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MEDPAC'S JUNE REPORT TO CONGRESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

JUNE 18, 2014

Serial No. 113–HL13

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE

20–997 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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MEDPAC'S JUNE REPORT TO CONGRESS

WEDNESDAY, JUNE 18, 2014

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

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, June 11, 2014
No. HL–13

CONTACT: (202) 225–3625

Chairman Brady Announces Hearing on MedPAC's June Report to Congress

House Ways and Means Health Subcommittee Chairman Kevin Brady (R–TX) today announced that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) June report to the Congress. The report details the Commission's recommendations for reforming Medicare payment policies. The Subcommittee will hear from MedPAC's Executive Director, Mark E. Miller, Ph.D. **The hearing will take place on Wednesday, June 18, 2014, in 1100 Longworth House Office Building, beginning at 10:00 a.m.**

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

BACKGROUND:

MedPAC advises Congress on Medicare payment policy. The Commission is required by law to submit two reports to Congress on an annual basis. The first report reviews Medicare payment policy and is due by March 15. The second report examines specific issues facing Medicare and is due by June 15.

In its June 2014 report, MedPAC examines:

- The need to compare Medicare's policies across traditional fee-for-service, Medicare Advantage, and Accountable Care Organizations;
- Policy options for financial assistance for low-income beneficiaries in the context of its June 2012 recommendation to restructure the Medicare benefit design;
- Whether changes to Medicare's risk adjustment methodology, which accounts for severity of patient illness, can improve payment accuracy;
- Payment changes to bolster primary care and ensure access to these services;
- How payments to Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs) differ for the treatment of similar patients; and
- The impact of improved medication adherence on overall Medicare spending.

In announcing the hearing, Chairman Brady stated, **"It is our duty to make sure we have a strong Medicare program that works for seniors and taxpayers. MedPAC is a key advisor in this effort. I am pleased that the Commission continues to call attention to the need to improve Medicare's benefit design. This commonsense step would modernize the Medicare benefit so it looks more like other health plans. I commend the Commission for highlighting the need to compare fee-for-service to Medicare Advantage and other payment system options. We owe it to our seniors to provide an apples-to-apples comparison of quality and cost of these options in their geographic area. This hearing enables the Committee to hear MedPAC's valuable insights on these and other important issues."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's June 2014 Report to Congress.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, July 2, 2014**. 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) 225–3943 or (202) 225–3625.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman BRADY. Good morning, everyone. I would like to welcome back the Medicare Payment Advisory Committee. Neither MedPAC nor its witness here today, Executive Director Mark Miller, is a stranger to this Committee. MedPAC is the key non-partisan advisor with a lot of analytical firepower. There is bipartisan interest in this work.

MedPAC issues two reports annually to the Congress. Its March report focuses on the adequacy of payments made to the various Medicare providers. The Committee pays close attention to those important findings, and has had MedPAC testify on them in past years. The June MedPAC report focuses on how to improve the Medicare program.

Improving Medicare, that is the focus of our hearing today. We are at a critical juncture. The program faces serious financial challenges. The Part A Trust Fund, which was paid out to more than it takes in over the past several years is slated to go bankrupt in just over a decade. The funding needed for the Part B Trust Fund will be in—such an increasing drain on the treasury that it is sure to crowd out other priorities. According to independent researchers, this important program pays out, on average, three times the benefit it collects from workers over their lifetime.

We are in a state of flux on how we pay our health care providers in Medicare. The popular Medicare Advantage program faces severe cuts after several years of the White House delaying the damaging Affordable Care Act cuts. Providers increasingly have their payments tied to performance, whether in traditional fee-for-service or some alternative payment model.

The MedPAC June 2014 Report addresses a number of policy issues that are key to improving Medicare's viability and future direction. The report reiterates MedPAC's 2012 recommendation to improve the design of the confusing and outdated Medicare traditional fee-for-service benefit for seniors. It also discusses policy options that could help to ensure that the new benefit design works for low-income seniors.

MedPAC has outlined a design that brings clarity through a single deductible and uniform cost sharing and peace of mind by capping the amount that seniors have to pay out of pocket. The design would also reduce the need to buy a supplemental policy.

Benefit redesign is not a new issue. The Bowles-Simpson Commission appointed by President Obama, and the bipartisan Policy Center have also recommended it. The Committee has called attention to it, even devoting a hearing exclusively to the topic last year.

At that hearing, I asked witnesses to conduct what I view as the most informative analysis: beneficiary impact over multiple years. The fact that a senior may pay a little more in any given year is not nearly so important as avoiding the years in which a senior may face frighteningly high costs. Any beneficiary who has high costs, such as those that come with a stay in the hospital, will see a significant reduction in out-of-pocket costs. Since we know the majority of seniors will have a hospital stay over the course of their lifetime—some, many trips to the hospital—this protects seniors from cost spikes in a year when they are particularly sick.

With a mom who relies on the confusing Medicare system, I am sold. If it were up to me, this common-sense change would already be done. Hearing MedPAC's views on how an improved design can work for low-income seniors furthers the discussion. I am confident that this reform can be done in a way that has net benefit for beneficiaries, even as it reduces future expenditures. Listening to those who have concerns, we must continue to work to make this happen.

The report also highlights the need to be able to compare traditional fee for service, Medicare Advantage, and the accountable care organizations. We owe it to our seniors to provide an apples-to-apples comparison of quality and cost of these options in their area. This effort can also provide vital information to set the stage for more sweeping reforms that further empower seniors and are more responsive to senior health care needs.

The report also examines how payments to in-patient rehab facilities and skilled nursing facilities differ for the treatment of similar patients. This is a continuation of a robust site-neutral payment policy discussion that has happened over the last few years. The House passed a site-neutral policy back in 2011. In fact, a provision establishing parity between in-patient hospital and long-term care hospital payments was signed into law late last year. This is a topic of great interest to Members of this Committee, and has significant impact not only on health care providers, but seniors and taxpayers. MedPAC's work has been instrumental. We appreciate its continued focus.

The report looks at whether the method of accounting for expected patient costs or risk adjustment can be improved. This is important, because we need to make sure payments to Medicare Advantage plans and providers are as accurate as possible.

There is a lot of interest in the topic of medication adherence, which means taking medications exactly as prescribed by the doctor to result in better patient health and outcomes. The report examines the extent to which better adherence by seniors reduces overall Medicare spending.

Finally, the report discusses possible payment policy changes to bolster access to primary care.

Well, before we hear from Mr. Miller I want to say that this MedPAC report is not a book that will just sit on the shelf. For many of the issues, it represents an ongoing dialogue. This hearing is a valuable part of that conversation. I look forward to working with the Members of the Committee and MedPAC to enact policies that make the Medicare program work better for beneficiaries, for providers, and taxpayers.

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

[No response.]

Without objection, so ordered.

I now recognize the Ranking Member, Dr. McDermott, for 5 minutes for the purposes of his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Welcome, Dr. Miller, for coming today to discuss MedPAC's most recent report. It is an important hearing, and I hope that we can have a constructive conversation this morning that focuses on finding solutions to the challenges that Medicare faces in a way that protects beneficiaries.

Through its expertise and non-partisan analysis, MedPAC in the past has helped Members of Congress come together to discuss options for reform that improve the payment system, cut down costs, and improve the quality of care that beneficiaries receive. Now, we may not always agree, but reports like the one we are discussing today often start as a good point for a starting point of a discussion.

Unlike previous reports, the MedPAC has submitted to Congress a report that does not contain any recommendations. Instead, today's report represents a number of ideas we can use as a framework for today's discussion. We do not need to leap to any conclusions, there is no crisis. We should hear, listen, question, analyze

what we hear, and, after a careful review of the issues, we can then determine what proposals to move on.

Whatever changes we make, we need to focus on some key principles.

First, we need to make sure that beneficiaries are protected from having to bear an increased financial burden. Current Medicare beneficiaries pay a greater share of their income for health care than the average American. And yet, often the Republicans say they need more skin in the game. They pay taxes during their working years to earn eligibility, and they continue to shoulder a share of the load through premiums, co-pays, or co-insurance and deductibles.

Second, we must get health care costs under control. We did a lot of great things through the Affordable Care Act, particularly in the protecting of consumers and expanding access to affordable health care coverage for millions of Americans. The ACA improves Medicare's benefits by improving coverage of preventative care, and increasing prescription drug coverage. And the ACA helped constrain Medicare spending such that we have record low-per-capita spending growth, below inflation in the years following enactment of health care reform.

We must continue this work by focusing on controlling costs and improving outcomes. Just this week a report from the Commonwealth Fund found yet again that the United States spends more per capita than any other country on health care, yet we don't get the best results. We have to fix that.

Third, we must make sure that payments are accurate and fair. This involves a careful review of how Medicare pays doctors and hospitals, with an eye towards overpayments, which need to be eliminated, and fraud, waste, and abuse in the system. This will allow us to strengthen the program without harming the beneficiaries.

Finally, we should focus on saving money through innovative payment models. The ACA introduced a number of promising reforms to Medicare, including accountable care organizations and the Medicare shared savings plan, which will cut costs without harming beneficiaries. We need to continue to remove barriers to setting up these innovative programs.

I am concerned that my Republican colleagues will use today's hearing to suggest radical changes in Medicare. Whether it is a proposal to eliminate the program's defined benefit through a voucher program, or increasing cost sharing for seniors, I have heard a lot of bad ideas in the past. MedPAC has not suggested we make any of these changes in its report, and I hope our conversation doesn't use this hearing as a cover for those kind of bad ideas. I know that the chairman is interested in making changes to make Medicare stronger, and I hope to work with him. Thank you very much. And I yield back the balance of my time.

Chairman BRADY. Thank you, Doctor. And we will now hear from Mr. Miller. And you are recognized 5 minutes for the purpose of your oral statement.

STATEMENT OF MARK E. MILLER, PH.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Chairman Brady, Ranking Member McDermott, distinguished Committee Members, thank you for asking the Commission to testify today.

As you know, Congress created MedPAC to advise it on Medicare issues. And in the June report you will see themes that we have often repeated: moving the Medicare program away from a fragmented, volume-driven system to one that is coordinated across providers and settings, and focused on patient outcomes; rewarding providers and plans that take risk and improve quality with higher payments and reduced regulatory oversight; assuring that Medicare's payment systems don't favor one payment model over another; and assuring that traditional fee for service remains an option, but at the same time assuring that that payment system is accurate, accountable, and as fair as possible.

Medicare now has 3 payment systems: 30 million beneficiaries are in traditional fee for service; 5 million are in accountable care organizations; and 15 million are in private plans. The Commission's June report discusses synchronizing Medicare's payment, quality measurement, risk adjustment, and regulatory oversight across the three payment systems. Our motivations are to protect the patient by setting common risk adjustment and quality standards, to assure fairness among plans and providers within a market by setting common financial and quality standards, and to protect the taxpayer by assuring that Medicare supports the lowest cost, highest quality payment system in any given market.

Regarding this last point, we used data from 31 markets to compute current payments and to simulate a common benchmark for Medicare across ACOs, traditional fee-for-service, and private plans. There is a lot of technical details here, but here are two take-aways. A common benchmark could make ACOs and MA plans more competitive with fee-for-service. And, most importantly, the simulations show that driving volume to any one model may not be desirable because no one model is always the most efficient in a given market.

Just as an aside, I would also note that on Monday we put out new guidance to the Congress and HHS on the next generation of ACOs that we believe is consistent with these longer-run goals.

Moving on to quality measurement, the Commission has become concerned that Medicare's quality programs are overbuilt, burdensome, focused on process, rather than outcomes, and out of synch with the private sector. To address these issues, the Commission discussions have evolved towards an alternative view that would focus on a small set of population-based outcomes and patient experience measures, and then to compare and report quality across traditional fee-for-service, ACOs, and private plans. For the purposes of rewarding and penalizing, our conversations are incomplete. But the direction of the discussion is around using those population measures for ACOs and managed care plans, while continuing to use provider-based outcome measures for fee-for-service.

Moving on to modernizing fee-for-service, in this report we explore three ideas. With respect to beneficiaries, we provide information on the Medicare support programs and reiterate the Commis-

sion's recommendation to increase eligibility for the program up to 150 percent of poverty. This recommendation should be viewed in the context of the Commission's broader recommendation on reforming the traditional fee-for-service benefit in order to rationalize that benefit design, to protect the beneficiary from high and unpredictable out-of-pocket costs, and to create price signals to discourage first dollar supplemental coverage. The MSP expansion will offer greater out-of-pocket assistance to low-income beneficiaries under the reform benefit design.

With respect to provider payments, the report discusses primary care services, which the Commission believes are under-valued in the physician fee schedule. The policy idea would maintain the primary care add-on in a budget-neutral manner, but would move to paying for these services on a patient basis, rather than on a service basis. We believe that this would give physicians, advance practice nurses, and other qualified professionals the resources and flexibility to provide non-face-to-face services, and to provide coordination services.

Finally, we continue the discussion of our site-neutral payment policy. As this Committee well knows, MedPAC has made recommendations to narrow payment differences in the ambulatory setting and between the in-patient hospital and the long-term care hospital setting. In this report we begin the discussion of narrowing payment differences for in-patient rehab and skilled nursing facilities—again, focusing on trying to identify comparable patients, where this makes sense.

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

[The prepared statement of Mr. Miller follows:]

TESTIMONY

Report to the Congress: Medicare and the Health Care Delivery System

June 18, 2014

Statement of

Mark E. Miller, Ph.D.

Executive Director

Medicare Payment Advisory Commission

Before the

Subcommittee on Health

Committee on Ways and Means

U.S. House of Representatives

Glenn M. Hackbarth, J.D., Chairman · Michael Chernew, Ph.D., Vice Chairman · Mark E. Miller, Ph.D., Executive Director

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Chairman Brady, Ranking Member McDermott, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). Thank you for inviting the Commission to be here this morning to discuss MedPAC's annual report on Medicare and the healthcare delivery system.

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

Introduction

As part of its mandate from the Congress, each June the Commission reports on issues affecting the Medicare program, including changes in health care delivery in the U.S. and the market for health care services. In this year's report, the Commission has begun to explore the concept of synchronizing Medicare policy across the three major Medicare payment models – traditional fee-for-service (FFS), Medicare Advantage (MA), and the newest model, the accountable care organization (ACO). The Commission's interest in this topic is motivated by concern that Medicare's payment rules and quality measurement programs are different across the three models. The inconsistencies result in different levels of program support for one model over another and an inability to discern whether one provides higher quality care to beneficiaries than another. Synchronizing policy across the models is a longer term policy problem; as Medicare continues to move away from FFS towards value-based payment models, developing consistent policies across models will be critical to supporting an efficient, well-functioning, and high-quality program. In this report, the Commission also identifies a number of areas within FFS where policy changes may be warranted in the shorter term.

The topics covered in the June report are:

- *Synchronizing Medicare policy across payment models.* Medicare currently finances care through FFS, MA, and more recently through ACOs, which are a variation of FFS. In each model, Medicare has different—and sometimes conflicting—policies concerning payment, risk adjustment, quality measurement, and other issues. The Commission believes that, over the long run, Medicare's payment rules and quality improvement incentives will need to be reconciled across the three payment models. To illustrate this issue, we examine setting a common spending benchmark—tied to local FFS spending—for MA plans and ACOs.
- *Improving risk adjustment in the Medicare program.* Risk adjustment is currently used to ensure that Medicare's payments track the expected costs of beneficiaries. We examine three models for improving how well risk adjustment predicts cost for the highest cost and lowest cost beneficiaries and suggest that given the limitations of those models, administrative measures may be needed to address problematic incentives for patient selection that are created by the current risk adjustment model.
- *An alternative approach to measuring quality of care*. Current quality measures are overly process oriented and too numerous, they may not track well to health outcomes, and they create a significant burden for providers. Furthermore, many of them may not be appropriate for each of the three payment models, nor support comparing quality across the payment models. We examine which approaches to quality measurement would be appropriate for each payment model and consider using population-based outcome measures (e.g., potentially avoidable admissions and emergency department visits for the population in each model in an area) to compare quality within a local area across Medicare's three payment models. Provider-specific quality measures may still be needed for FFS payment adjustments.
- *Paying for primary care using a per-beneficiary payment.* The current FFS-based primary care bonus program (Medicare's Primary Care Incentive Payment Program) expires at the end of 2015.We consider an option to continue additional payments to primary care

practitioners, but in the form of a per-beneficiary payment. The current FFS approach encourages volume. A per-beneficiary approach is intended to foster care coordination, since it would provide some amount of payment for the non-face to face activities the practitioner performs, such as making telephone calls to patients or specialists to whom their patients are referred.

- *Medicare payment differences across post-acute settings*. Medicare's payment rates often vary for treating similar patients in different settings, such as inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs). We examine three conditions and assess the feasibility of paying IRFs the same rates as SNFs for patients recovering from these conditions.
- *Financial assistance for low-income beneficiaries.* We discuss how changing income eligibility for the Medicare Savings Programs could help low-income Medicare beneficiaries afford out-of-pocket costs under a redesigned Medicare FFS benefit package.
- *Measuring the effects of medication adherence on medical spending for the Medicare population*. We examine the effects of medication adherence for congestive heart failure patients and find that greater medication adherence is associated with lower medical costs, but that the effect is dependent on the beneficiaries' previous health status, decays over time, and is sensitive to how the spending effects are modeled.

In an online appendix, as required by law, we review CMS's preliminary estimate of the update to payments under the physician fee schedule for 2015.

Synchronizing Medicare policy across payment models

Background

Historically, Medicare has had two payment models: traditional FFS and Medicare Advantage (MA). Traditional FFS pays for individual services according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans capitated payment rates to

provide the Part A and Part B benefit package (except hospice). Starting in 2012, Medicare introduced a new payment model: the Accountable Care Organization (ACO). Under the ACO model, a group of providers – still paid FFS – is held accountable for the overall spending and quality of care of a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives given to private plans under the MA program.

The Commission believes that, over the long run, Medicare's payment rules and quality improvement incentives will need to be reconciled across the three payment models. Without synchronization across the models, the program cannot assert that all three models are providing similar value to the program and the beneficiary. This report represents the Commission's initial exploration of synchronizing Medicare policy across payment models and is not intended to be a definitive or comprehensive discussion. In this initial analysis, we focus on setting a common spending benchmark—tied to local FFS spending—for MA plans and ACOs as a key element of synchronization. Additional Commission work in this area will include: examining common approaches to quality measurement and risk adjustment, examining beneficiary decision making and choices, and identifying areas where regulatory relief could be granted when providers assume risk.

Comparing Spending Benchmarks Across Models

The benchmark refers to the level of program spending that will trigger a potential bonus or penalty. For example, if spending in an ACO is materially below the ACO's benchmark, the ACO would share in savings with Medicare. Similarly, if an MA plan bid is below the plan's benchmark, the MA plan would keep some of those savings through rebate dollars, which are used to fund the cost of extra benefits or lower premiums to attract enrollees. By contrast, if ACO spending is above the ACO benchmark, the ACO would be penalized by paying a share of the excess to Medicare. If the MA plan bid is above the plan benchmark, it would be become less attractive to beneficiaries because the beneficiary would need to pay the difference between the benchmark and the MA bid.

Currently, benchmarks for ACOs and MA plans are set through different formulas, resulting in different levels of payment between the two models, even in the same market. In addition, the method Medicare uses to set ACO's benchmarks can result in markets with multiple ACOs, each with a different benchmark.

As a starting point for our analysis comparing spending benchmarks across the three models, we explore the effects of setting the benchmark for both ACOs and MA plans equal to spending in FFS (). Through a simulation of program spending based on a synchronized benchmark tied to FFS, we illustrate that no single payment model is uniformly less costly than another model in all markets across the country. Which model is least costly—and consequently which ACOs and MA plans may want to enter a given market—would be sensitive to how benchmarks are set.

We used data for 646,000 individuals assigned to Pioneer ACOs and compared the expected FFS spending on these individuals with actual ACO program spending and simulated MA program spending.[1] Comparing the estimated spending for the three models using 2012 MA benchmarks, in the 31 areas we studied, we found that program spending was lowest in the ACO model in 18 of the 31 areas. Simulated MA payment was the lowest-spending payment model in only 1 of 31 markets. This result is generally because MA plans have benchmarks set by law that are above FFS rates, allowing them to bid above FFS costs, and consequently the plans receive payments above FFS levels. When we compared estimated spending using a scenario where MA benchmarks were moved to 100 percent of FFS spending (plus a 3 percent quality bonus), MA would be the lowest program payment model in 12 of the 31 markets in our simulation. In 11 markets, ACOs would continue to generate savings larger than MA; this could happen in cases in which MA plans bid near the FFS benchmark and ACO program spending is below average FFS spending in the county.

[1] The simulated level of MA spending is what the Medicare program would have paid MA plans (including rebate dollars) if the 646,000 beneficiaries had chosen to join MA plans in proportion to each MA plan's current market share in each beneficiary's county of residence.

The fundamental lesson from the simulations is that relative to FFS, MA and ACO spending varies by market. Driving volume to one model may not be desirable if that model is not always the best with respect to program cost and quality of care. By setting benchmarks to be equal across each model, the financial performance of each model can be evaluated consistently within a market. With common quality measures, beneficiaries could also judge which model provides better care in their market. Policymakers may want a common benchmark to level the playing field and encourage beneficiaries to choose the model that will most efficiently give them the care and services that fit their individual preferences. However, whether there is a truly level playing field depends on how overall financial neutrality across payment models is achieved.

Improving risk adjustment in the Medicare program

Appropriate risk adjustment is an important part of paying providers and plans fairly and equitably for the care of patients with different clinical needs. In this report, the Commission considers how Medicare's tools for risk adjustment in Medicare Advantage (MA) could be improved.

Health plans that participate in the MA program receive monthly capitated payments for each Medicare enrollee. Each capitated payment has two parts: a base rate, which reflects the payment if an MA enrollee has the health status of the national average beneficiary; and a risk score, which indicates how costly the enrollee is expected to be relative to the national average beneficiary. The purpose of the risk scores is to adjust MA payments so that they accurately reflect how much each MA enrollee is expected to cost. Currently, Medicare uses the CMS–hierarchical condition category (CMS–HCC) model to risk adjust MA payments. This model uses beneficiaries' demographic characteristics and medical conditions collected into hierarchical condition categories (HCCs) to predict their costliness. Although it is an improvement over past models, the Commission finds that the CMS–HCC model predicts costs that are higher than actual costs (overpredicts) for beneficiaries who have very low costs, and lower than actual costs (underpredicts) for beneficiaries who have very high costs. These prediction errors can result in

Medicare paying too much for low-cost beneficiaries and not enough for high-cost beneficiaries, while on average payments are correct. These underpayments and overpayments raise an issue of equity among MA plans. Plans that have a disproportionately high share of high-cost enrollees may be at a competitive disadvantage relative to those whose enrollees have very low costs.

In an effort to identify ways to improve how well risk adjustment predicts costs for the highest and lowest cost beneficiaries, the Commission explores three alternative methods discussed in the literature. We find that all three would introduce some degree of cost-based payment into the MA program, which could reduce incentives for plans to manage their enrollees' conditions to hold down costs. The Commission concludes that because of the limitations of these models, administrative measures, such as penalties for disenrollment of high-cost beneficiaries, may be needed to reduce incentives for plans to engage in patient selection.

This issue is important not only for the MA program; it also has implications for the Medicare program as it concerns equity among MA plans, FFS Medicare, and ACOs. If equity among these three payment models is a goal, risk adjustment that results in more accurate payments for high-cost and low-cost beneficiaries is vital for both the program and the beneficiary. From the program perspective, if the MA sector can attract low-cost beneficiaries (for which Medicare overpays) and avoid high-cost beneficiaries (for which Medicare underpays), Medicare could end up paying more to care for beneficiaries who enroll in MA than it would have if they remained in FFS. From the beneficiary perspective, sicker beneficiaries' access to MA plans could be restricted if the plans avoid these beneficiaries because Medicare underpays for their care.

Measuring quality of care in Medicare

The Commission has been making quality measurement recommendations for Medicare since 2003, and has long supported public reporting of quality measures. Over the past decade, the Commission has recommended that Medicare measure quality of care in FFS Medicare separately for each provider type (hospitals, physicians, etc.) and MA plans, using a small set of process, outcome, and patient experience measures to minimize the administrative burden of

measurement on providers and CMS. The Commission has also held that Medicare should base a small portion of FFS providers' or MA plans' payments on their performance on the selected quality measures. The Commission has stated that outcome measures, such as mortality and health-care-associated infection rates, should be weighted most heavily when adjusting payment.

Since 2003, the Congress has enacted quality reporting programs for all of the major FFS provider types and MA plans, and has mandated payment adjustments, referred to as value-based purchasing, for hospitals, dialysis facilities, MA plans, and physicians. Adjustment of payment based on quality is also a central component of Medicare policy for ACOs. Overtime, the Commission has become concerned about the direction of Medicare's quality measurement programs, particularly in FFS Medicare. These programs rely primarily on clinical process measures for assessing quality—measures that are often not well correlated to better health outcomes. Additionally, the Commission believes there are too many measures, which—coupled with the diversity of measures required by private payers—places a heavy reporting burden on providers. In short, Medicare's quality measurement systems are becoming overbuilt, too process focused, and out-of-synch with private payers. The Commission is concerned that this direction is becoming incompatible with the goal of promoting clinically appropriate, coordinated, and patient-centered care.

In this report, we examine alternative approaches to quality measurement and consider the appropriateness of different types of measures for each of the three payment models in Medicare: FFS Medicare, MA, and ACOs. One alternative we explore in greater depth is using population-based outcome measures. Examples of population-based outcome measures include potentially avoidable hospital admissions and potentially avoidable emergency department visits. Population-based outcome measures are intended to gauge the experience of care across all patients in an area and reflect the quality of the entire health care delivery system, not just one provider. Many of these measures would be less burdensome to providers to report, since they could be gleaned from the Medicare claims data (data for patient experience measures would need to be gathered through patient surveys). Also, unlike many of the clinical process measures currently being used by Medicare, population-based outcome measures are, by definition, directly

related to patients' health outcomes. Such an approach could be useful for public reporting of quality and making payment adjustments within the MA and ACO models, and would more readily allow a common set of quality measures across public and private payers.

The Commission believes it may be desirable and feasible to transition Medicare over the next decade to a quality measurement system that uses a small number of population-based outcome measures to evaluate, compare, and publicly report on quality within a local area across Medicare's three payment models—FFS Medicare, MA, and ACOs. The same population-based measures also could be used to make payment adjustments within or across the MA and ACO models, but may not be appropriate for adjusting FFS Medicare payments in an area, because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. Therefore, at least for the foreseeable future FFS Medicare will need to continue to rely on provider-based quality measures to make payment adjustments. The program should endeavor to keep this set of measures small and focused on outcomes.

In addition to population-based outcomes, another area of quality measurement that the Commission is exploring is the feasibility of measuring the potentially inappropriate use of clinical services (i.e. "overuse" measures). While overuse is more likely to occur in payment models such as FFS Medicare that create incentives to provide services with little or no benefit for patients, evidence of overuse also has been found in capitated payment arrangements. Because of the potential for harm to beneficiaries and wasteful program spending resulting from overuse, the Commission is examining the potential for applying overuse measures in Medicare, particularly in FFS.

Per-beneficiary payment for primary care

The Commission has a long-standing concern that primary care services are undervalued by the Medicare fee schedule for physicians and other health professionals compared with procedurally based services. That undervaluation has contributed to compensation disparities—average compensation for specialist practitioners can be more than double the average compensation for

primary care practitioners. For example, annual compensation for radiologists was approximately $460,000 in 2010, compared to $207,000 for primary care physicians. Such disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided. While Medicare beneficiaries generally have good access to care, in both patient and physician surveys, access for beneficiaries seeking new primary care practitioners raises more concern than access for beneficiaries seeking new specialists.

With the goal of directing more resources to primary care and rebalancing the fee schedule, the Commission made a recommendation in 2008 for a budget-neutral primary care bonus payment, funded by a reduction in payments for non–primary care services. The Patient Protection and Affordable Care Act of 2010 (PPACA) created a bonus program, but it was not budget neutral and thus required additional funding. The program provides a 10 percent bonus payment for primary care services performed by primary care practitioners from 2011 through 2015.
The primary care bonus program expires at the end of 2015. While the amount of the primary care bonus payment is not large and will probably not drastically change the supply of primary care practitioners, it is a step in the right direction. Additionally, the Commission has become increasingly concerned that FFS is ill suited as a payment mechanism for primary care. FFS payment is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward on-going, non-face-to-face care coordination for a panel of patients.

In this report, we consider an option to continue to support primary care practitioners, but in the form of a per-beneficiary payment financed from within the fee schedule. Replacing the primary care bonus payment with a per-beneficiary payment would be a move away from a FFS volume-oriented approach toward a beneficiary-centered approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination. In establishing a per-beneficiary payment for primary care, several design issues would need to be considered.

- *Practice requirements for receipt of the payment*. One policy design question is whether to be eligible to receive the per-beneficiary payment, a practice should meet certain requirements. On the one hand, given the current inequities in the fee schedule, Congress may wish to make this payment for primary care available *without* practitioners having to meet requirements. On the other hand, Congress could impose requirements that relate to practice services, such as providing after-hours access and phone and email contact to patients. However, evidence concerning the effect of practice requirements on reducing health care spending and improving quality is not clear.

- *Attribution of beneficiaries to primary care practitioners.* Unlike the service-based, primary care bonus payment, a per-beneficiary payment necessitates attributing a beneficiary to a practitioner to ensure that the right practitioner gets paid and that Medicare does not make duplicate payments to multiple practitioners on behalf of the same beneficiary. In an ideal world, a Medicare beneficiary would designate her primary care practitioner. The designated primary care practitioner would provide the majority of the beneficiary's primary care for that year and for years to come, fostering a strong relationship and continuity of care. However, in practice, attributing a beneficiary to the right practitioner can be complicated, and the report includes further discussion of methods for attribution.

- *Funding.* One funding method is to apply an equal percentage reduction to the payments of those services most likely to be overpriced, such as procedural services, or all services in the fee schedule except those eligible for the primary care bonus. Another funding method is to reduce the payments of services specifically identified as overpriced, service by service, and fund the per-beneficiary payment with the savings. Under both funding methods, we are assuming that beneficiaries are not charged cost sharing to fund the per-beneficiary payment for primary care.

The Commission will continue to consider these and other issues and may consider recommendations to the Congress on a per-beneficiary payment for primary care.

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

The Commission holds that the same services for similar patients should be paid comparably, regardless of where the services are provided. This will help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. Two settings where certain groups of patients with similar care needs are treated are inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs). In this report, the Commission compares Medicare payments for three conditions frequently treated in both settings. Because there is some overlap in the patients treated in both settings, there is a need to develop site-neutral policies that eliminate unwarranted payment differences. The Commission is not alone in its interest in aligning payments between IRFs and SNFs. Since 2007, administrations' proposed budgets under presidents from both parties have included proposals to narrow prices between IRFs and SNFs for select conditions commonly treated in both settings.

Using several criteria, we selected three conditions frequently treated in IRFs and SNFs—patients receiving rehabilitation therapy after a stroke, major joint replacement, and other hip and femur procedures (such as hip fractures)—and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We examined the characteristics of patients admitted to SNFs and IRFs and did not find large differences, especially for the orthopedic conditions, but there was more variation across the stroke patients. There was considerable overlap of risk scores, ages, comorbidities, functional status at admission, and predicted costs for therapy and nontherapy ancillary services (such as drugs). The average functional status at admission and patients' comorbidities overall did not differ substantially and the two settings admitted similar shares of dual-eligible and minority beneficiaries. Differences in outcomes between IRFs and SNFs were mixed: unadjusted measures showed larger differences between the settings, and risk-adjusted measures generally indicated small or no differences between the settings.

For the three conditions, we found that if IRFs were paid at the SNF rates, their aggregate payments for the three select conditions would decline. To provide protection for IRFs, the site-neutral policy could also be structured to maintain the add-on payments many IRFs receive for the select conditions. The impact of this policy was consistent across different types of IRFs (e.g., for-profit, non-profit). Although certain types of providers have higher shares of site-neutral cases, they also tend to have higher add-on payments that dampen the impact of a site-neutral policy.

If payments for select conditions were the same for IRFs and SNFs, the Commission believes that Medicare should consider waiving certain regulations for IRFs when treating site-neutral cases to level the playing field between IRFs and SNFs. Waiving certain IRF regulations would allow IRFs the flexibility to function more like SNFs when treating comparable cases. Selecting a handful of conditions to study allowed us to explore potential for site-neutral payments between IRFs and SNFs. We found that the patients and outcomes for the orthopedic conditions were similar and represent a strong starting point for a site-neutral policy. Patients receiving rehabilitation care after a stroke were more variable, and we conclude that additional work needs to be done to more narrowly define those cases that could be subject to a site-neutral policy and those that could be excluded from it.

Financial assistance for low-income Medicare beneficiaries

The fee-for-service (FFS) Medicare benefit package has remained essentially unchanged for Part A and Part B since the creation of the program in 1965. Under this structure, beneficiaries in FFS are not protected against high out-of-pocket (OOP) medical expenses. To protect against such high expenses, most beneficiaries have some degree of supplemental coverage. This coverage provides protections but is often a low value product for the beneficiary, and research has shown that supplemental coverage can lead to beneficiaries using more discretionary services because they have no financial incentive to consider the value of a service before choosing it. To address these concerns, in 2012, the Commission made a set of recommendations for a redesigned benefit

package that give beneficiaries better protection against high OOP spending, while creating financial incentives for them to make better decisions about their use of discretionary care.

Specifically, the Commission recommended that a redesigned traditional FFS benefit include:

- Catastrophic protection through an out-of-pocket maximum;
- Rationalized deductible or deductibles for Part A and Part B services;
- Improved OOP predictability by replacing coinsurance with copayments;
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum.

Under the recommended benefit design, the aggregate beneficiary cost sharing liability would remain unchanged. Some beneficiaries who incur very high Medicare spending would see their liability reduced, while others who incur low Medicare spending may experience higher liability. Overall, the added benefit protections are designed to make supplemental coverage less necessary. For those beneficiaries who wish to keep or initiate supplemental coverage after the benefit is redesigned, the Commission recommended that an additional charge be placed on supplemental policies to cover at least some of the added costs imposed on Medicare for having first dollar coverage. Depending on the level of additional charge and the resulting take-up of supplemental coverage, net program savings are realized.

Because reducing OOP costs (deductibles, copayments, or coinsurance) can increase program cost dramatically and undermines beneficiaries' incentives to make cost-conscious decisions about discretionary care, the redesigned FFS benefit package keeps those costs in place. However, without additional help, Medicare beneficiaries with limited incomes could have difficulty paying those OOP costs. In this report, the Commission discusses how changing income eligibility for the Medicare Savings Programs (MSPs) could help low-income Medicare beneficiaries afford out-of-pocket costs under a redesigned Medicare fee-for-service benefit package. The Commission made a recommendation in 2008 to align the MSPs income eligibility criteria with the Part D low-income drug subsidy (LIS) income eligibility criteria, effectively

increasing the Part B premium subsidy to beneficiaries with incomes up to 150 percent of the federal poverty level. MSPs provide financial assistance with the Medicare Part B premium for beneficiaries with incomes up to 135 percent of the poverty level. Beneficiaries with incomes up to 100 percent of the poverty level also receive assistance with other OOP costs (i.e., premiums, deductibles, and coinsurance). Medicare's Part D prescription drug benefit incorporates a subsidy structure that provides assistance to beneficiaries with incomes up to 150 percent of the poverty level. Increasing the MSP income eligibility criteria to 150 percent of the poverty level would provide additional financial assistance to lower income beneficiaries by subsidizing their Part B premium, thus giving them resources to pay their OOP costs at the point of service. The Commission believes this is a targeted and efficient approach to help poor and near-poor beneficiaries with their OOP medical expenses.

Measuring the effects of medication adherence for the Medicare population

Medication adherence is viewed as an important component in the treatment of many medical conditions. Adherence to appropriate medication therapy can improve health outcomes and has the potential to reduce the use of other health care services. At the same time, improved adherence increases spending on medications. This issue has led to a proliferation of research on policies that encourage better adherence to medication therapy (e.g., reduced patient cost sharing) and the impact of improved medication adherence on health outcomes, typically measured by the use of other health care services.

In this report, we examine the effects of medication adherence on medical spending for the Medicare population. Our analysis focused on evidence-based medication regimens for one condition—congestive heart failure (CHF). The results of our analysis show that:

- Better adherence to a CHF medication regimen is associated with lower medical spending among Medicare beneficiaries with CHF, but the effects likely vary by beneficiary characteristics (e.g., age).
- Beneficiaries who follow the recommended CHF therapies tended to be healthier before being diagnosed with CHF than nonadherent beneficiaries, with fewer medical conditions

and lower medical spending. Thus, our estimated effects could reflect both the benefit of adhering to the recommended medication and the fact that adherent individuals were already healthier.

- The effects of medication adherence on medical spending diminish over time. Our analysis shows savings in the first six months of the medication regimen, but after six months, these savings decrease.
- The estimated effects of medication adherence on medical spending are highly sensitive to how these effects are modeled. Thus, even within the same data set, it may be possible to reach very different conclusions about the effects of adherence, based solely on how adherence is defined, which criteria are used to select the study cohort and how the model is specified. For example, accounting more completely for beneficiary health status (e.g., mortality) in the model reduced the effect on health care spending by half.

Although our analysis examined only one condition and is therefore not generalizable to other conditions or populations, our findings highlight the complexity of interpreting estimates of the effects of medication adherence as measured by spending differentials between adherent and nonadherent individuals. This difficulty may be exacerbated by the more complex health profiles of the Medicare population compared with the general population often used in studies of medication adherence.

Conclusion

MedPAC's June report identifies several areas within FFS for which restructuring payments to support quality and efficiency may be warranted and for which MedPAC may consider recommendations to the Congress in the future. A number of these issues could be addressed in the shorter term, and could serve as building blocks for broader payment reforms. This report also initiates a longer-term conversation about synchronizing Medicare policy across the three major payment models. MedPAC looks forward to continuing analysis that could support efforts to address inconsistencies within and across Medicare's payment models.

Chairman BRADY. Thank you, Mr. Miller. I want to talk a little about—or ask you a little about—the recommendation to redesign the Medicare fee-for-service benefit. The current—for seniors, the current benefit design is very confusing. It really is, essentially, two different insurance products, one for the hospital nursing facility care, another one for physician services and other out-patients. Every one has its own deductible cost-sharing requirements, adding in a Part B medicine benefit and often a supplemental plan. You know, it is tremendously confusing.

So, I am pleased the Commission wants to address these problems. Can you explain the benefits to seniors of a redesign? And my thinking is, you know, the current system works fine as long as you never go to the hospital, you know. But seniors are going to go to the hospital. And some—many times in their lifetime. And so, having a redesign that provides, you know, one clear deductible that creates a co-payment, rather than co-insurance, so there is more, I think, limits to those, and then an out-of-pocket cost where, in those years where you are ill and in the hospital, you are not going to go lose your life savings as a result of it.

Can you talk a little about sort of the context we ought to be viewing this? And we all want to make sure that we are protecting low-income seniors, as well.

Mr. MILLER. Okay. So I think, if you want to talk about it from the beneficiaries' point of view—and I think that that was a motivation for a lot of the Commission's work here—the first thing is that the benefit, as it is designed, doesn't include a catastrophic cap. And the market has changed significantly on that point over time. The managed care plans all provide catastrophic caps, for example.

And so, the first benefit to the beneficiary is to have a catastrophic cap, where their out-of-pocket would stop at some point. You know, we have modeled different options, but let's just say $5,000. So that is the first thing.

The second thing is line of sight on their out-of-pocket costs. So right now you have a couple different deductibles, as you have said, and you also have percentage-based co-payments. I am going to pay 20 percent of something. And so, the Commission would rationalize those deductibles and move from co-insurance percentages to a co-payment amount for a service. And the hope here is that the beneficiary has a clear line of sight on what their out-of-pocket will be.

And then that, coupled with catastrophic, brings me to the third point, and make the need for the supplemental insurance significantly less, because they have greater protections and greater certainty about what they are going to be paying out of pocket. And so, the need for supplemental insurance, if that becomes much less, you have just relieved the beneficiary of the premium for—that they pay for the supplemental insurance.

And then a final point, which you have also referred to, is if you have protections up to, say, 150 percent of poverty for low-income, then you are helping beneficiaries with any of their premium costs.

Chairman BRADY. Two things to that point. Should we be looking at the Medicare savings plan program in the context of this redesign?

And, secondly, are there benefits to continuation of care by redesigning the Medicare benefit?

Mr. MILLER. Yes, we are talking about 150 percent in the context of the broader re-benefit design. I am not sure if I followed the continuation of care——

Chairman BRADY. And the re-design is—by this providing clarity and line of sight, in looking at your recommendations there seems to be a suggestion that this also helps seniors as they experience a continuation of care, from leading in the hospital and——

Mr. MILLER. Right, I now follow your point. I am sorry I missed it.

Yes, and we did—actually, we did some analysis for this Committee very directly on this question and gave it to you a while back. But for example, there are numbers like, you know, nine percent of beneficiaries have a hospitalization in a single year, but over multiple years—say 4 years—you can get up into 40 and 50 percent of beneficiaries having a hospitalization. And so, the benefit, the insurance value benefit, if you will, to a redesigned, you know, benefit, is that it also provides protection over a longer run.

Chairman BRADY. Can I switch about MedPAC's discussion measuring quality by focusing on the entire patient population, as opposed to assessing each individual provider? Being able to compare quality in an area between fee-for-service, Medicare Advantage, and other options, I think, is a very important thing. I understand the Commission's reluctance to adjust provider fee-for-service payments, because it makes them accountable for things outside their control.

My question is, in the context of how Medicare pays physicians, considering that the current sustainable growth formula adjusts payments based on the collective actions of physicians nationwide, wouldn't adjusting payments to physicians in a relatively small area signify an improvement?

Mr. MILLER. I think this is something of a trade-off in the sense that at the national level it seems very clear that you have sort of a tragedy of the commons type of situation. So I might—if volume increases as a physician, I might be concerned about a fee reduction. But if that fee reduction is shared across the entire country, then I might benefit more in the short run by increasing volume, and then have the fee reduction shared by all physicians.

It is arguable that doing that on a smaller basis would do two things: make the physician more aware of the pool of physicians that they are actually at risk with, and perhaps give them more of a jump-start to moving into more organized systems. Say, as long as I am being judged with other physicians, maybe I want to pick those physicians and go to an accountable care organization.

However, it is really important for me to say this: the Commission was concerned that in that circumstance, in a fee-for-service environment, there is no unified entity, so they were concerned about judging providers on that basis because of that. But that is kind of your trade-off.

Chairman BRADY. No, I appreciate it. A final point, not a question, but I appreciate the Commission's work on trying to create an apples-to-apples comparison across all three of the payment models: spending benchmark, quality measurement, risk adjustment,

regulatory oversight. I think for us to continue to improve the Medicare system, it is really critical we have an apples-to-apples comparison. So thanks for the work you are doing there.

Mr. MILLER. Thank you.

Chairman BRADY. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

You made a passing comment about paying primary care physicians for per-patient amount, rather than per-service. I have always thought that we would have a much better system if everybody had a medical home, some general medical person who knew them and knew their situation. And it sounds to me like you are talking about a plan where you would give a fixed amount to a doctor to pay to do the general medical things that are necessary. They could then refer out for the rest of their care to the more general system.

I would like you to talk a little bit about what you meant by that.

Mr. MILLER. Yes. That is what we meant by that, that the notion would be that, instead of a primary care physician or advanced practice nurse, or whatever the professional is that is providing the primary care service, in order to get reimbursed they have to see the patient and they have to—you know, face to face, and provide a service.

But I think the Commission's view is that, particularly and more coordinated systems, you want that professional to have the flexibility to do things like make phone calls, deal with the patient through email and phone calls, and also the flexibility to coordinate their care, which they aren't directly paid for now. So, the notion is moving to a payment for a population that you have responsibility for, rather than paying them service by service.

To your medical home point, this concept is not inconsistent with that thought. We are not saying it has to be a medical home, but we are saying that the payment should move more to a patient-based payment, which then gives resources for the professional to be flexible.

Mr. MCDERMOTT. Are you talking, then, to a large organization getting a certain payment to cover, let's say, 30,000 people that get $100 a month for each one of—I am just picking numbers out of the——

Mr. MILLER. Doesn't have to be a large organization. We would see this as, you know, this is how we would pay primary care providers and services in Medicare, whatever their situation is. So, no, it is not you have to be organized to do this.

Mr. MCDERMOTT. I mean most seniors—8 out of 10—don't go to the hospital in a given year—moreover, a four or five-year period, as Mr. Brady has said. Aren't they protected by their supplemental insurance from the co-payment problems?

Mr. MILLER. Yes. If I understand your question, yes. If you have a supplemental product, you can purchase products that cover your first dollar, your deductible in your hospital case, and you can purchase products that have a back end catastrophic coverage. That has produced a supplemental market.

And without being, you know, too unpleasant about it, there is a lot of questions about the value of some of those products—the

premiums people pay in exchange for the value that they get. And those products also impose additional costs on the taxpayer, because they generate services. There is fairly clear evidence on that.

And so, the thinking is——

Mr. MCDERMOTT. Tell me about the evidence that that——

Mr. MILLER. Say again.

Mr. MCDERMOTT [continuing]. Having this supplemental policy generates——

Mr. MILLER. Yes, what we——

Mr. MCDERMOTT [continuing]. Services, where is the data that says——

Mr. MILLER. Okay, and we have published it, and we can make sure that we, you know, re-deliver it to you. There is a fair amount of evidence that when you—and not just a beneficiary, any person—of first-dollar coverage in their consumption of health care, utilization increases. And the issue with these products is the price I pay to get that product is about the actual wrap-around services, and the price doesn't contemplate the additional cost to the program that the product imposes.

Mr. MCDERMOTT. Is it—am I correct in thinking that 90 percent have supplemental coverage, about 90 percent?

Mr. MILLER. Yes, and that is composed of three types. One is employer-sponsored insurance. One is the private Medigap—individual Medigap market. And then another number is their Medicaid supplemental.

And the kind of comments I am making, and what the Commission is talking about with this benefit redesign pertain to the employer-provided and the Medigap products. And our view there is the beneficiaries should have the choice of accessing those products. But the products' price should more fully respect—or reflect the full cost of purchasing that product, which is the wrap-around services and the additional costs that they impose on the program.

Mr. MCDERMOTT. Thank you.

Chairman BRADY. Thank you. Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. Mr. Miller, the Commission report talks a lot about how Medicare under-values primary care services, including the fact that average compensation for specialists can be more than double what primary care practitioners earn.

It is also my understanding that cognitive physicians, like neurologists and rheumatologists, are in a similar position to primary care in income, recruiting, and even—cognitive providers perform care coordination for beneficiaries with multiple chronic conditions, often for an aging population.

My question is, does the Commission have any plans to also recognize cognitive providers, along with primary care providers, in its recommendations?

Mr. MILLER. Okay. And this is a matter of degree, rather than philosophical difference.

So, if you think about the Medicare physician fee schedule, I think what the Commission—you know, if all 17 were here—would say to your answer—to your question is this. There is great concern that the procedural side of the fee schedule is over-valued. If you go to the cognitive side, there is concern that that is under-valued,

because we are talking about time-based services. You don't have as much ability to generate volume and compensate yourself.

And so, cognitive becomes more of the concern. But if you have to pick priorities, and there is limited amounts of dollars, then the Commission's point is the first and primary—or first concern is the primary care sets of services, and I will stop in just one second. And I think part of that reasoning is they see that as so critical to the care coordination that many people are looking for in the system.

So it is not—you know, I completely—you know, the Commission disagrees, it is really a matter about—of priorities.

Mr. JOHNSON. Okay. But you are looking at it.

Mr. Miller, the June report repeats a previous finding that Medicare Advantage beneficiaries who dis-enroll and return to fee-for-service Medicare have a 16 percent higher fee-for-service spending. Does that mean that Congress ought to build in extra incentives to keep beneficiaries in Medicare Advantage?

Mr. MILLER. We haven't made a recommendation on—a direct recommendation on this point yet, but you are picking up on, decidedly, what—the issue that is being raised in the report. The actual number these days—we have re-estimated it using some later data—it is about 12 percent. But your point still stands. And I think there is some concern here that if you find a plan that has excessive dis-enrollment relative to what you see out there in the environment generally, you might want to contemplate some kinds of incentives or penalties to forestall that kind of action.

And one of the things I would relate that to is we can always try and prove risk adjustment. It will probably be imperfect for a long time, and maybe forever. There are other administrative actions that you can take to try and get the behavioral response that you are looking for, and that is one of them.

But, yes, you get about a 4 percent dis-enrollment occurring every year, and those people tend to be about 12 percent more expensive than average. And I just don't want to vilify the plans here. Beneficiaries dis-enroll for their own reasons, as well. So this is both the beneficiary and the plan that are involved in the dis-enrollment.

Mr. JOHNSON. Thank you. I appreciate your comments.

Mr. MILLER. Can I say one thing really quickly? I forgot to say to Mr. McDermott the other supplemental coverage is managed care. I didn't mention that in answering your question. Sorry about that.

Chairman BRADY. No, thank you.

Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

And, Mr. Miller, thank you for being here. I would like to touch on the under-value of primary care, as well. And specifically, in the ACA, we put in provisions to provide incentive payments for primary care docs. And in your report you state that access for beneficiaries seeking new primary care physicians raises more concerns than access for beneficiaries seeking new specialists. And I hear that in my district, as well. Folks tell me that they have long wait times for appointments, there is few docs, primary care docs, who will take new Medicare patients.

And why is this problem persisting? And have the incentive payments helped to reduce this—the extent of the problem?

Mr. MILLER. Okay. I don't—going to the last part of your question first, I don't want to overstate that the primary care add-on payment, which we recommended—and we, you know, accept responsibility for, and the Congress enacted, and so we think that that is the right direct—I don't want to overstate that this will correct the primary care, you know, wait times and difficulties that people are experiencing.

But we think it is a really important signal to primary care providers about the value that they can potentially provide in care coordination in a reformed system. And we think that it is important that that signal persist.

We do think that the fee schedule is out of balance for these types of services, and we are trying to say there is some attention to trying to rectify it.

Last thing I will say and I will stop is we have also talked about other things to get greater value in that fee schedule, but I won't go into them in the interest of your time.

Mr. THOMPSON. So we should continue——

Mr. MILLER. Yes.

Mr. THOMPSON [continuing]. After the 2015 date when the incentives expire, we should continue to do those?

Mr. MILLER. The Commission has not made a hard recommendation on that, but the conversations that they are having, and that they are going to pick up with in the fall are all headed in that direction.

Mr. THOMPSON. So thank you for being respectful of my time——

Mr. MILLER. Trying to.

Mr. THOMPSON [continuing]. But let's go into those other things that we should be doing——

Mr. MILLER. Okay——

Mr. THOMPSON [continuing]. In addition to the incentive payments.

Mr. MILLER. No, no problem. I just didn't want to get you off your point, and you may have had another one.

So, for example, in our SGR recommendations that we have made to the Congress—and you know, these are not popular, but none of our stuff is—so one of the things is we have made a set of recommendations on data collection and requirements for the secretary to identify over-price procedures in the fee schedule. We think that most of those over-price procedures reside on the procedural side of the fee schedule. Then you would have resources that you could re-balance to the cognitive or to the primary care side of the fee schedule, as you saw fit. That is one thought.

A second thought is that—and again, this is somewhat unpopular—in solving the SGR issue, in order to keep the cost of the SGR fix down—and, remember, it used to be a lot more expensive than it was—you can differentiate the conversion factor for primary care or cognitive, or whatever the Congress decided, relative to the procedural services. And that is another way to get a re-balancing effect.

Mr. THOMPSON. Is there anything else that Congress should do to try and get a handle on this problem?

Mr. MILLER. I am sure I am forgetting something, but those are certainly the things off the top of my mind.

Mr. THOMPSON. Okay. If you remember, why don't you drop me a line?

Mr. MILLER. We will do that. And we talk to your people all the time.

Mr. THOMPSON. Thank you. I yield back.

Chairman BRADY. Thank you. Dr. Price.

Mr. PRICE. Thank you, Mr. Chairman, and I want to thank you again for holding this hearing. I appreciate MedPAC's work in so many areas to try to make a health care system that works for patients. As I often times say, we tend to forget the patient in many of these discussions. We talk about money, we talk about other sorts of things, but often times forget the patient.

I want to thank MedPAC for what appears to be a further maturation of and appreciation that patients in various medical specialties are actually different, that one-size-fits-all doesn't often times—doesn't work hardly at all, in terms of health care.

To that end I want to talk a little bit about medical specialties and the difference that they have, and specifically pathologists, as it relates to meaningful use requirements and electronic health records. You are familiar with that program, are you not?

Mr. MILLER. A bit. I am not real deep right at the moment, but I will do my best.

Mr. PRICE. The kind of rewards, incentives that are being provided for physicians as it relates to electronic medical records and meaningful use are pretty much standard across the board. So we have got pathologists who, candidly, look at slides all day, or lab results all day, and are being asked to figure out whether or not that slide has an allergy or whether it smokes. And that doesn't make a whole lot of sense, does it?

Mr. MILLER. To the extent that I understand what conversation I am in the middle of, no.

Mr. PRICE. Well, all right.

[Laughter.]

Maybe I could ask MedPAC to take a look at that, because this is resources that are being utilized and caring for Medicare patients in a way that, frankly, doesn't make a whole lot of sense for either the patients or the physicians that——

Mr. MILLER. And the question is whether there should be differential requirements across specialties on the EHR——

Mr. PRICE. Exactly.

Mr. MILLER [continuing]. Meaningful——

Mr. PRICE. Exactly.

Mr. MILLER. I can take that question back.

Mr. PRICE. Let me come to something that you have been pushing on for a long time, and that site-neutral payments in the surgical setting. Obviously, ambulatory surgery centers, you mention that we ought to be looking for the lowest cost and the highest quality. And ASCs often times provide the highest quality at the lowest cost, and you have been a champion on that.

I want to touch on the site-neutral payments that you have mentioned here in this report on SNFs and IRFs, skilled nursing facilities and in-patient rehab facilities. And I am curious as to whether or not CMS has given you any feedback on your recommendation.

Mr. MILLER. And we have not made a recommendation yet. We are exploring this. We have just entered this particular area. They are aware that we are working on it. I don't think I have gotten feedback as in, "Way to go," or, "Stop what you are doing," nothing like that.

Mr. PRICE. Can you imagine any reason why CMS ought not be supportive of site-neutral payments for various facilities providing similar care to patients, regardless of that site?

Mr. MILLER. Oh, and I didn't mean to imply that they were broadly hostile to this at all. I was thinking very narrowly about the in-patient—or, sorry, the rehab and the skilled nursing facility. I haven't gotten a lot of feedback on that.

I think there is a sense and an understanding at CMS that this is an issue. I think there are some differences about how they would go about it, but I don't think they are ignoring it. Let's put it that way.

Mr. PRICE. I think it is a healthy discussion to have, and I think we are actually having some admission on the part of CMS that, again, that one-size-fits-all doesn't actually work.

I want to also commend MedPAC for the work that you are recommending, or the discussion that you are having around quality measures. Those of us who have been physicians and practice clearly understand that one patient and another patient, even though they have exactly the same diagnosis, the quality treatment for each of those patients may be significantly different. Is that not true?

Mr. MILLER. Agreed. And we are trying to not only get a more consistent set of quality measures, there is a very strong motivation on the part of the Commission to relieve the burden on the provider.

Mr. PRICE. And to that end, wouldn't it be most—do you think it would be helpful to have the quality measures be determined primarily by those folks actually providing the car, the specialty societies, and not have them be a—the kind of duplicative and often times contradictory measures that we currently have in place?

Mr. MILLER. Well, this was going too well to last, and so here we are.

[Laughter.]

I think the Commission has great concern that the quality measures, if they are determined entirely by the specialty societies—there is two concerns. Number one, that it creates and reinforces silo types of approaches to care: "Here is my set of metrics for the thing I did," as opposed to what was the general outcome for the patient throughout the entire episode; and I think the second concern that the Commissions have—and this is with all respect, but the specialty societies all say it about each other—some of them have rigorous standards, some of them less so.

Mr. PRICE. And my time has run out, but I look forward to having—maybe we can get another round, Mr. Chairman, as we move forward. Thank you.

Mr. MILLER. And, if not, we are happy to get on the phone and talk to you about this, as always.

Chairman BRADY. Thank you. Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman. Thanks for holding this hearing.

Mr. Miller, thank you for your testimony today, and for the work MedPAC does. I wasn't going to ask you this in my question period, but since Dr. Price raised it, I have teamed up with him in regards to the whole meaningful use with certain specialties, especially as it relates to pathologists. So maybe we can follow up with you in regards to legislation that we specifically introduced to try to get MedPAC's response to it, as well as a letter that we are doing to CMS to try to highlight this issue. There have been some extensions, we are not sure if there is going to be another extension in the future. But, nevertheless, it would be nice to get MedPAC's incentive on it.

You know, in past MedPAC reports to this hearing, I have been not so much critical, but impatient with MedPAC's recommendations in regards to payment reform. So I want to ask you yet here today—I mean there are a lot of tools out there, a lot of different payment models that are moving forward, a lot of experimentation taking place. But from MedPAC's perspective, where can we be accelerating this payment from fee-for-service to a quality or value-based reimbursement system?

Where are there some very promising initial results coming back that is showing us that we can get much better quality of care, but also at a much better price?

I think—I forgot who it was, Dr. McDermott or someone just cited the Commonwealth study that just came out this week, showing that we are still, by far, spending way too much per beneficiary in health care, as an entire system. And often times, getting worse results compared to most of the other developed countries around the world.

And I think part of this is being driven by this archaic payment system that rewards volume over value. And I know MedPAC has had recommendations in the past. But right now, from, you know, where you see us today, where do you think we can be pushing more aggressively to get to a value or outcome-based reimbursement system?

Mr. MILLER. Okay. That is a pretty—you know, broad and complicated. But I would say a few things.

I think, you know, we are going to be living with fee-for-service for some period of time and, you know, perhaps forever. And I am not sure that that is a bad thing, because fee for service can be efficient and high quality in some parts of the country. But I think there are pursuits inside fee for service that can produce better quality results. Here is one.

The re-admissions penalty, which is, again, not a popular idea, but it is—it looks like re-admissions are falling, and people are paying a lot more—hospitals are paying a lot more attention to it.

On more of a systems-wide basis, you know, the ACO concept is still a concept, still entirely unproven, but we have been talking a lot to accountable care organizations on what is going on out there, and decidedly—at least for some of them—it changes the under-

lying dynamic. You know, generating services is working against you. And as long as the quality standards are clear and present, they move more in that direction.

And I think another area that we are talking about in this report is the notion of population-based quality measures. So get out—and I know there is some conflict over here—but get above the individual process-based, "I did this particular thing," and say, "Is this population avoiding admissions that are unnecessary? Are they staying out of the emergency room? Are they not being re-admitted?"

A concept that we are only breaking ground on is the notion of can we count how many healthy days they have at home. That is what everybody wants. Can we start to construct measures that say, "This is really where you want to be?"

And then, finally, I think, you know, bringing both the beneficiary and the provider into the—we, MedPAC, I think the Congress in general, have spent a lot of time on trying to design payment systems and measurement systems to incent the provider, but also bring the beneficiary into that process too, so that you have both actors at the point of contact involved.

Mr. KIND. And that is—I would love to be able to follow up with you and see what we can explore and move forward on.

But one other thing before my time expires. Obviously, we had the CMS data dump on physician reimbursements recently. And, yes, it does provide a glimpse, but it was an incomplete picture, because it also didn't explain what results were happening, what the protocols of care—and I also discovered during that that you have multiple doctors using the same billing number. I mean, does that make sense? Don't we want to dis-aggregate that information if we want to really drill down to find out where the reimbursements are going, and if there is perhaps some over-utilization occurring?

Mr. MILLER. Yes. I think the ability—I mean there are 10 tax identification numbers, and then there are individual provider numbers. And I think it probably makes a lot more sense to be able to track through to the individual provider, because if there is a particular provider who is ordering a bunch of services that are really out of synch with general accepted practice, it is hard to get at that if you can't get to the individual.

Mr. KIND. All right, thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman.

Dr. Miller, thank you for joining us here today. Medicare Part D, we are learning that there is cost savings, that costs are less than originally projected. Can you speak briefly to that, and how and why you have seen that take place?

Mr. MILLER. I think probably the single most important reason that that is the case is that there was a fairly heavy move to the use of generic drugs that was driven inside the Part D program that may have resulted in the expenditures that were less than what was being projected when the program was implemented. But if there was one thing to point to, I think it is probably that.

Mr. SMITH. And how about the penalty that is—rather than mandating seniors have Medicare Part D, there is a provision that is a penalty if they don't sign up during the open enrollment period.

Mr. MILLER. Which is pretty true throughout Medicare. If you don't sign up for Part B, it is kind of the same——

Mr. SMITH. Right, but there is no individual mandate, if you will. Correct?

Mr. MILLER. There is no individual mandate. That is correct.

Mr. SMITH. And can you speak to the effectiveness of that provision?

Mr. MILLER. In lowering cost?

Mr. SMITH. Well, not necessarily just in lowering costs, but in incenting individuals to sign up.

Mr. MILLER. Well, I think the existence of a penalty probably focuses the attention of the beneficiary, if that is what you mean. And I think it was put into Part D and into Part B because of the concern about selection. If you don't move broad ranges of the population into these programs, what you get is the sickest, and then the premiums become unsustainable over time, and the program collapses—in the extreme. It is death spiral in the—you know, kind of the actuarial terms.

So, those things are created to draw the beneficiary or whoever the person is, his attention to purchase the insurance, so that you get a relatively broad representation of risk.

Mr. SMITH. Very well. I thank——

Mr. MILLER. Is that what you are asking?

Mr. SMITH. Yes. Thank you very much.

Mr. MILLER. Okay.

Mr. SMITH. I yield the balance of my time to Dr. Price.

Mr. PRICE. Oh, thank you. Thank you very much. I was—I am sorry Mr. Kind left, because I was remiss in not thanking him for his assistance on this issue of some specialties, especially pathologists, and the meaningful use in electronic medical records.

And you did make a comment to—in response from Mr. Kind, though. You said that re-admissions were falling. Have you looked at the change in observation status in hospitals?

Mr. MILLER. Observation status has been increasing. We have looked at the relationship between those two. We don't think that that is driving the impact that we are seeing on admissions. But we are looking at observations. We do think that there are some real issues there. We are looking at the to-midnight rule, which I think has been a subject of some conversation.

I am not in a position to give you, you know, data and analysis, although I may have some fact points. But the Commission—the staff right now—I haven't rolled it out in front of the Commission—is looking at an alternative approach that would change—I don't want to get too deep here—the in-patient payment system to make it more clear when a person is in-patient, and to pay on a more rational basis, so that there is not as much need for this observation spike——

Mr. PRICE. I think that would be extremely helpful, because all you have to do is go to an emergency room and you ask them where their observation beds, and they have increased—well, now

that we have observation beds. The only reason for that is because of a payment system that we have put in place, as you know.

I want——

Mr. MILLER. This fall we will have some of this information out in our public meetings, and you and your staff can start paying attention.

Mr. PRICE. Great. I would like to touch on the recommendation or the comment that you made in the report about paying—using a per-beneficiary payment. Some people have called that capitated payment system. How does what you envision to be appropriate differ from what some folks call concierge medicine, or personalized medicine? How does the paying a primary care physician or a medical home physician differ from what you are envisioning?

Mr. MILLER. Well, I——

Mr. PRICE. Or does it?

Mr. MILLER. Well, I think I see the linkage that you are making.

The—I think the first distinction—and maybe it is the only one I can think of off the top of my head—is that what a concierge payment usually gets you is exclusive access to a physician. And generally, physicians use it to lower their panel counts, and then focus more attention on an individual patient.

This wouldn't have any exclusivity to it. The payment would be attached to the provider on the basis of a preponderance of contact with a patient. And we would say, "Okay, you seem to be seeing this patient for their primary care. Here is a block of dollars for you to coordinate and, you know, have non-face-to-face service with that beneficiary." That portion does sound like the concierge type of experience. The exclusivity, I think, would be a difference, though.

Mr. PRICE. Maybe we can take a peek at that.

Mr. MILLER. Yes, absolutely.

Chairman BRADY. Thank you. Mr. Pascrell.

Mr. PASCRELL. Mr. Chairman, thank you. This year's June MedPAC, Director Miller, reaffirmed—in my mind, anyway—that we don't have to scrap the current system in order to save Medicare. I think it is conclusive evidence to that effect.

We are talking today about strengthening Medicare. The Affordable Care Act is already hard at work actually testing the new payment system and the delivery system. That will lead to innovation, not only for Medicare, but everybody in the entire health care system.

The point I would like to make is that health care reform is already moving Medicare, I think, in a new direction. That is my estimation of what is going on. And we should always be open to new ideas. There is no two ways about that. But I think my colleagues need to take a look at the work happening today that is making and moving Medicare towards paying for the quality of services, not necessarily the quantity of services, for our seniors.

Here is my first question to you. Health care, to me—health care reform is entitlement reform. Not only did the Affordable Care Act reduce costs for Medicare, it also reduced costs for beneficiaries. Mr. Miller, can you discuss the ways in which the Affordable Care Act has helped the solvency of Medicare?

Mr. MILLER. Well, I mean, I think a couple of things. The changes in the basic payment rates for the fee-for-service providers that were restrained as part of the ACA meant that there would be lower spending for that reason. So, you know, the reductions in the market basket, I think, you know, might be a way to talk about that vocabulary.

I think a second reason is the reduction in the managed care payments, which the Commission did a lot of work demonstrating that we were basically subsidizing and paying more than we needed to to get that benefit. And I think that lowered expenditures.

What I think the jury is still out on is, for example, take ACOs. You now have five million people in ACOs. So decidedly, there is change occurring. There results are mixed, which, actually, I think everybody expected them to be.

Mr. PASCRELL. Right.

Mr. MILLER. So the ACOs are actually saving money. There seems to be increases in quality, pretty broadly, but some are saving money, some are not.

Mr. PASCRELL. Before we get into out-of-pocket expenses—I am very concerned about that—you don't disagree that the life of Medicare has been extended about eight years because of the ACA?

Mr. MILLER. Well, I am not sure I have walked through that thinking for myself. I know the trust fund is extended. There is lower expenditures in Medicare rates right now. That is extending the life of the trust fund. There is big discussions about how much of that is secular and how much of that is ACA.

But to your question, the things I pointed to did reduce Medicare's spend.

Mr. PASCRELL. The average Medicare beneficiary has an average annual income of less than $23,000. I am concerned that if it doesn't provide adequate financial assistance for lower income beneficiaries, benefit redesign puts these beneficiaries in a very, very vulnerable financial situation. And they may—it may discourage them from assessing—accessing the care they need because of the cost. I am very concerned about that.

We discussed this when putting the bill together. While the intention of setting an out-of-pocket maximum is to protect beneficiaries from high out-of-pocket spending, it would only be effective for those who have the financial means to reach that threshold. When MedPAC proposed Medicare benefit redesign back in 2012, which was also referenced in the most current report in June, does MedPAC envision redesigning the benefit for the purposes of achieving cost savings of the program? Is that the reason why you have suggested that?

Mr. MILLER. No, but I am going to parse my way through this answer carefully.

The benefit redesign portion of our proposal is explicitly—and we say this very clearly—designed not to increase the aggregate liability for the beneficiaries. We all understand the distribution——

Mr. PASCRELL. Right.

Mr. MILLER [continuing]. Can change, but the aggregate liability.

However, we have said that the first dollar coverage should have an additional charge to it. And our hope is that people see that

they don't need it, and then they drop the first dollar coverage, and that frees up more resources for them. But if they choose to hold on to it, then they would pay more for that product.

Mr. PASCRELL. Right, because, Mr. Chairman, we have talked about this several times about out of pocket. So we need some kind of a balance here so that, you know, we don't cut off our noses to spite our faces.

Chairman BRADY. Let's see if we can find that common ground as we go forward.

Mr. PASCRELL. Thank you.

Chairman BRADY. Which is why the recommendations are, I think, helpful in this discussion. So thank you.

Mrs. Black.

Mrs. BLACK. Thank you, Mr. Chairman. And I appreciate your allowing me to be sitting in on this Committee.

Thank you, Mr. Miller, for being here today. This is such an important subject matter, and we need to continue to make sure we are discussing it. In your June report you discuss the quality in fee for service and in the Medicare Advantage program, and I would like to discuss just a few concerns about how the quality is measured in Medicare Advantage, especially among that dual eligible population.

I don't have to tell you, you know that dual eligibles only account for about 19 percent of Medicare beneficiaries, but they account for about 34 percent of all the Medicare spending. So this is an important population. And having been a nurse for over 40 years, and having worked with this population, I certainly recognize that they are the most vulnerable, they have the highest rates of chronic illness, of disability, mental illness, and frailty than the rest of the Medicare or the Medicaid populations. And this means that Medicare Advantage will play a critical part in getting those services that they so critically need, and the larger services in coordinated care and benefits to access those services that beneficiaries most in need of, and especially in care management, in managing their care, since they have so many issues.

Would you agree that we need to take into account these fragile populations when we make comparisons across the fee-for-service and the accountable care organizations with Medicare Advantage plans to make sure that we are really comparing apples to apples in both our costs and our quality.

And then, if so, I would like for you to speak to how you think we might be able to do that.

Mr. MILLER. Okay. So let me take this through a couple of steps here.

So, the plans in managed care that take a lot of dual eligibles, the special needs plans, are—take a lot of these populations, although these populations are throughout the plan types.

What we have done is we have looked at the risk adjustment system. And a way to think about it is, if this is your distribution of your population—expensive people, not expensive people—the risk adjustment system overpays a bit for not expensive, underpays for expensive people. And then, if you, as a managed care plan, kind of go after this end of the distribution, you could be potentially disadvantaged.

We made three recommendations recently in which we said, "If you make these technical changes"—and I will take you through them, if you really want to glaze over—but, "If you make these three changes, it will move a little bit more to this balance." So we think that that is a way to approach these kinds of payments and quality measurement in a way that is a bit more equitable.

Now, as everything in health care, things get a little bit complicated. When you look at these plans' financial performance, they aren't really on a profit basis. That disadvantage—I mean, in some cases, have the highest profits relative to other plans. And so, you know, what we think should happen here is that there should be a common suite of measurements across any plan type, so that the beneficiary can look at it and say, "This plan does well, this plan doesn't do well," whatever the—or fee-for-service, whatever the case may be.

I have talked to these plans many, many times, and they say, "You know, the way you do it in"—or, "The way Medicare does it in managed care, it is not fair to us." And I say to them, "What measures would you add to this suite that capture your line of business better than is happening now?" And I have to say they have not come forward with those measures.

And so, I see your point. I—we have made these recommendations for the risk adjustment. We think if there are measures that this portion of the industry can come forward and say, "This is really what we are about," the Commission's view is let's evaluate them and make them part of the measurement process. But, to date, there hasn't been a lot forthcoming.

Mrs. BLACK. Do you have any research that you are currently doing, or plan to do, in being able to put forward some measures that you think would be applicable?

Mr. MILLER. See, we are a very small operation. There is 30 of us at the—on staff anyway, and we don't really view ourselves as the people who create the measures. We try and draw them from the environment, evaluate them, point them out, and say, "Here is a good set of work that is occurring." We can try and put effort into that.

But to date, no, we have not come up with a set of measures that at least those special needs plans would say, "Yes, that is the set-up measures." We have talked to them a bit about them, but we haven't gotten a lot of traction.

Mrs. BLACK. I was just curious, because there are certainly areas such as the chronic illness, and the disability, and the mental illness that set a stage for saying, "Here are the disease processes that are going to cost more," as to whether you have actually seen any measures out there that you think would be applicable for what is already there.

Mr. MILLER. Now, to those types of things, at least, our risk adjustment recommendations should address some of that. So, if—one of the measures is basically a chronic condition count. And when you enter that into the model, it makes this risk adjustment system more balanced.

So, to the extent that those are conditions that are present, we have made recommendations, and we have done research. I thought you were asking more about this is an activity that we are

engaged in, and we should be measured on this activity. That is where we haven't brought new information to the conversation.

Mrs. BLACK. I think it is both areas.

Mr. MILLER. I agree with you. And one we have standing ideas. One we are trying to work with the industry to identify them.

Mrs. BLACK. Thank you. Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mrs. Black, for joining us. If anyone thinks this is a check-the-box hearing, they are wrong—MedPAC does a report, we hold a hearing, that is it. Truth is, this Committee has spent, as you would imagine, a lot of time on the rollout of the Affordable Care Act, and spent a lot of good time, and I think a fairly historic agreement on how we fix permanently how we reimburse our doctors in Medicare.

Now we are turning to how do we improve the Medicare program. There is a lot of challenges to it, there is a lot of opportunities. And it is my hope that we will build on some of the recommendations, adjust them, and, on a bipartisan basis, find a way to improve Medicare for our seniors.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, Mr. Miller, I ask that the witness respond in a timely manner. And I thank you for your testimony on behalf of MedPAC here today, and the hearing is adjourned.

[Whereupon, at 11:09 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

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TESTIMONY TO THE HOUSE COMMITTEE ON WAYS & MEANS FOR A *HEARING ON MEDPAC'S JUNE REPORT TO CONGRESS* ON JUNE 18, 2014

The American Health Care Association (AHCA) respectfully submits the following testimony to the Members of the House Committee on Ways & Means in regard to the *Hearing on MedPAC's June Report to Congress* on June 18, 2014. With more than 12,000 skilled nursing center members, AHCA is committed to improving lives by delivering solutions for quality care.

To that end, the Association stands ready to work with the Congress on strategies to improve post-acute care (PAC) payment systems which will improve the quality of care for people, produce Medicare programmatic efficiencies, and support a dynamic and innovative PAC sector. The latter is particularly important as the Centers for Medicare and Medicaid Services (CMS) and states experiment with alternative payment methods (APM) and delivery systems both for Medicare-only beneficiaries and persons who are eligible for Medicare and Medicaid (e.g., duals).[1] All of these efforts are aimed at improving beneficiary outcomes and addressing Medicare spending, which will significantly grow as the baby boom generation reaches retirement age.[2]

Already, AHCA worked with the Congress on the Skilled Nursing Facility Hospital Readmission Reduction Program contained in the *Protecting Access to Medicare Act of 2014* (P.L. 113–93). The Association has had a hospital readmission goal as part of its Quality Initiative for over three years. Now, the most recent data shows that skilled nursing centers are reducing rehospitalization rates. Furthermore, the recently enacted law establishes specific targets to further encourage nursing facilities to better coordinate care with hospitals, physicians, and other post-acute care providers, as well as save the Medicare system $2 billion in the next 10 years.

To further enhance Medicare beneficiary care and shore up the Medicare program, the Association supports the development of site neutral system and believes that MedPAC's efforts lay a strong foundation for moving forward expeditiously. We propose that the Congress:

1. Adopt MedPAC's recommendation and pass legislation to implement a site-neutral payment system for select orthopedic conditions treated in both inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs);
2. Hold on the implementation of waivers. There are waivers that we believe should be granted for SNFs, such as the 3-day inpatient hospital requirement, but final

[1] These include accountable care organizations (ACO), bundling, and CMS' Financial Alignment Demonstration. Medicare Advantage is not new to Medicare but it's rapid expansion and plan control over site of care also must be considered.
[2] Congressional Budgeting Office. The Budget and Economic Outlook: 2014 to 2014. February 2014.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

judgment on waivers cannot be made until the fundamental analyses that need to be done are completed. Similarly, we believe that research is needed on IRF waivers before they are granted.

3. Swiftly pass the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

Site Neutral – An Opportunity for Exploration

Currently, the Medicare system reimburses each type of PAC provider according to different payment methodologies. Existing payment policies focus on phases of a patient's illness defined by a specific service site, rather than on the characteristics or care needs of the Medicare beneficiary. As a result, patients with similar clinical profiles may be treated in different settings at different costs to Medicare. This payment system fails to encourage collaboration and coordination across multiple sites of care and provides few incentives that reward efficient care delivery. Such misalignment long has been understood and acknowledged.

Years ago, key policy thinkers, institutes and government agencies started to address the failures and to develop concepts that in effect were "site-neutral." Site neutral means that care should be patient-centered organized around the individual's needs, rather than around the settings where care is delivered.

In recent years, a number of efforts have laid the foundation for a site neutral system. Most recently, MedPAC unveiled its case for site-neutural payments for several conditions that are treated in both SNFs and IRFs. Its data and analyses are compelling and groundbreaking. The Commission's work is the culmination of two years of site neutral policy analysis and builds upon a strong movement toward the need for a site neutral policy that began in 2005. A few of the key milestones include the following:

- In May of 2005, the CMS Administrator created a Policy Council to improve our nation's health care system. One of the Council's first priorities was to develop a plan for PAC reform. The Council developed a set of PAC reform principles to drive the PAC system toward the delivery of high-quality care in the most effective manner and, thus, improve payment efficiency.

- The Deficit Reduction Act (DRA) of 2005 mandated a demonstration that also supports site neutral. The DRA effort resulted in the development of a common assessment tool which could facilitate significant movement toward the ability to compare patients across settings as well as reshape current PAC payment systems to pay for similar services to similar patients despite the settings.

- Released in 2011, the "President's Plan For Economic Growth And Deficit Reduction, Legislative Language and Analysis," the Budget proposed to restructure PAC payments. The legislative language adjusted Medicare payments

for three conditions involving hip and knee replacements and hip fracture as well as other conditions selected by the Secretary at her discretion. The Budget document indicated that these conditions are commonly treated at both IRFs and SNFs, but Medicare pays significantly more when treated in IRFs. The Budget document clearly articulated that IRFs provide intensive inpatient rehabilitation care that may not be needed for patients with certain conditions and whose care needs could reasonably be expected to be met in a SNF.

- In the April 2013 Moment of Truth Project report, "A Bipartisan Path Forward to Securing America's Future," the Co-Chairs, Erskine Bowles and Senator Alan Simpson, proffered a plan to put America's fiscal house in order. As part of the plan, they proposed reforming PAC payments and included a proposal to equalize payments between across PAC settings.

- President Obama's fiscal year 2014 budget also proposed a restructure of PAC payments for three conditions, involving hip and knee replacements and hip fractures as well as other conditions to be selected by the Secretary of Health and Human Services.

- In March 2014, MedPAC unveiled its work on site-neutral PAC. The Commission examined three specific conditions (stroke, major joint replacement, and hip fractures) and concluded the following:

  - For select conditions, characteristics of beneficiaries admitted to IRFs and SNFs in the same market were similar;
  - In addition, the prevalence of comorbidities of beneficiaries were similar but patients treated in SNFs were more likely to have several of the comorbidities; and
  - Where available, risk adjusted measures indicated few differences between IRFs and SNFs for identified conditions. Specifically, the research showed no significant differences in risk-adjusted readmission rates between IRFs and SNFs, no significant differences in mobility, and, with respect to self-care, there were no significant differences for orthopedic conditions but some higher rates of improvement for IRF patients.

Most recently, in its June 2014 Report to Congress, MedPAC elaborates upon its March 2014 statements. Specifically, in the June 2014 report, the Commission examined three conditions – stroke rehabilitation, major joint replacement, and other hip and femur procedures – and found that patients and outcomes for orthopedic conditions were similar and such cases represent a strong starting point for a site neutral policy when using risk adjusted measures.

However, the efforts listed above as well as MedPAC research all are limited by data. Additional resources and study are needed to ensure a viable patient-centered system based upon a site neutral payment system will be successful and produce the desired

outcomes for people as well as the Medicare program and support a dynamic and innovative PAC sector.

AHCA recommends that the Congress adopt MedPAC's recommendation and pass legislation to implement a site-neutral payment system for select orthopedic conditions treated in both IRFs and SNFs.

The U.S. Department of Health and Human Services, recent Congressional legislation (e.g., the Deficit Reduction Act, the IMPACT Act of 2014), the Administration, and MedPAC all have examined approaches to rationalizing payments across different provider types and settings. Last year MedPAC began an examination of how Medicare could equalize payments for similar patients treated in long-term care hospitals (LTCHs) and acute care hospitals. In his remarks to Congress in 2013, the MedPAC executive director indicated that equal payments for similar PAC services would build on the Commission's work examining Medicare's payments for select ambulatory services.

In its most recent *Report to the Congress,* MedPAC states the following:

> "Site-neutral payments stem from the Commission's position that the program should not pay more for care in one setting than in another if the care can be safely and efficiently (that is, at low cost and with high quality) provided in a lower cost setting. As a prudent purchaser protecting the taxpayers' and beneficiaries' interests, Medicare should base its payments on the resources needed to treat patients in the most efficient setting, adjusting for patient severity differences that could affect providers' costs."[3]

In their analysis MedPAC selected three conditions to study, allowing them to explore a "proof of concept" of site-neutral payments between IRFs and SNFs. Those conditions included patients receiving rehabilitative care following a stroke, major joint replacement, and other hip and femur procedures (e.g., hip fracture). They found that patients and outcomes for stroke rehabilitation were more variable and concluded that additional work needs to be done to more narrowly define those cases that could be subject to a site-neutral payment policy and those that could be excluded from it. However, they found that the patients and outcomes for the orthopedic conditions were similar and could be a strong starting point for implementation of a site-neutral payment policy.

The Commission explains that site-neutral payments for orthopedic conditions could be implemented in the near-term and would serve as building blocks for broader payment reforms such as bundled payments and Accountable Care Organizations (ACOs). AHCA supports MedPAC's position on site-neutral payments and recommends that the Congress swiftly pass legislation to implement site-neutral payments for select conditions treated in both IRFs and SNFs.

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[3] *Report to the Congress: Medicare and the Health Care Delivery System*, June 2014, page 97.

Immediate movement on MedPAC's suggested site neutral approach is needed (e.g., testing for specific conditions). Efforts to maximize the potential of ACOs, bundling, and other potential care/payment reforms depend upon the alignment of care across the acute and post-acute spectrum. If such efforts are not undertaken, inappropriate cost data, inappropriate Medicare payment, and clinically inappropriate sites of care will be drawn into the fabric of the new systems and contribute to their failure.

AHCA recommends that the Congress swiftly pass the IMPACT Act of 2014.

There is currently no way for policymakers and health care analysts to compare patient outcomes and functional status across care settings because there is no unified assessment tool for providers to use to capture this information. Absent this data, it is difficult to move forward with meaningful reforms that would rationalize payment systems across PAC providers. Standardized post-acute assessment data are the necessary building blocks for any meaningful payment reform that would rationalize payments across PAC settings.

MedPAC first raised the need for a common PAC assessment tool in 2005[4]. In the Deficit Reduction Act of 2008, the Centers for Medicare and Medicaid Services was first directed to test the concept of a common standardized assessment tool in the form of the post- acute care reform demonstration. In their March 2014 *Report to the Congress,* MedPAC recommended that Congress enact legislation that would implement a common assessment tool across PAC providers. AHCA supports that recommendation.

Last year the Chairmen and Ranking Members from both the Senate Finance Committee and the House Ways and Means Committee invited Medicare PAC stakeholders to provide their ideas and solutions for PAC reform. The Committees received more than 70 letters from stakeholders (including AHCA) echoing the need for standardized post-acute assessment data across Medicare PAC provider settings. In March of this year, in response to overwhelming support for such a policy, staff of the House Ways and Means and Senate Finance Committees released a discussion draft of a legislative proposal outlining a policy that would begin the implementation of a common assessment instrument across PAC settings.

That proposal, titled the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014,* would require PAC providers to begin reporting standardized patient assessment data by October 1, 2018, (and January 1, 2019, for home health agencies [HHAs]) by integrating common questions into individual provider sectors' existing patient assessment instruments. AHCA supports this proposal and recommends that the Congress waste no more time in enacting the legislation.

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[4] *Report to the Congress: Medicare and the Health Care Delivery System*, June 2005, page 119.

AHCA Site Neutral Concept

We strongly support a PAC site-neutral payment system which would restructure Medicare to revolve around the beneficiaries' needs rather than around the settings where care is delivered. The Association is examining a site-neutral solution to improve and stabilize the Medicare program.

Under AHCA's solution, patients would be grouped by their clinical condition and severity of illness. Each group would have a set Medicare payment that would cover the expected costs of providing the appropriate type, duration and mix of services. Medicare payments would be the same for each PAC provider regardless of where the patient is being treated.

We would achieve such programmatic changes by:

1. Moving forward with MedPAC's initial steps,
2. Studying which conditions could be added to a site neutral system; and
3. Gathering data that would allow for additional comparative analysis of SNF and IRF settings under the auspices of the IMPACT Act.

This person-centered PAC approach would level the "paying" field to motivate providers to offer the highest quality option in order to continue receiving patients. Additionally, a site-neutral payment system would further care coordination and collaboration between providers. Such incentives are beneficial for seniors, who would receive better care, as well as taxpayers, who would enjoy a more cost-effective Medicare system.

Conclusion

As noted above, we are not alone in our support of a site neutral arrangement. Acknowledgements by the Administration and non-partisan groups reflect growing interest in implementation of a site-neutral payment policy.

We can prevent the looming Medicare solvency crisis as 10,000 of our nation's baby boomers turn 65 with each passing day. America's skilled nursing care centers are developing solutions that will combat efficiency problems including a site-neutral payment policy for PAC providers. A site neutral payment policy solution is not only better for the government and taxpayers, it is also better for people and their families. The Association is ready to address our nation's fiscal issues with this concept and looks forward to working with Congress on site neutral payment policy and other critical health care policy solutions and issues.

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