs was based on CMS' 2008 projected estimate of what FFS costs would be in 2009. Changes to the FFS spending levels, such as those related to the physician fee schedule, can have either positive or negative impacts on FFS spending levels.

For 2009, changes to FFS spending not accounted for in our estimates are likely to have a small effect on FFS spending levels, bringing the MA to FFS ratio down by approximately one percentage point. However, coding patterns in the MA program are also not accounted for in MedPAC's estimates. Adjusting our estimate of the MA to FFS

ratio to account for the coding adjustment would increase the MA to FFS ratio. The combination of the coding effect (which works in one direction, increasing the ratio) and the difference between past and current projections of FFS spending for 2009 (working in the other direction) is likely to mean that the 114% figure underestimates the MA to FFS ratio for 2009.

Q12. During MedPAC's most recent public meeting, staff presented four options for changing the MA payment system. What would be the impact of each of these proposals on MA enrollees in Florida? How many MA beneficiaries nationwide would be expected to lose their MA plan under each of these scenarios?

A12. This question and a discussion of our findings will be published in MedPAC's June 2009 Report to the Congress. However, we do not anticipate publishing state-specific estimates.

Q13. Last year Congress acted to significantly reduce the availability of MA PFFS plans to Medicare beneficiaries starting in 2011. Has MedPAC estimated how this action is likely to affect the MA benchmark to FFS ratio in the future? Will it increase or decrease? If so, by how much? Similarly, how will decreasing the presence of PFFS in the future change MedPAC's finding that tax payers spending $1.30 for each $1.00 in additional benefits that MA organizations provide?

A13. It is difficult to predict how the MA to FFS ratio will change in the future as a result of the policy change around private fee-for-service (PFFS) plans. PFFS plans have the option to convert to network plans and remain in the program. Because we do not know the extent to which this will occur, we cannot fully project the effects of recent changes affecting PFFS plans. That said, our June Report to the Congress will provide some estimates of the impact of PFFS changes, although these impacts will be rudimentary.

Q14. Has MedPAC estimated the effect on beneficiaries if CMS's proposed changes to the MA payment methodology move forward? Would you anticipate that CBO would reduce its score for the president's competitive bidding proposal or other proposed reductions to MA rates if the 45 Day Notice changes are implemented?

A14. MedPAC has not estimated the effect of this particular policy on beneficiaries, but as noted above, our forthcoming Report to Congress will include a lengthy discussion of a range of payment policy changes on beneficiaries' access to plans and extra benefits.

MedPAC is unable to comment on the likelihood that CBO will change its scoring of any policy options.

Q15. MedPAC seems to be leaning in the direction of supporting additional payments to high quality MA plans. This approach seems reasonable, but how does MedPAC propose to determine which MA plans fit into this category? Should we also be providing incentives to MA plans that are found to outperform FFS Medicare? How would we measure this?

A15. The Commission has had discussions about ways to maintain high quality plans in the Medicare Advantage program. This is consistent with the Commission's 2005 recommendation to the Congress to authorize a pay-for-performance program to reward MA plans that provide higher quality care. With the current state of quality metrics, plans can be compared against each other using the measures that are part of CMS's star-rating system (for example, the Healthcare Effectiveness Data and Information Set (HEDIS®) data that plans report, and beneficiary surveys such as the Health Outcomes Survey).

Ultimately, however, high quality plans could be paid more than FFS if their quality were higher than FFS. Payments would be in essence a quality-adjusted 100 percent of FFS. It is not now possible to make a direct, broad-based comparison of quality in MA plans versus FFS. The methodology that CMS might use to make a comparison between the two sectors is the subject of a separate report mandated in MIPPA, which is due to the Congress in March 2010.

Q16. Will MedPAC be making any recommendations to add MA-type benefits to FFS, so that beneficiaries who lose their vision or dental coverage will still have access to these benefits?

A16. MedPAC recommendations are made based on a consensus process among the commissioners and this question has not been considered by the Commission. Please also see the answer to Q2 regarding additional benefits for lower-income individuals.

[Submissions for the Record follow:]

Statement of Betty Waite, Medway Home Healthcare

Please vote "NO!" to the proposed Medicare home health benefit cuts in the President's budget. These cuts will be devastating to our senior citizens, who are already struggling to pay for their medicines and health care. Working at a home health agency, I know first-hand that many seniors omit medications prescribed by their physician, simply because they have to choose between eating or buying a medication. If we make more cuts to them, it will seem like "kicking them when they are down!"

Also, I know from personal ongoing experience in dealing with Medicaid, how frustrating and time-consuming that process is. If Medicare becomes a continual "fight" to have coverage for home health benefits, we may as well "write off" our senior citizens! The time alone spent in trying to get acceptance for treatment, not to even mention the reduced payment, is enough to make agencies dread getting a Medicaid patient. If Medicare becomes the same hassle, I feel that home health agencies will begin to disappear. It just won't be worth the continual hassle, besides being unable to pay the employees for their services.

If cuts must be made, make them in the right places rather than stripping our senior citizens of health services. Stop the benefits for all of the outsiders/aliens who come to our country and haven't paid their dues for benefits. Another solution that would immediately provide money is to make the elected officials—from the President on down—to live on Social Security and pay for their health care when they reach 65 years of age, just the same as the "common" person. There would be a much better understanding of the senior's problems if this were done!

If home health benefits are decreased, the expense to seniors will show a drastic INCREASE overall. Home care manages numerous health problems with coordination among physicians, home care nurses, labs, therapies, etc., and the patient is never admitted to a hospital for the treatment. If home care disappears or is severely restricted, these seniors will have to be admitted to a hospital, which will certainly be more expensive than staying in their home and only paying for a particular service.

Recommendations: Congress should:

1. Reform the Medicare home health payment model to achieve a more reliable payment distribution that reflects varying resource uses and costs incurred in producing care to individual patients.
2. Reject any proposals to cut the home health market basket inflation update or impose additional rate reductions for home health agencies.
3. Reinstate the 5% add-on payment for home health services provided to patients in rural areas.
4. Block the home health case mix rate reductions and reform the regulatory process for evaluating case mix changes.
5. Reject proposals to bundle home health payments into hospital or other provider payments.

Thank you in advance for representing the home health agencies and employees. Please vote "NO!" to these restrictive changes to Medicare.

Yours truly,
Betty Waite, RN
Medway Home Healthcare

Statement of Carlo J. DiMarco, American Osteopathic Association

The American Osteopathic Association (AOA) would like to thank you and Members of the Committee for the opportunity to provide comment on the recently released Medicare Payment Advisory Commission's (MedPAC) "Report to Congress: Medicare Payment Policy." Overall, we are encouraged by the Commission's attention to such issues as updates to the physician payment formula and the need to address the looming shortage of primary care physicians.

The AOA applauds the Commissions recommended 1.1 Medicare physician payment update for 2010. Our priority remains the development and implementation of a comprehensive Medicare payment formula that eliminates the continued use of the flawed sustainable growth rate (SGR) methodology. However, we must ensure that access to physician services is not jeopardized as a result of the pending 20 percent reduction set to take effect on January 1, 2010. Additionally, we continue to strongly support increased payments directly targeted at primary care physicians. We believe that reform of the payment formula, creation of new delivery models such as the patient-centered medical home, and financial incentives will assist in the growth of the primary care physician workforce. The AOA continues to be supportive of budget neutrality; however, budget neutral adjustments should not occur within Medicare Part B. Application of such adjustments within Part B only, threatens access to other physicians and exacerbates workforce shortages in specialties such as general surgery. We would instead support a broader application of budget neutrality that would apply uniformly across all Medicare programs.

The AOA is concerned by MedPAC's recommendation to reduce the indirect medical education adjustment (IME) in 2010 by 1 percentage point to 4.5 percent per 10 percent increment in the resident to bed ratio (Section 2a-2). Appropriate funding for graduate medical education (GME) is vital to building a more robust physician workforce. Many institutions, particularly in rural areas, struggle to maintain training programs at current funding levels. Given that studies show most physicians practice within 100 miles of where they received training, we believe that this proposal contradicts the Commission's stated goal of ensuring Medicare beneficiaries' access to care.

The AOA strongly supports the Commission's recommended 0.6 percent increase in reimbursements for Ambulatory Surgical Centers (ASC). These facilities offer high quality patient care; often in otherwise underserved areas. However, ASC payments have not been updated since 2003. Physician-led ASCs provide a high-quality, cost-effective alternative to inpatient hospital care for surgical services and, as such, should be reimbursed adequately for the efficient services they provide to beneficiaries.

MedPAC's recommendation to address the issue of escalating costs associated with Medicare Advantage (MA) plans through the elimination of the stabilization fund for regional PPOs is a first step toward ensuring equity in reimbursements. We support an examination of the benchmarks used to evaluate MA plan bids; however, we caution Congress against excluding IME from the benchmarks, which would cut necessary resources for hospital-based GME programs. The AOA encourages lawmakers to engage in a meaningful discussion on the comparative abilities of Medicare Advantage and traditional Medicare in meeting the increasingly com-

plex needs of a rapidly expanding population of seniors with extended life expectancy.

The development of a quality incentive program proposed within the fee-for-service payment update recommendations presents an opportunity to improve the quality of care within hospital settings. However, we believe that the development of quality measures must be led by physicians with clinical expertise and that all measures should be adjusted for risk, patient compliance, patient mix and geography. The AOA looks forward to working with the Centers for Medicare and Medicaid (CMS) to establish a sensible quality incentive program that will not discriminate against physicians who provide care to high-risk patients.

Again, we thank you for your attention to these issues and to the potential impact MedPAC's recommendations may have on physicians' ability to provide quality care.

Sincerely,
Carlo J. DiMarco, DO
President, American Osteopathic Association
C: Members, Ways and Means Committee

Statement of Chris Doherty

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Statement of Christopher R. Blagg, MD and Robert S. Lockridge, MD

Thank you for this opportunity to comment on the Medicare Payment Advisory Commission's (MedPAC) March 2009 Report to the Congress on Medicare Payment Policy. Our particular concern relates to the section of the Report on outpatient dialysis services and home hemodialysis.

One of us (CRB), a professor emeritus of medicine at the University of Washington and for many years the executive director of the Northwest Kidney Centers in Seattle, has been involved with home hemodialysis since the first patient was trained to use this modality at the University in 1964. The other (RSL) is a private nephrologists responsible for the largest nightly home hemodialysis program in the United States and a clinical associate professor at the University of Virginia.

We appreciate that the section on outpatient dialysis services includes the comments that "Home dialysis offers several advantages to patients . . ." and "interest in more frequent hemodialysis regimens has grown substantially during the past decade because of studies showing improved outcomes and quality of life." We have three concerns we believe are important for the Congress to understand if many more U.S. patients are to have access to the best dialysis care—home hemodialysis, and particularly more frequent and longer home hemodialysis: 1) as CMS develops its bundling program for dialysis reimbursement that this not adversely affect the use of home hemodialysis; 2) that reimbursement for training patients to do home hemodialysis be separate from the bundle and be set at an appropriate level; and 3) that reimbursement in the bundle is adequate to create an incentive for more frequent and longer hemodialysis. The first two of these issues are also of importance for peritoneal dialysis which is also a home treatment, but we leave this to be addressed by others.

A Brief History[1]

Home hemodialysis was introduced in 1964 as a way of reducing the cost of dialysis so that more patients could be treated. It soon became obvious that it also provided much better patient survival, quality of life and opportunity for rehabilitation than conventional hemodialysis in a dialysis facility or hospital. The best results were seen in patients who dialyzed overnight three times a week. Prior to start of the Medicare End-Stage Renal (ESRD) Program in 1973, home hemodialysis was being used by 35 to 40% of the 10,000 or so dialysis patients in the United States. In fact, the rehabilitation of home hemodialysis patients and of patients with a successful kidney transplant and their ability to reintegrate into society and return to work or school or other activities was a significant factor in obtaining passage of the legislation.

Following 1973, the use of home hemodialysis in the United States declined for a number of reasons—with near-universal entitlement the character of the patient population changed, with a rapid increase in diabetics and other sicker patients and in elderly patients; at the same time, for the first five years of the program home

hemodialysis was inadequately paid for, while reimbursement for in-facility dialysis was very generous; new dialysis facilities proliferated rapidly, so providing much needed access to care; for-profit dialysis became an increasingly important source of dialysis care; and there was a shortage of physicians and staff with experience in home hemodialysis.[2]

In the early 1980s Congress's concern about the declining use of home hemodialysis led to establishment of the composite rate equalizing reimbursement for home dialysis with that for center treatment, intended to provide a financial incentive in the hope of increasing home dialysis. However for other reasons, clinical as well as financial, the use of home hemodialysis continued to decline, so that by 2002 the USRDS reported there were only 1,756 such patients out of 308,409 U.S. dialysis patients (0.57%).

The situation began to change in the late 1990s with several developments including the growing realization that more frequent and longer hemodialysis dramatically improves patient survival, quality of life and rehabilitation, markedly reduces hospitalization and greatly reduces the frequency of symptoms during dialysis and the post-dialysis fatigue that over the years have come to be accepted as normal by U.S. patients dialyzing in centers and their physicians. At the same time, new patient-friendly equipment designed for home use was being developed and introduced. As a result of these and other reasons, the number of home hemodialysis patients has more than doubled over the last 4 years to approximately 4,300 patients in December 2008, an increase of about 30% over the number at the end of 2007, and the two largest for-profit corporations have actively begun to support home hemodialysis.

1) Conventional Home Hemodialysis

Patients in the U.S. dialyzing in center three times a week generally receive a total of 11 to 12 hours of dialysis weekly. Home hemodialysis allows freedom to dialyze longer with a more convenient schedule, and it has been known since the 1960s that, in addition to the cost savings, the advantages of dialyzing at home include better patient survival and quality of life, increased independence, responsibility and confidence, flexible scheduling without the need to travel to a unit, comfort, convenience and less risk of infection. A study using 1994 USRDS data showed that the relative risk of death with three times a week home hemodialysis, adjusted for age, sex, race, cause of renal disease and comorbid conditions, was 42% lower than for patients dialyzing in a U.S. center.[3] As of 2007, 841 of the 3.764 U.S. home hemodialysis patients (22.3%) were on three times a week home hemodialysis.[4] More recently it has become obvious that treatment at home also gives the opportunity for more frequent and/or longer hemodialysis.

It is important that any bundling should continue the practice established with the composite rate more than 25 years ago that reimbursement for a home hemodialysis be equal that for a center hemodialysis so as to provide an incentive for patients to be offered home dialysis. While this had little effect for many years, the two major for-profit dialysis corporations are now actively pursuing more home hemodialysis.

2) Home Hemodialysis Training

Since the start of the Medicare ESRD Program, reimbursement for a training hemodialysis has been fixed at $20 more than reimbursement for a conventional dialysis under the composite rate. This is grossly inadequate as training requires specialized nursing and other staff, space for training, and development and maintenance of a training program designed to provide patients with safe hemodialysis at home. Training usually takes from 4 to 6 weeks and at 3 dialyzes per week Medicare provides a supplement of $240 to $360 for completed training. Programs that train patients know that it costs $2,000 or more in excess of the Medicare reimbursement to train a patient. CMS may know what actual training costs are from existing facility cost reports, but this assumes uniformity of allocation of costs in the reporting and so it may be necessary to review this in more detail in a number of the larger home programs,.

It is important that reimbursement for home hemodialysis training not be included in the bundle, and that CMS sets reimbursement for this at an appropriate level if home hemodialysis is to increase.

3) Longer and/or More Frequent Hemodialysis

It has been known since the 1960s that three times a week 8 hour dialysis at home or in a center provides much better patient survival and quality of life than three times a week center hemodialysis.[5] It also greatly reduces the symptoms during dialysis and the post-dialysis fatigue that is associated with center hemodialysis as practiced in the U.S. so that recovery after dialysis is reduced from an average

of 6 to 7 hours to only a few minutes,[6] reduces or eliminates the need for antihypertensive medications, slows the progression of coronary artery calcification, reduces the frequency of arrhythmias[7] and unlike conventional in-center hemodialysis in the U.S. maintains normal nutrition over the years.[8] This because the patient is getting 24 hours of dialysis a week rather than the 10 to 12 hours a week typically received by a center patient. The more hours of dialysis a week the more the treatment comes to resemble the excretory effect of normal kidneys, and the longer dialysis avoids the rapid changes in fluids and electrolytes seen with conventional short dialysis that result in the symptoms patients experience during and after dialysis. Obviously this treatment is best carried out at home overnight, although some programs now provide three times a week overnight hemodialysis in center for some patients.

It has also been known for some time that dialysis patient deaths and cardiac incidents are significantly more frequent on the day after the two day gap between treatments that occurs with three dialyses in the seven day week.[9] This is addressed in some programs by providing alternate night home hemodialysis. As of 2007, 8% of home hemodialysis patients were on this treatment.[4]

Over the last 10 or 12 years experience has been growing rapidly in the U.S. and elsewhere around the world with the striking added benefits of more frequent hemodialysis and there are now more than several hundred papers in the world literature. Although more frequent dialysis can be done in a center this results in logistical and scheduling issues and so again the obvious place for such treatments is the home. Typically the two modalities are short "daily" (5 to 7 times a week) dialysis for 2 to 4 or 5 hours and long overnight "nightly" (5 to 7 nights a week) dialysis for 6 to 8 hours. As of 2007, 63.7% of U.S. home hemodialysis patient were on short daily hemodialysis and 6.0% were on long nightly dialysis.[4] Both modalities have been shown to improve survival and quality of life even further than conventional three times a week dialysis—for example, the relative risk of death has been shown to be of the order of 60 to 70% less than that of U.S. center dialysis patients.[10] These treatments have other benefits including a very significant reduction in hospitalizations and in erythropoietin requirements and, in the case of long nightly dialysis, elimination of the need to take phosphate binders. Most recently it has been shown in a large number of patients that patient survival with short daily hemodialysis is almost identical with the survival of patients with a successful kidney transplant from a deceased donor,[11] and that survival with long nightly dialysis is similar.[12] In fact, a few of these patients who have previously had a transplant that has failed have asked to be taken off the transplant list because they feel so well on more frequent dialysis. Interestingly, nephrologists who have seen the benefits of these treatments say that if they had kidney failure their choice of treatment would be long nightly hemodialysis or a transplant. Clearly increased frequency of dialysis and longer treatment hours both are of great benefit for patients and are best carried out at home—emphasizing the need to encourage the use of home hemodialysis generally.

Both short daily and long nightly hemodialysis very significantly reduce hospitalization days, but as this saving is in Part A Medicare it has not so far been regarded as an offset for the extra Part B Medicare costs associated with more frequent dialysis. Our estimate is that the extra costs in Part B are equivalent to an extra one to one and a half dialyses per week. Including more frequent dialysis in the bundle will consequently be difficult. We feel it most important if U.S. patients are going to have access to the best dialysis care, reimbursement must allow for more frequent and longer home hemodialysis.

As the number of patients treated by more frequent hemodialysis is still small, less than 1.5% of all dialysis patients, we suggest the Secretary could be empowered to include specific reimbursement for this modality in the same way that adjustments are made for geographic factors, pediatric facilities and facilities situated in rural areas. This could then be modified later as more experience is gained.

We thank you for considering our comments. If you have any questions or requests for more information we will be happy to respond.

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Statement of Medical Rehabilitation Providers Association

On behalf of the medical rehabilitation providers and their patients, the American Medical Rehabilitation Providers Association (AMRPA) is pleased to provide this summary of key principles to be considered during the health care reform debate. AMRPA represents over 350 inpatient rehabilitation hospitals, rehabilitation units, outpatient rehabilitation service providers, and several skilled nursing facilities providing medical rehabilitation services to over 700,000 people a year. AMRPA looks forward to working with the Congress and the Administration in addressing the critical health care issues facing our nation.

AMRPA members provide a wide range of medical rehabilitation services to all age groups, including a growing population of veterans with service-related injuries. Medical rehabilitation involves intensive rehabilitation therapy for individuals experiencing serious illness or injury, including stroke, spinal cord injuries, and traumatic brain injury (TBI), among others. The goal of medical rehabilitation is to maximize health, functional skills, independence, and participation in society. Our members' goal is to ensure that persons who experience these serious illnesses or injuries have access to medically necessary rehabilitation services, which enable patients to return to home, work, or an active retirement.

AMRPA is conscious of the public's growing concern about the state of the American health care system. The millions of uninsured and underinsured individuals and high insurance costs for those without coverage demonstrate the inadequate access to quality, affordable health care.

AMRPA is concerned that the health care reform debate has not focused adequately on the needs of medical rehabilitation patients. Medical rehabilitation can prevent people from being admitted to other settings, such as nursing homes, for costly long-term care and, in so doing, can produce tremendous health care cost savings.

The American Medical Rehabilitation Providers Association has adopted principles for health care reform to ensure that the needs of people who have experienced an illness, injury, or health disorder, people with disabilities, and medical rehabilitation providers continue to be an integral part of the health care system.

- AMRPA believes that any health care reform legislation should: a) provide coverage without regard to age, income, disability or employment status b) allow individuals to retain the ability to choose their own health care providers across the continuum of care;

c) ensure that persons of all ages and their families are able to secure health care insurance without being denied based upon pre-existing conditions; and d) provide individuals with the ability to move between jobs without losing health care coverage.

- AMRPA believes that health care reform proposals should address the rapidly rising costs of health care delivery without compromising access to quality care. Health care reform legislation should ensure appropriate use of health care services and promote greater efficiency in the health care delivery system.

Health care fraud and abuse contribute to the high cost of health care delivery. Administrative and regulatory complexities could be modernized through universal use of health information technology, including electronic medical records, by all provider groups. Medical rehabilitation providers should be compensated at fair and equitable rates in all settings throughout the continuum.

- Health care reform must correlate payment incentives to ensure that high quality care is provided. Payment incentives should be aligned to achieve optimum care for patients, rather than driving patients to a particular setting. AMRPA believes that data must be collected on the effectiveness of care. Improving the quality of care, through such key measures as quality of life and functional status, social and community participation, and outcomes reporting should be encouraged in the health care reform debate.
- Health care reform legislation must ensure continued access to medical rehabilitation services in settings appropriate to a patient's medical and functional needs.
- Preventive and primary care efforts should recognize that medical rehabilitation services prevent and reduce subsequent, more expensive medical care. Proposed health care reforms should recognize medical rehabilitation's efficacy in reducing the health care system's reliance on costly long-term care, as medical rehabilitation patients are able to return to productivity in the workforce and independent living. Over 80 percent of patients receiving medical rehabilitation services go home and return to work, school, or an active retirement. Case management must be a priority to ensure continued successful medical rehabilitation.
- Persons with functional loss must have access to medical rehabilitation services that are:

(1) expert and based on the best available evidence; (2) delivered in the medically appropriate setting; (3) focused on prevention of medical complications; (4) intended to optimize function; and (5) based on goals that are relevant to health, function, activity and participation in society, not just survival.

Additionally, the President's Fiscal Year 2010 Budget Blueprint contains a proposal to bundle payments for acute and post-acute hospital care. Under the proposal, acute hospitals would receive bundled payments that cover both hospitalization and care from certain post-acute providers for the thirty (30) days after the hospitalization.

AMRPA believes that bundling can result in an adverse effect on patient care, in terms of access as well as quality. Bundling as described creates a conflict of interest for acute care providers, giving them strong financial incentives to deny or abridge needed medical rehabilitation services. Acute care hospitals with, and especially those without, inpatient rehabilitation units will have an incentive to shorten or eliminate these services.

The bundled payment system proposal should be examined closely, pilot-tested, and the problems presented must be resolved prior to implementation. This reform concept poses a variety of access, policy, data, and administrative issues that must be carefully evaluated and thoughtfully resolved. Simple identification of issues cannot solve a complex problem.

Prior to implementing bundled payment rates, Congress should obtain extensive data on the clinical condition, costs, access and outcomes for potentially affected patients and post acute care providers. The ideal system would ensure access, preserve patient choice, align incentives for the patient's benefit, and improve outcomes.

Medical rehabilitation providers should be compensated at fair and equitable rates in all settings throughout the continuum.

In closing, the American Medical Rehabilitation Providers Association applauds the commitment to health care reform and is eager to work constructively with Congress and the Obama Administration to ensure access to medically necessary medical rehabilitation for Medicare beneficiaries, persons with disabilities and other Americans in need of this care.

Attachment A: Overview of Medical Rehabilitation

What are medical rehabilitation services?

Medical rehabilitation is an integral part of the American health care system. Medicare rehabilitation services include the services of rehabilitation physicians (physiatrists and other rehabilitation trained and experienced physicians), rehabilitation nurses, occupational and physical therapists, speech language pathologists, respiratory therapists, psychologists, social workers, orthotists, prosthetists, audiologists, and other qualified rehabilitation professionals. These services and professionals are provided to people in order to minimize physical and cognitive impair-

ments, maximize functional ability and restore lost functional capacity. Medical rehabilitation is most effective when applied during the acute stage soon after the trauma, be it illness or injury, has occurred or the condition has been detected. Each person is individually assessed, and a comprehensive multidisciplinary treatment plan is tailored to meet his or her goals.

Who benefits from medical rehabilitation services?

Common conditions requiring rehabilitation are: stroke, brain injury, spinal cord injury, arthritis, cancer, neurological disorders such as Parkinson's and Cerebral Palsy, joint disorders, osteo and rheumatoid arthritis, joint replacements or amputation, sensory deficits, chronic intractable pain, heart attack, other major multiple trauma, Guillain-Barre, chronic pulmonary disease, as well as congenital or developmental disabilities. By minimizing the effects of limitations, medical rehabilitation improves the quality of life for these people and their families and eliminates the need for countless hours of care and expense.

Where are medical rehabilitation services delivered?

Depending on an individual's medical and functional needs, medical rehabilitation services are delivered in a variety of settings, including rehabilitation hospitals, rehabilitation units in general hospitals, skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies and clinics, patients' homes, through home health agencies, and residential rehabilitation centers. As of early 2008 there were 222 rehabilitation hospitals, 923 rehabilitation units, 516 CORFs, and over 15,000 SNFs certified under the Medicare program.

Who delivers medical rehabilitation services?

These services are provided by physiatrists and other qualified rehabilitation physicians, occupational, physical and respiratory therapists, rehabilitation nurses, speech-language pathologists, audiologists, psychologists, social workers, orthotists, prothotists, recreation therapists, music therapists and rehabilitation counselors, supported by suppliers of rehabilitation technology, research, equipment and supportive services.

Who covers medical rehabilitation services?

Medical rehabilitation services are a standard benefit in most health insurance packages currently offered by both public and private payers.

Medicare—Medicare is a primary payer for medical rehabilitation services in an array of settings. It represents over 60% of inpatient rehabilitation hospital and unit revenues.

Medicaid—For low income individuals, state Medicaid plans cover an array of rehabilitation services as optional Medicaid benefits. A number of states buy into Medicare to support services, but some states do not cover the deductible and coinsurance. This creates a financial impediment to access.

Private Insurance—The private health insurance industry routinely offers coverage of medical rehabilitation services and assistive devices. Inpatient and outpatient rehabilitation services and sites are commonly covered by the Blue Cross/Blue Shield plans. However, some plans have coverage restrictions which undermine the effectiveness of the benefit.

Managed Care—Most managed care plans cover some medical rehabilitation services as part of their benefit packages. Benefits are generally case-managed with stringent utilization oversight. Frequently, stroke patients who would achieve better outcomes in a rehabilitation hospital or unit are sent to a nursing home.

Workers' Compensation—Medical rehabilitation services are an integral response to workplace injuries, facilitating the employee's return to productive employment.

Statement of The American Health Care Association

The American Health Care Association (AHCA) which represents nearly 11,000 dedicated long term care providers, commend Chairman Stark, Ranking Member Herger and the Members of this Committee for allowing our profession to express our views surrounding the Federal Government's approach to funding nursing facility care for our nation's seniors.

We urge you to keep in mind that preserving adequate Federal Medicare funding in the FY 2010 budget will not just be a key factor in ensuring seniors retain access to quality long term care during today's challenging economic times, but also whether or not our profession will be able to continue successfully treating the changing

patient population envisioned by all of us supportive of broad-based health care reform.

In short, Mr. Chairman, the recommendations offered by MedPAC will undermine U.S. seniors care needs, jeopardize quality, destabilize the long term care sector, and is directly at odds with the economic stimulus objectives outlined by the Obama Administration and Congress.

Medicare-Medicaid Cross Subsidization Requires Realistic Solutions

MedPAC's continuing and exclusive focus on Medicare ignores the real and growing interdependence between Medicare and Medicaid. While 65 percent of skilled nursing facility patients rely on Medicaid to fund part, or all, of their nursing facility stay, those benefits account for only half of nursing facility revenues. Given that the prevalence of Medicaid patients in our nation's nursing facilities is four times that of the acute care sector, special consideration of the relationship between Medicare and Medicaid is highly relevant.

In a recent letter to President Obama, U.S. Representatives Earl Pomeroy (D–ND), Shelley Berkley (D–NV), Shelley Moore Capito (R–WV) and Ginny Brown-Waite (R–FL) point out the vital fact that approximately 80 percent of nursing home patients rely on Medicare or Medicaid to pay for their long term care, and that given that the fastest growing segment of our population is those 85 and older, our nation's need for long term care will continue to increase significantly. "Providing appropriate funding for Medicare and Medicaid," they state, "will ensure that this ever-increasing population will have access to needed long term care when the time arrives."

Continues the letter: "Unfortunately, the Medicaid reimbursement for care at a skilled nursing facility (SNF) has long been inadequate. This funding shortfall has been calculated at $4.2 billion nationwide in 2008, or to put it another way, a loss of $12.48 per patient, per day. Medicare reimbursement supplements this perpetual underfunding and until the Medicaid shortfall can be addressed we ask that you consider the interdependence of these programs when finalizing your FY 2010 budget proposal."

Mr. Chairman, the bipartisan observations offered by your colleagues in their letter to President Obama reflect the reality patients and providers face in the real world, and Medicare-Medicaid cross-subsidization issue is increasingly problematic for all stakeholders. The perilous state budget picture whereby seniors' Medicaid funds are being targeted for cuts makes this situation still worse.

MedPAC's enduring failure to recognize the growing funding interdependence between Medicare and Medicaid should not prevent the Obama Administration and Congress from making rational, independent determinations regarding the importance of providing this vital annual cost of living adjustment.

We strongly support a new provision in the recently passed *Children's Health Insurance Program Reauthorization Act of 2009,* which calls for establishing a Medicaid and CHIP Payment and Access Commission (MACPAC). Working constructively with both commissions regarding eldercare funding issues is key to ensuring that all Medicare payments are not considered in a vacuum and that all payers are recognized when it comes to nursing facility payments.

Medicare Increases Needed for Wage Increases, Investment in HIT & Sustained Quality

As the intent of the recently-passed *American Recovery and Reinvestment Act* (ARRA) is to create jobs and spur economic activity, MedPAC's recommendation in terms of SNF Medicare funding will do just the opposite—and besides derailing sector stability, will cause the loss of the very frontline care jobs key to the provision of quality care.

Given the dramatic cost increases facilities face in key areas including labor, energy, and health information technology, the failure to recommend an inflationary market basket update defies common sense, and is wholly inadequate to sustaining care quality gains—especially as these cost increases stem from factors beyond providers' control.

For example, the shortage of nurses and other direct care workers coupled with the fact that long term care must compete with other employers both within and outside the health care sector for these employees, contributes significantly to rising labor costs. When facility operating margins are further reduced, we are far less able to recruit and retain qualified care givers, modernize and refurbish aging physical plants and equipment, acquire and implement new technologies to accommodate advances in medical practices, and meet the increasingly complex care needs of an aging population.

As illustrated in the chart above, the increases in nursing facility costs from 2001–2007 exceeded the increases in the market basket updates each year (FY 2002 to FY 2009). It is obvious that a full market basket update is critical to enabling nursing homes and Medicare to continue to move forward in providing quality services for our nation's most vulnerable citizens.

The Changing Role of the Nursing Facility

A recent analysis of trends in New York State nursing home care is illustrative of the marketplace realities MedPAC routinely ignores. A 2008 report from the *United Hospital Fund* documents the growing role skilled nursing facilities play as providers of short-term care for seniors continuing recuperation after a hospital stay.

The report finds that the "number of patients staying in a nursing home for less than two months more than tripled," from 1996 to 2005. In addition to this rise in short-stay patients, the study further concludes that, "between 1996 and 2005, both long-term residents and short-term patients have become more disabled, and more of them are cognitively impaired. In 2005, there were also more mental health diagnoses among them than in earlier years." The authors suggest the findings of this study are representative of national trends. These facts further demonstrate why MedPAC's recommendations are out of touch with skilled nursing facility patient needs and desires.

It is important to recognize the nursing home of the 21st century is far different from its predecessors, and while it's excellent news that patients are returning home more quickly, the nature of treating the older, sicker patients themselves is increasingly problematic in the face of possible Medicare cuts.

AHCA FY 2010 Budget Recommendations

It is a public policy error for MedPAC to dismiss the Medicare-Medicaid "cross subsidization" issue as irrelevant to the debate at hand. Based strictly upon the facts, market trends, and fiscal reality, MedPAC's recommendations should be rejected. AHCA supports the following:

- Congress should maintain the FY 2010 full market basket for skilled nursing facilities;
- Congress should amend MedPAC's charter to require the Commission to consider operating margins of all Government payers and the adequacy of all Government funding in making its recommendations. This approach will enhance economic stability and quality improvements;
- MedPAC should factor into its recommendations long term care's progress in improving quality. Funding volatility undermines providers' ability to remain focused on continuous quality improvement.

At the end of the day, Mr. Chairman, the matters at hand are relatively simple: When Medicare funding for skilled nursing services is stable, quality of care and services improves. When Medicare funding is inconsistent and unstable—especially in the face of growing demand—our nation's long term care infrastructure deteriorates, to the detriment of every senior today and every retiree tomorrow.

Statement of Val J. Halamandaris, The National Association of Home Care and Hospice

The National Association for Home Care & Hospice (NAHC) is the largest national home health trade association. Among our members are all types and sizes of Medicare-participating care providers, including nonprofit agencies such as VNAs, for-profit chains, public and hospital-based agencies and free-standing agencies.

NAHC is pleased to submit this statement for the record to the Committee on Ways and Means Subcommittee on Health on the Medicare Payment Advisory Commission's (MedPAC) recommendations and report to Congress on home health care payment adequacies. In its 2009 report to Congress, MedPAC recommended that Congress eliminate the home health market basket update for 2010 and accelerate the application of the 2011 coding creep adjustment proposed by the Centers for Medicare and Medicaid Services (CMS) for 2011 (2.71 percent) to 2010—reducing current rates in 2010 by 5.46 percent while not accounting for any inflation in costs. MedPAC also recommended that Congress direct CMS to rebase home health payments in 2011, using 2007 costs as a base. In September 2008, MedPAC recommended that there be trials to test out bundling of Medicare provider payments, such as post acute care payments, surrounding hospitalizations.

NAHC believes that MedPAC's recommendations fail to address the true financial status of home health agencies. The recommendations are based on an incomplete analysis of Medicare cost report data that excludes a significant segment of home health agencies, ignores essential home health care service costs, and relies on a methodology that treats home health services as if they were provided by one agency in just one geographic area. If accepted, the MedPAC recommendations will severely compromise continued access to care.

In specific response to the recommendations, we note the following:

- CMS administratively has promulgated a 2.75 percent across-the-board rate reduction for home health services for 2008, 2009, and 2010, as well as a 2.71 percent cut for 2011. The 2.75 percent cuts scheduled for 2008 and 2009 have been implemented. Over the next five years (2009–2013) these cuts will reduce outlays for home health by $7.59 billion unless Congress blocks them. These reductions are based on an unfounded allegation by CMS that case mix weights have increased without attendant changes in patient characteristics, referred to by CMS as "case mix creep" or "upcoding."
- In February 2009, the Office of Management and Budget included MedPAC's 2009 recommendations for deep cuts to home health care as part of the President's proposed FY 2010 budget. Over five years these harmful cuts would take more than $13 billion from the Medicare home health program. The Administration's budget also calls for the bundling of hospital and post acute care payments beginning in 2013.
- MedPAC's proposed freeze in home health payments, coupled with the CMS regulatory payment reductions and rebased payment rates, would reduce home health payments by $550 million in 2010, by $2.5 billion in 2011, and by $13 billion from 2010 through 2014. These cuts would come from a benefit that is about $15.5 billion per year ($2 billion less than in 1997) and under control in terms of expenditure growth (see chart below).
- Currently, about one third of Medicare home health agencies (HHAs) have negative Medicare profit margins. The National Association for Home Care & Hospice (NAHC) has calculated that by 2011, nearly two-thirds of home health agencies will have negative Medicare profit margins if MedPAC's proposed freeze, accelerated CMS regulatory cuts, and rebasing of payment rates are implemented.
- MedPAC fails to evaluate the impact on care access that occurs with the current wide ranging financial situation of HHAs. Regardless of average margins, there is a wide range in agency margins and thus a wide range in impact that the proposed across-the-board cuts in payments would have. Additionally, there is no evaluation to date of the completely reformed home health payment model put in place in 2008. In the event that the wide range in margins continues, a more sophisticated payment model connecting payments to resource use should be developed. Otherwise, there will be large sections of the country at risk of losing all access to home health services.
- MedPAC's proposal to reduce home health payments is based on claims that home health agencies are making excessive profit margins on Medicare services. MedPAC's financial analysis of Medicare HHAs, projecting a 12.2 percent margin for 2009, is unreliable. First, it does not include any consideration of the 1,626 agencies (21 percent) that are part of a hospital or skilled nursing facility. In some states, hospital-based HHAs make up the majority of the providers (ND 85.0 percent; SD 76.5 percent; MT 66.7 percent; OR 63.0 percent). Facility-based HHAs have an average Medicare profit margin of negative 6.19 percent. Second, the MedPAC analysis uses a weighted average, combining all HHAs into a single unit, rather than recognizing the individual existence and local nature of each provider. It sees a single national profit margin for freestanding agencies as representative of over 9,700 very diverse HHAs. When all agencies' margins are included and given equal weight, the true average Medicare margin would be closer to 5 percent. About one third of home health agencies currently have negative margins. Third, MedPAC margin data fails to recognize many agency costs, including the cost of telehealth equipment, increasing costs for labor, emergency and bioterrorism preparedness, and system changes to adapt to the new home health payment changes.
- Home health agencies are already in financial jeopardy as a result of Medicaid cuts and inadequate Medicare Advantage and private pay rates. Ongoing study of home health cost reports by the National Association for Home Care & Hospice indicates that the overall financial strength of Medicare home health agencies is weak. The average all-payor profit margin for freestanding HHAs is reduced to 4 percent when taking into account losses from non Medicare payors.

- Recent cost reports reveal that the average Medicare margin for rural agencies is negative 3.52 percent. The loss of the 5 percent rural add-on payment for home health services in rural areas, which expired on December 31, 2006, has resulted in reductions in service areas, agency closures, and reports that some agencies had to turn away high resource use patients who are more expensive for agencies to serve. In many rural areas home health agencies can be the primary caregivers for homebound beneficiaries with limited access to transportation.
- The "case mix creep" adjustment ignores increases in patient acuity, particularly a significant increase in orthopedic and neurologically impaired patients requiring restorative therapy. These changes in patient characteristics are documented in a report from the Lewin Group and directly correlate with changes in case mix weights.
- CMS alleges that the entire change in the average case mix weights between 1999 and 2005 is the result of provider upcoding or factors unrelated to changes in patient characteristics. If this had occurred one would expect to see a significant increase in Medicare home health expenditures. In fact, as the chart below indicates, Medicare home health expenditures are far lower than the Congressional Budget Office (CBO) had expected under the new Home Health Prospective Payment System and are $2 billion less than in 1997.
- The MedPAC proposal to test the bundling of post-acute care services, including home health payments, needs to be defined. At this point, it appears conceptual rather than concrete in terms of the bundling operation. Depending on how a post-acute care bundling model is constructed, it could compromise both the quality and availability of home health care for Medicare beneficiaries. It may cause major disruption to the health care industry, be anti-competitive, increase the Federal regulatory burden and erect a new and unnecessary barrier to beneficiaries' access to quality care. If the bundling is administered by hospitals, there are additional issues of concern. Hospitals have no experience in the management of post acute care and no infrastructure to manage utilization review. Hospitals are the highest cost sector so this is not the place to locate efficiencies in post acute care. If bundled payments are considered, they should go to community-based providers that have a breadth of experience in providing post acute care and avoiding unnecessary hospitalizations.
- Medicare home health services reduce Medicare expenditures for hospital care, inpatient rehabilitation facility (IRF) services, and skilled nursing facility (SNF) care. For example, a study by MedPAC shows that the cost of care for hip replacement patients discharged to home is $3500 lower than care provided in a SNF and $8000 less than care provided in an IRF, with better patient outcomes.
- With communication and technological advances over the last ten years, the home health community has pioneered leading-edge models and therapeutics to deliver comprehensive, high quality, patient centered care across the health care delivery system. These models lead to better patient care coordination, medication management, disease and chronic care management, and behavioral and preventative education. The innovative approaches of today's home health care show great promise in addressing many of the concerns associated with disparities in health care and access in rural communities.
- Home health agencies have already experienced a disproportionate amount of cuts in reimbursement as a result of the Balanced Budget Act of 1997 (BBA). Based on CBO's 1997 10-year projections of the impact of the BBA, Congress expected to reduce Medicare home health care outlays by FY 2006 from a projected $40.4 billion to $33.1 billion. The Congressional Budget Office (CBO) now estimates that home health outlays for FY 2006 were in fact $13.1 billion. This reduction was far in excess of the reduction originally envisioned by Congress.
- The number of Medicare beneficiaries receiving the home health benefit has dropped from 3.6 million in 2007 to 3.2 million. When the current home health prospective payment system (PPS) was implemented in 2000, CBO projected that Medicare would expend $23.3 billion on home health care in 2007. Instead of $23.3 billion, Medicare spent $15.5 billion in 2007, $8 billion less than projected and $2 billion less than in 1997. Home health care as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.6 percent today. By 2016 OMB projects that it will drop to 3.0 percent.

NAHC recommends that Congress should 1) Reform the Medicare home health payment model to achieve a more reliable payment distribution that reflects varying resource uses and costs incurred in providing care to individual patients; 2) Reject any proposals to cut the home health market basket inflation update or impose additional rate reductions for home health agencies; 3) Reinstate the 5 percent add-

on payment for home health services in rural areas; 4) Block the home health case mix rate reductions and reform the regulatory process for evaluating case mix changes; and 5) Reject proposals to bundle home health payments into hospital or other provider payments.

Mr. Chairman, NAHC appreciates the opportunity to provide these comments to the Committee on Ways and Means Subcommittee on Health on Medicare home health care payment adequacy. We look forward to working with the Subcommittee as it studies and considers NAHC's recommendations on MedPAC's report to Congress.