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 TWELFTH CONGRESS

SECOND SESSION

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MEDPAC'S JUNE REPORT TO CONGRESS

TUESDAY, JUNE 19, 2012

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

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, the Honorable Wally Herger [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

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

Tuesday, June 19, 2012

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) June report to the Congress. The report details the Commission's recommendations for reforming Medicare and its payment policies. The Subcommittee will hear from MedPAC's Chairman, Glenn Hackbarth. **The hearing will take place on Tuesday, June 19, 2012, in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

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

BACKGROUND:

MedPAC advises Congress on Medicare payment policy. The Commission is required by law to submit its second annual report on Medicare payment policies by June 15.

In its June report, MedPAC suggested reforming traditional Medicare benefit design to adjust beneficiary cost-sharing requirements and to encourage beneficiaries to be more involved in their care, providing illustrative options for improved patient cost sharing. The Commission also examined care coordination for dual-eligible beneficiaries, provided recommendations for improvement to the Program for All-Inclusive Care for the Elderly (PACE), reviewed the type of care provided through Medicare Advantage Special Needs Plans, and offered a critique of the demonstration program for dual-eligible beneficiaries currently being implemented by the Centers for Medicare and Medicaid Services.

Also included in MedPAC's June report is a statutorily-mandated examination of several topics related to Medicare beneficiaries residing in rural areas, including access to care, quality of care, adequacy of payment, and potential payment adjustments. The Commission did not supply recommendations in reviewing rural Medicare payment policies, but suggested principles to better inform Congress going forward.

In announcing the hearing, Chairman Herger stated, **"Given the current fiscal issues facing the Medicare program, it is critical that the Committee ensures that taxpayer and beneficiary dollars are being spent appropriately. MedPAC's thoughts on reforming Medicare's benefit design are important as the Committee considers much needed and long-overdue structural improvements to the program. Similarly, as Congress explores how to address the needs of beneficiaries living in rural areas while fulfilling its responsibility to taxpayers, MedPAC's insight as to whether special provider payment adjustments are warranted is also helpful."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's June 2012 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 Tuesday, July 3, 2012**. 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 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

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

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Chairman HERGER. The subcommittee will come to order. Today we will be hearing from the Medicare Payment Advisory Commission, MedPAC, on the analysis and recommendations contained in its June 2012 report. This subcommittee has heard from numerous witnesses over the last year and a half about the financial challenges facing the Medicare program.

In fact, the Medicare trustees reported in April that the program will go bankrupt in 2024, a mere 12 years from today. Clearly time is of the essence.

The subcommittee has also heard from several experts on ways to reform and improve the program in order to bring the program into the 21st century, slowed the rate of growth and protect Medicare for future generations. It is in this vein that we welcome MedPAC chairman, Glenn Hackbarth here today, to discuss the commission's June report.

The commission has scrutinized the design of the traditional Medicare benefit and found it lacking. The traditional Medicare benefit consists of a patchwork of premiums, deductibles, copayments and co-insurance. It neither encourages appropriate utilization of care nor protects beneficiaries from the high out-of-pocket costs. Because of this fragmented structure, nearly 90 percent of Medicare beneficiaries have some type of supplemental insurance, and the evidence shows that supplemental coverage that eliminates some of the beneficiaries' cost-sharing responsibility result in higher program costs and higher premiums for all beneficiaries.

I look forward to hearing more about MedPAC's recommendation on how to design a new benefit structure that meets and reflects the health care needs of today's seniors rather than remaining trapped in the 1960s.

The June report also contains a chapter that examines several topics related to Medicare beneficiaries in rural areas. While maintaining an appropriate level and quality of care in rural areas is a challenge, it is what our constituents deserve. This issue is of critical importance to me and the rural northern California district that I am privileged to represent. It is also important to many of the members of this panel as well as to maintaining a high-functioning health system. We must ensure that payments made on behalf of beneficiaries and taxpayers are appropriate. MedPAC took on this challenge and provided some suggestions on how Congress may devise policies to maintain rural beneficiaries access to quality care while ensuring taxpayer dollars are spent wisely.

This information is especially helpful as Congress assesses a series of special payment adjustments which are set to expire by the end of the year.

There are no one-size-fits-all answers to these challenging health care questions, but in light of Medicare's and our Nation's financial challenges, we must critically review our existing payment policies to ensure they are accomplishing their goals.

Finally, I am eager to discuss MedPAC's view on how to better improve care coordination for Medicare beneficiaries, including the dual-eligible population. The dual eligibles are among our Nation's most vulnerable and have unique challenges. There are several current delivery systems within Medicare that integrate care for these beneficiaries which show promise. However, with the new duals demonstration program being rolled out by the Centers for Medicare and Medicaid Services, some of the past successes may be at risk.

Further integration is clearly necessary, but I am concerned that the administration's unilateral action to address this population's needs may undermine the protections guaranteed to all Medicare beneficiaries. This is a critical issue to get right the first time, and I know that MedPAC is concerned about it as well.

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

Without objection, so ordered.

I now recognize Ranking Member Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. Thank you, Chairman Herger, and thank you, Chairman Hackbarth, for being with us today.

I look forward to your suggestions on how we can improve Medicare, and I want to congratulate and thank you for accepting an appointment for another term as chairman.

Medicare is one of our Nation's best programs, but it has always been a work in progress, and it needs ongoing fine-tuning and changing to keep it relevant so that it will operate in the best interest of the millions of seniors and Americans living with disabilities who rely on this program.

For that reason, I am concerned about the proposals or any proposals that would shift costs to beneficiaries. Doing so I think would devastate them. The majority of them already live on tight fixed incomes, and what is more, research has shown that increased cost sharing leads to a reduction not only in unnecessary health care but these increased costs also discourage people from receiving necessary health care.

The home health copayment, for instance, I think is largely ascribed to be used by old, sick, poor widows, and raising the price that they have to pay is just one more Republican effort to deny equal rights to women.

I would like to remind all of us that MedPAC's report has given us a bunch of recommendations for payment updates that would yield savings without squeezing the beneficiaries. As we look to year-end business and needing to fix the physician payment system, and there are other offsets available as well. The overseas contingency operation's money is available to us, and I dislike the notion that we need to increase costs for beneficiaries in order to fix the physician payment system.

I look forward to your thoughts, Chairman, and for the people eligible for Medicare and Medicaid, I hope you will address this idea that Medicare is going to go broke one of these days. The adjustments necessary to keep Medicare alive for the next 75 years I think are less than a 3 percent increase in premiums. And while I hope we don't have to do that, there are many other options, age differences changes that we have already done, raise, allowing earned—unearned income to be used in the tax, a host of changes all of which are modest and could would keep Medicare alive, and I hope that you will address some of those options that are available to us.

I thank you.

I thank, again, Chairman Herger, for holding this hearing and inviting you back to inform us about the state of Medicare.

Thank you Mr. Chairman.

Chairman HERGER. Thank you.

Today we are joined by Glenn Hackbarth, the chairman of MedPAC. Mr. Hackbarth has served as MedPAC's chairman for 10 years and is appearing before this subcommittee for the second time this Congress.

We are pleased to have you with us once again. You will have 5 minutes to present your testimony. Your entire written statement will be made a part of this record. You are now recognized for 5 minutes.

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

Mr. HACKBARTH. Thank you, Chairman Herger and Ranking Member Stark, and other Members of the Subcommittee, I appreciate this opportunity to talk about our June 2012 report.

The report contains six chapters and covers quite a bit of ground, including reforming Medicare's benefit design, care coordination, care coordination, in particular, for dually eligible beneficiaries, risk adjustment in Medicare Advantage plans, serving rural beneficiaries and Medicare coverage for home infusion services.

In the interest of time, I am going to focus my opening comments on just two of those chapters, the one on benefit design and the one on serving rural beneficiaries.

Our chapter on benefit design includes a unanimous recommendation that the Congress should redesign Medicare's benefit package with the following elements: First, no change in aggregate beneficiary cost sharing at the point of service; second, add to the program an out-of-pocket maximum, catastrophic limit as it is sometimes called; third, wherever possible use fixed dollar specific, dollar amount copays instead of a percentage co-insurance; fourth, give the Secretary of HHS broad authority to modify the benefit package within parameters established by the Congress consistent with the principles of value-based insurance design; and finally, impose an additional charge on supplemental insurance purchased by Medicare beneficiaries.

This recommendation is based on the following assessments and conclusions by MedPAC. First of all, cost sharing at the point of service is a blunt instrument that nonetheless is an essential tool in a fee-for-service, free choice of provider insurance program like Medicare. That said, we do not believe that aggregate patient cost sharing should be increased above the current level. We do believe however that the current structure is outdated, and its very design creates uncertainty and thereby fosters demand for supplemental insurance coverage.

We believe an effective redesign of the Medicare benefit would reduce uncertainty by adding catastrophic coverage and converting co-insurance to fixed dollar copays.

We do not favor prohibiting supplemental coverage. But we do believe that beneficiaries should bear at least a portion of the added cost that that supplemental coverage imposes on the Medicare program and the taxpayers.

Now let me turn to the chapter on rural care. The Patient Protection and Affordable Care Act asked MedPAC to report on the following aspects of rural health care for Medicare beneficiaries. First, access to care, quality of care, the adequacy of Medicare payments to rural providers, and the appropriateness of the special payment adjustments in the Medicare payment system for rural providers.

To respond to your request, we collected information from beneficiary surveys and focus groups, site visits to rural providers, Medicare claims and cost reports, Medicare reports on quality of care for rural providers, as well as meetings with many associations that have an interest and expertise in rural issues.

Our major findings are as follows: On access, we find that there are large differences in service use across regions in the United

States, a fact that is well known to this subcommittee, but only small differences between urban and rural providers in the same region. To us, this suggests that access to care is similar for rural and urban beneficiaries. We also find that beneficiaries' satisfaction with access is similar for rural and urban Medicare beneficiaries.

On the issue of quality of care, we find that quality provided by rural providers is similar for most types of services, although rural hospitals have somewhat higher mortality and score less well on some process measures of care.

In part, these differences may be due to lower volume in rural hospitals and different incentives for coding accurately as well as the need to provide emergency services in remote areas.

Third, on the issue of payment adequacy, we find that Medicare payments are comparable for rural and urban hospitals, and then, as for the rural special payments of which there are a dozen, we have evaluated each using three criteria: One, is the payment provision targeted to isolated providers; two, is the magnitude of the adjustment empirically justified; and three, does the special payment preserve incentives for cost consciousness?

For many of the 12 special payment provisions, targeting could be tighter in the magnitude of the adjustment that are justified, although the same might be said of some of the urban special payments as well.

With that, Mr. Chairman, I am happy to answer your questions.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare
Payment Advisory
Commission

TESTIMONY

***TESTIMONY IS EMBARGOED UNTIL 10:00 AM
TUESDAY, JUNE 19, 2012***

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

June 19, 2012

Statement of

Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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

Glenn M. Hackbarth, J.D., Chairman • Robert Berenson, M.D., F.A.C.P., Vice Chairman • Mark E. Miller, Ph.D., Executive Director
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Chairman Herger, Ranking Member Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's June Report to the Congress and our recent recommendations on Medicare payment policy.

The Medicare Payment Advisory Commission is a Congressional agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends tax dollars responsibly. 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, we examine several issues central to beneficiaries' experience of the Medicare program. While much of the Commission's work focuses on providers and their payment incentives, how beneficiaries view the Medicare program and how they make decisions about their health care are vital to the program's success. Aligning incentives for beneficiaries and providers and the design of the program has the potential to improve health, to improve the experience of health care provided through Medicare, and to control costs for the beneficiary and the taxpayer alike. In our June report we review:

- The design of the fee-for-service (FFS) Medicare benefit package, which has remained essentially unchanged for Part A and Part B since the creation of the program in 1965. We recommend creating an out-of-pocket maximum cost-sharing amount to protect beneficiaries against high medical expenses; replacing coinsurance with fixed-dollar copayments; giving the Secretary authority to adjust cost sharing according to the value of the service; and including a charge on supplemental insurance to account, in part, for the additional cost supplemental coverage imposes on Medicare.
- Care for beneficiaries in rural areas of the United States, including access to care for rural beneficiaries, the quality of the care they receive, special rural payments, and the adequacy of payments for rural providers. We also develop and bring forward several principles to help formulate and guide rural policies in the future.

- Improving care coordination for beneficiaries dually eligible for Medicare and Medicaid, a population that may benefit the most from improved care coordination, including recommendations to make the Program of All-Inclusive Care for the Elderly (PACE) program more effective and available. We also discuss issues involving forthcoming demonstrations to integrate Medicare and Medicaid's care for the dual-eligible population, including subgroups of dual-eligibles with special needs.
- Risk adjustment for Medicare payments to Medicare Advantage (MA) plans. Accurate risk adjustment is essential to pay plans correctly. Although not a central issue for beneficiaries themselves, risk adjustment can create incentives for MA plans to select beneficiaries with certain characteristics because a plan's financial performance will be determined by the mix of beneficiaries it enrolls.
- An assessment of care coordination for beneficiaries in FFS Medicare with an emphasis on the results of past Medicare care coordination demonstration projects and a review of new models.
- Medicare's payment for home infusion. We examine issues related to Medicare payment for infusion of drugs in the beneficiary's home and the circumstances under which enhanced coverage could better meet the beneficiary's needs and save money for the program.

In an appendix, as required by law, we review CMS's preliminary estimate of the update to payments under the physician fee schedule for 2013.

Reforming Medicare's benefit design

Medicare's FFS benefit package under Part A and Part B has remained substantially unchanged since 1965. During that time, insurance products in the private sector have undergone numerous changes, medical technology has evolved radically, and Medicare payment systems have changed as well. Because Medicare FFS prices and the amount of services beneficiaries receive have grown dramatically, some beneficiaries may now incur very large cost-sharing liability (i.e., medical bills remaining after Medicare has paid its share). The fact that no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur under the current benefit design is thus a great concern. Although the chance of a beneficiary experiencing catastrophic liability in any one year may be relatively low, as shown in Table 1, the probability of a beneficiary experiencing very high liability increases over multiple years. For example, while only 6 percent of beneficiaries would see $5,000 or more in annual cost sharing liability in any one year, 13 percent could expect to see that much liability in any one of four years.

Table 1. More beneficiaries would be better off with an out-of-pocket maximum over time

Fee-for-service beneficiaries who had:	2009	2006–2009
1 or more hospitalizations	19%	46%
2 or more hospitalizations	7	19
$5,000 or more annual cost sharing liability	6	13
$10,000 or more annual cost sharing liability	2	4

Source: MedPAC analysis based on data from CMS.

In part due to the limitations of the FFS benefit design, about 90 percent of beneficiaries receive supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. This additional coverage protects beneficiaries from unlimited out-of-pocket (OOP) spending, but it also reduces their incentives to weigh decisions about the use of care because many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements. Moreover, most of the costs of the resulting increased utilization are borne by the Medicare program. As a matter of equity among beneficiaries and fiscal sustainability, Medicare should recover at least some of those additional costs.

The Commission recommends reforming the traditional benefit package so that it would:

- Protect beneficiaries better against high and unpredictable OOP spending by including an OOP cap and substituting fixed copayments for coinsurance that varies with the price of a service. The OOP cap would also increase equity among beneficiaries by giving all beneficiaries protection against catastrophic expenses. Now only those who can afford to purchase supplemental insurance (or receive it through an employer or Medicaid) have this essential protection.

- Not increase average beneficiary cost-sharing liability, nor reduce the actuarial value of the Medicare benefit package to achieve these beneficiary protections.

- Give the Secretary flexibility to change cost-sharing rules, which would provide a way to recognize that services can be of different and changing value to the program and its beneficiaries. Current law makes it difficult to change Medicare's benefit design as our health care system evolves. Congress would retain ultimate control over the benefit package and its design.

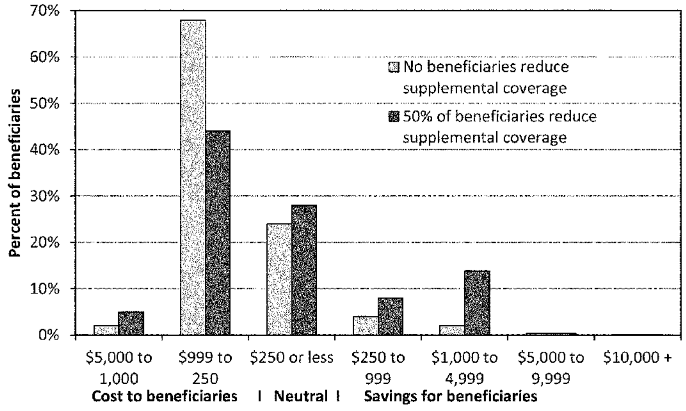
To pay for the increased protection in this design while keeping average beneficiary liability unchanged, we included an additional charge on supplemental insurance (we have excluded MA plans—because the MA plan, not Medicare, is at risk for benefit designs that increase costs relative to their capitation payments—and Medicaid; thus the charge is only on medigap or employer-sponsored retiree plans). That charge funds the OOP cap and is designed to recover some of the cost of the increased utilization resulting from supplemental insurance that is now borne by the program. Beneficiaries who now have supplemental insurance would have the option of retaining it and paying the additional charge, choosing a less expensive plan, or dropping supplemental insurance entirely. The latter options would be more attractive than they were previously because of the increased protection in the reformed Medicare benefit. They would also have the additional salutary effect of creating stronger incentives for beneficiaries to make better decisions about their use of discretionary care. Beneficiaries would also continue to have the option of joining an MA plan.

Some have proposed prohibiting first dollar coverage in supplemental policies, which would require beneficiaries to pay a copayment or coinsurance for every service they receive. However, the Commission believes that such an unwieldy regulatory approach may unduly limit beneficiary choice; we believe that risk-averse beneficiaries should be allowed to purchase supplemental insurance, but at a price that better reflects the increased costs to Medicare induced by such insurance.

In the report, for illustration, we demonstrate how a benefit design meeting those goals could result in a cap on beneficiaries' OOP liability while leaving the average cost-sharing liability of beneficiaries unchanged. The illustrative design incorporates a $5,000 per year OOP maximum and a schedule of copayments including $20 for a primary care visit and $40 for a specialist visit. It includes an additional charge of 20 percent on supplemental insurance, which yields modest net savings to Medicare under the reformed benefit package. The specific amount of savings depends on how many beneficiaries choose to scale back or no longer purchase supplemental insurance.

The analysis that follows helps illustrate how beneficiaries under different circumstances might fare under a reformed benefit design. In Figure 1 we look at two scenarios. In the first scenario (the light colored bars) no beneficiaries decide to reduce supplemental coverage. Many would see an increase in combined OOP costs and supplemental premiums because of the 20 percent additional charge, with almost 70 percent seeing additional costs of $250 or more. For just over 20 percent the change would be about neutral with savings or costs of $250 or less. Few would see savings.

Figure 1. More beneficiaries would see savings as they reduce supplemental coverage



Source: MedPAC based on CMS data.

In the second scenario (the dark bars), half of the beneficiaries are assumed to reduce supplemental coverage because of the greater protection against unpredictable OOP costs. Fewer beneficiaries than in the first scenario see higher costs (for example, the percentage with additional costs of $250 to $999 declines from about 70 percent to just over 40 percent) and more would see savings, with over 20 percent seeing savings of $250 or more.

There would be more beneficiaries seeing significant savings because many would no longer be paying supplemental premiums (the percentage with savings between $1,000 and $4,999 increases from 2 percent to almost 14 percent) and some would see very large savings because of the OOP maximum. It is important to note that premiums for supplemental insurance exceed the expected value of supplemental benefits. Beneficiaries are willing to pay these premiums because they are risk averse and value the additional insurance protection. The illustrative benefit package would provide a sense of security by protecting against unpredictable OOP costs and some beneficiaries would reduce supplemental coverage. Those beneficiaries would very likely see savings as a result. Figure 1 is limited to one year of data. More beneficiaries would be likely to see savings over multiple years, because, as shown in Table 1, more beneficiaries are exposed to the risk of a catastrophic expense over a longer period of time.

Under this illustrative benefit design, some beneficiaries will see an increase in their OOP costs. This increase funds the catastrophic protections for beneficiaries with expenses exceeding $5,000 and keeps the average beneficiary's financial liability unchanged.

We have simulated the effects of the particular design outlined in the report to illustrate how a reformed benefit design could work. Because of the many tradeoffs and considerations in any benefit design, we are not recommending a particular detailed design. Rather, the Commission recommends that the Congress should direct the Secretary to develop and implement a FFS benefit design that would replace the current design and would include:

- an OOP maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- 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 OOP maximum;

- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on individually purchased and employer-provided supplemental insurance.

Serving rural Medicare beneficiaries

The Patient Protection and Affordable Care Act of 2010 required that the Commission report to the Congress on:

- rural Medicare beneficiaries' access to care,
- quality of care delivered by rural providers,
- special rural Medicare payments, and
- the adequacy of Medicare payments to rural providers.

In addition to the findings presented on each of those four topics, we also present a set of principles that are designed to guide expectations and policies with respect to rural access, quality, and payments. By following this set of principles, Medicare policy can be refined to more efficiently provide access to high-quality care for rural beneficiaries.

Methods

We realize that there is great diversity in rural America and tailored our data collection and analysis to address that. We used multiple sources for our data, including:

- Beneficiary focus groups, site visits to providers in rural areas, meetings with associations representing rural beneficiaries and providers, and input from our own Commissioners with extensive experience as rural providers and/or serving rural Medicare beneficiaries,
- Beneficiary survey data, including the Commission's national telephone survey,
- Examination and analysis of claims data to evaluate beneficiaries' service use and certain outcomes (such as mortality and readmissions), and
- Examination and analysis of cost report data to evaluate providers' costs and the profitability of serving Medicare beneficiaries.

In the analysis, where possible, we subdivide rural areas into categories based on proximity to urban areas and population:

- Metropolitan (urban)

- Rural micropolitan: counties with a city of 10,000 to 50,000 people
- Rural adjacent: counties without a town of 10,000 or more people that are adjacent to urban areas
- Rural nonadjacent: counties that are not adjacent to an urban area and do not have a town of 10,000 or more people
- Frontier: counties with a population density of six or fewer people per square mile. (The Commission makes this distinction where possible.)

These detailed analyses are available in our June report.

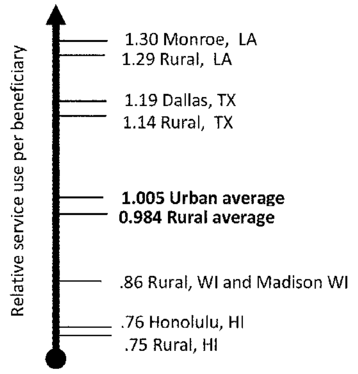
Access

When evaluating access, we focus on beneficiary-centered indicators rather than provider-centered ones. These indicators include patient claims data, beneficiary surveys, and beneficiary focus groups.

Looking at utilization of health care services, we find that despite lower physician-to-population ratios and difficulties of recruiting physicians to practice in rural areas, beneficiaries in urban and rural areas used comparable amounts of health care in every service we examined and across the spectrum of rural areas (from those adjacent to urban areas to those in sparsely populated frontier counties). For example, beneficiaries in urban areas have about 10.1 office or outpatient visits per year, and beneficiaries in the five categories of rural areas have between 10.7 and 9.8. Similarly, they experience very similar rates of hospital admissions, averaging from 0.31 to 0.35 per year in the five rural areas and 0.33 in urban areas. This might seem counterintuitive given that there is a lower ratio of physicians to beneficiaries in rural areas than in urban areas. However, rural beneficiaries travel for care and obtain about 30 percent of their care in urban areas. As a result they have somewhat longer travel times. One study found that 41 percent of rural residents traveled more than 30 minutes for medical care, compared with 25 percent for urban residents.

Although we find very similar use of health care services across the urban and rural spectrum at the national level, there are significant differences in health care service use by Medicare beneficiaries across regions of the country. However, there is little difference between rural and urban beneficiaries' service use within those regions. In Figure 2, we see that at the national level service use in urban areas relative to the national average is 1.005 and in rural areas 0.984, a very small difference. However there are large differences between regions of the country, ranging from 0.76 to 1.30 relative to the national average in urban areas. Looking at regions where service use is high, such as Louisiana, service use is high for both urban beneficiaries (1.30) and for rural beneficiaries (1.29). Similarly, in low-use regions such as Hawaii, service use is low for urban beneficiaries (0.76) and also for rural beneficiaries (0.75).

Figure 2. Urban and rural service use is similar within states, but wide regional variation exists



Source: MedPAC analysis of beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims data.

Beneficiaries in rural and urban areas also report similar levels of satisfaction with access to care, even if some rural beneficiaries have to travel outside their area to obtain care. In Table 2, we display several measures of patient experience. The results are very similar across all of these measures in both urban and rural areas with slight differences. For example, slightly fewer urban beneficiaries (78 percent) report no problem getting a new primary care physician than rural beneficiaries (83 percent), while the reverse is true for specialists.

Table 2. Urban and rural satisfaction with access is similar

Selected patient experience questions	Urban	Rural
Never experience unwanted delay in getting an appointment		
• For routine care	76%	72%
• For illness or injury	83	83
No problem getting a new physician		
• Primary care	78	83
• Specialist	88	85
Rate their hospital highly	67	67
Rate their hospital poorly	9	8
Definitely would recommend hospital	70	67
Definitely would not recommend hospital	6	5

Source: MedPAC telephone survey conducted from May to September 2010 on physician access and MedPAC analysis of Hospital Consumer Assessment of Healthcare Providers and Systems data, accessed July 2011.

We find the volume of care is comparable with and without adjustments for health status. Notwithstanding, some are concerned that rural populations have a significantly greater illness burden than urban populations that is not detected by Medicare claims data. However, we see no clear evidence that rural Medicare beneficiaries are older, are sicker, or consistently live in communities with greater levels of poverty. For example, rural beneficiaries' self-reported indicators of health are not consistently lower or higher than those in urban counties, as indicated by limitations in activities of daily living (ADLs), self-reported health, and several clinical conditions. Although some rural areas tend to have poor and sick populations (looking across Medicare beneficiaries and others), differences in health status and wealth appear to differ far more among regions of the country than across the rural/urban continuum.

Considering these findings, the Commission has determined this ***principle for access: All beneficiaries, whether rural or urban, should have equitable access to health care services. However, equitable access does not necessarily mean equal travel times for all services or that all services are available locally.***

Beneficiaries in small rural communities often have to travel farther to see specialists because there are too few local residents to support some specialties, but that does not mean they do not have access to those services. We evaluate whether beneficiaries have equitable access by examining the volume of services received, as well as beneficiaries' reported satisfaction with access to all services.

Quality

With respect to quality of care, we do not find major differences in quality between urban and rural providers in most sectors. Patient satisfaction is similar, and quality measures for skilled nursing facilities, home health agencies, and outpatient dialysis facilities do not show major differences between urban and rural providers or across the rural spectrum. For example, the average rate of potentially avoidable hospitalizations from skilled nursing facilities is 19 percent in urban areas and the same or lower in rural areas. Similarly, hospital readmission measures do not point to major differences based on rural or urban location. However, we do find that rural hospitals do not perform as well as urban hospitals on most process measures and on condition-specific 30-day mortality rates—consistent with long-standing findings in the literature—even after adjusting for the effect of low-volume.

We have determined the following ***principles for quality: Quality metrics should be reported by even the smallest providers. Expectations for quality of care in rural and urban areas should be equal for nonemergency services rural providers choose to deliver. By contrast, emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural health care providers.***

When measuring the quality of emergency care, for example, low-volume rural hospitals' performance on quality of emergency care could be compared to the average for other small hospitals, rather than the average for all hospitals. Alternatively, a small hospital's quality outcomes for emergency care could be compared to the expected outcomes if that hospital no longer offered emergency care and patients had to travel longer distances for emergency services.

Payment

With respect to payment, we find that in general the adequacy of FFS payments to rural providers does not differ systematically or significantly from the adequacy of urban providers' payments. On average, freestanding rural skilled nursing facilities and home health agencies have margins for Medicare patients similar to those of urban providers, with some rural and urban agencies having relatively high margins. When we examined the adequacy of physician payments, we found similar service use rates, similar ability to obtain appointments with existing and new physicians, and similar satisfaction with access. These indirect indicators suggest that payments to rural physicians are at least as adequate as those made to urban physicians. In addition, physician incomes per hour are comparable in rural and urban areas. However, the Commission has raised concerns about the adequacy of payments to primary care physicians relative to payments to subspecialists—concerns that apply to physicians in both rural and urban areas. A greater share of physicians in rural areas are primary care physicians.

Medicare payments are as adequate for rural hospitals as for urban hospitals, in part due to implementation of certain increases in rural hospital payments that followed from previous Commission recommendations. As a result, the number of rural hospital closures has declined dramatically in recent years. However, when we look at the current array of rural payment adjusters through our analytic framework, we find some problems. For example, the critical access hospital program has grown to more than 1,300 hospitals, and 16 percent of them are less than 15 miles from the nearest hospital. The low-volume adjustment (originally designed to take into account a hospital's total volume because that is what determines economies of scale) is now based only on the number of Medicare admissions, and thus perversely favors hospitals with larger non-Medicare shares. Looking at these and other examples, the Commission has determined the following ***principles for special payments:***

- ***Payments should be targeted toward low-volume isolated providers—that is, providers that have low patient volume and are at a distance from other providers.***
- ***The magnitude of special rural payment adjustments should be empirically justified. That is, the payments should increase to the extent that factors beyond the providers' control increase their costs.***
- ***Rural payment adjustments should be designed in ways that encourage cost control on the part of providers.***

Care coordination programs for dual-eligible beneficiaries

Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits and, given the medical complexity of some sub-populations, could particularly benefit from improved care coordination. In 2010, there were approximately 9.9 million dual-eligible beneficiaries—accounting for about 18 percent of Medicare FFS enrollment and 31 percent of Medicare FFS spending. They also account for about 15 percent of Medicaid enrollment and 40 percent of Medicaid spending. These individuals are often high cost; require a mix of medical, long-term care, behavioral health, and social services; and have more limited financial resources than the general Medicare population. Programs that help dual-eligible beneficiaries access and coordinate services could improve their quality of care and may have the potential to reduce Medicare and Medicaid spending.

We reviewed the two main integrated care programs for dual-eligible beneficiaries—PACE and dual-eligible special needs plans (D–SNPs)—and examined the structure of their care coordination models, quality outcomes, and Medicare payments. We also examined a set of demonstration programs in development by the states and CMS.

PACE is a provider-based integrated care program structured around day care centers, which serve about 21,000 beneficiaries this year. PACE makes it possible for frail beneficiaries to remain in the community, and there is evidence that the program improves the quality of care relative to FFS. We also found that: PACE sites operate on a small scale, enrollment in the PACE program is generally slow, PACE providers reported that they were able to reach positive margins after a few years of operation, and Medicare spending on PACE exceeds FFS spending for similar beneficiaries. PACE payments are based on the MA payment rates in force before enactment of the Patient Protection and Affordable Care Act of 2010; those rates are significantly higher than current law MA benchmarks, which govern payment for D–SNPs.

To make the PACE program accessible to more beneficiaries and to pay more accurately, the Commission recommends that the Congress should direct the Secretary to improve the MA risk-adjustment system. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay PACE providers based on the current MA payment system for setting benchmarks and quality bonuses. These changes should occur no later than 2015. After these changes are made:

- the Congress should change the age eligibility criteria for PACE to allow nursing home–certifiable Medicare beneficiaries under the age of 55 to enroll, and
- the Secretary should provide prorated Medicare capitation payments to PACE providers for partial-month enrollees and establish an outlier protection policy for new PACE sites to use during the first three years of their programs.

In addition, the Congress should direct the Secretary to publish select quality measures on PACE providers and develop appropriate quality measures to enable PACE providers to participate in the MA quality bonus program by 2015.

In contrast to the provider-based PACE program, D–SNPs are managed care plans that focus their enrollment on dual-eligible beneficiaries. D–SNPs enrolled about 1.16 million beneficiaries for plan year 2012. Some have state contracts to cover all of a state's Medicaid benefits, including long-term care, and some do not. We were not able to conclude whether D–SNPs provide better quality of care than FFS or other MA plans because of a lack of available quality data. Using the measures that are available for D–SNPs, we found that their quality of care is generally mixed. We found that plan bids for Medicare Part A and Part B services and Medicare spending on D–SNPs both exceed FFS spending, which raises the question of whether these plans can provide Part A and Part B services at a cost that is equal to or below FFS.

CMS is in the process of working with states to promote the development of integrated care demonstration programs. CMS has offered states the opportunity to test a capitated model or a managed FFS model. As the demonstrations are developed, a number of issues must be addressed:

- Is the scale of the demonstration in some states too large? Will the size of the demonstrations leave adequate comparison groups, and is there an orderly process for disenrollment if the demonstration fails?

- Are there plans with the requisite experience and capacity to handle the large scale of the demonstration?
- How will beneficiaries be matched to care delivery organizations that are appropriate to meet their needs under passive enrollment models, and can an opt-out enrollment policy be structured to accommodate beneficiaries with cognitive and other limitations?

The Commission's greatest concern is that all dual-eligible beneficiaries in a state will be enrolled in the demonstration—in effect, a program change rather than a demonstration. The Commission will continue to consider this and other concerns as we move forward.

Issues for risk adjustment in Medicare Advantage

Health plans that participate in the MA program receive monthly capitated payments for each Medicare enrollee. Each capitated payment is the product of: 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. If Medicare's risk-adjustment for MA systematically favors the selection of beneficiaries with less complex conditions over others, it could create incentives for plans to design their benefit packages and focus their marketing to preferentially attract those beneficiaries. Alternatively, if a plan's care delivery strategy focuses on patients who require the most complex care, such as those enrolled in D–SNPs, it could be disadvantaged. We examined the performance of the risk-adjustment system in the MA program and offer alternatives for improving its performance.

CMS uses the CMS–hierarchical condition category (CMS–HCC) model to risk-adjust each MA payment. This model uses enrollees' demographics and medical conditions collected into 70 HCCs to predict their costliness. It is a much better predictor of a beneficiary's costliness than the demographic-based model that preceded it. The demographic model explained only about 1 percent of the variation in costliness among individual beneficiaries, whereas the CMS–HCC model explains about 11 percent—about half of the variation predictable from past spending.

Nonetheless, systematic payment inaccuracies remain. For example, for all beneficiaries who have the same condition, the CMS–HCC model adjusts MA payments by the same proportion.

But disease severity can vary across beneficiaries with a given condition, and those with greater severity tend to be more costly. Therefore, for a given condition it is possible that plans can be financially advantaged or disadvantaged based on the disease severity of their enrollees.

Not only can systematic payment inaccuracies in the CMS–HCC result in opportunities for favorable selection in the MA program, plans that focus on high-risk populations, such as SNPs and PACE, may be adversely affected. If high-risk populations—such as those who have many conditions—are systematically underpaid, then plans specializing in high-risk populations will be at a financial disadvantage.

We explored several policy options for reducing these errors. We found that:

- Including beneficiaries' race and measures of income does not improve payment accuracy.
- Including the number of medical conditions a beneficiary has in the model improves payment accuracy.
- Using two years of diagnoses to identify beneficiaries' conditions improves payment accuracy for high-risk beneficiaries (but to a lesser extent than adding the number of conditions) and also reduces year-to-year fluctuations in beneficiaries' risk scores—which would result in more stable revenue streams for MA plans.
- Adding the number of conditions and two years of diagnosis data to the model results in more accurate payments and smaller year-to-year fluctuations in beneficiaries' risk scores.

Care coordination in fee-for-service Medicare

The lack of care coordination in the health care delivery system can negatively impact patients. Negative outcomes include unnecessarily repeated medical histories and tests, inconsistent medical instructions, poor transitions between sites of care, and unnecessary use of higher intensity settings. Gaps exist in care coordination because of the fragmentation of service delivery, the lack of tools to easily communicate across settings and providers, and the lack of a financial incentive to coordinate care. These gaps are particularly important for Medicare beneficiaries because they are more likely to have multiple chronic conditions than younger patients and thus more involvement with the health care system.

Findings from recent Medicare demonstrations on care coordination and disease management models have not shown systematic improvements in beneficiary outcomes or reductions in Medicare spending. Despite those findings, many health care providers and researchers still see significant potential for care coordination programs to improve care. The most successful model in the Medicare demonstrations emphasized restructuring systems to support a care coordination intervention. This finding supports the conclusion that successful care coordination cannot be a “plug-in module” but must be an integral part of the system providing the care.

Ideally, as more integrated payment and delivery systems evolve, the incentives for greater care coordination inherent in such systems will develop as well, leading to greater care coordination. However, in the interim, additional methods for encouraging care coordination may need to be pursued, including those that make explicit payments for related services to primary care clinicians—the linchpin of more coordinated care and eventual system redesign.

Policy options to improve care coordination in the current FFS system could include creating a per beneficiary payment for care coordination, adding codes or modifying existing codes in the fee schedule that would allow practitioners to bill for selected care coordination activities, and using payment policy to reward or penalize outcomes resulting from coordinated or fragmented care.

Medicare coverage of and payment for home infusion therapy

The Congress requested the Commission to conduct a study on home infusion therapy. Home infusion involves the intravenous administration of drugs to an individual at home. Home infusion involves several components (drugs, supplies, equipment, and nursing). Medicare FFS covers some or all components of home infusion, depending on the circumstances, with total program spending of about $1 billion in 2009. The Commission was asked to assess the benefits and costs associated with providing infusions in the home versus alternative settings, including whether savings could be achieved from broader Medicare coverage of home infusion. In addition, the Commission was asked to examine sources of data that could be used for setting home infusion payment rates, coverage and payment for home infusion by commercial insurers and MA plans, and potential abuse of a home infusion benefit.

We found that the most common payment method used by private health plans included a payment for drugs; a separate payment for nursing as needed; and a per diem amount covering supplies, equipment, pharmacy services, and additional services. Providers we interviewed described a wide range of payment levels for per diem services. All plans use utilization management techniques, particularly prior authorization, to ensure that home infusion is provided appropriately.

Whether home infusion yields Medicare savings or costs for an individual beneficiary depends on the setting where the beneficiary otherwise would have received infusions, how payments compare between infusion in the home and the alternative setting, how frequently the drug is infused, and how often home nurse visits are needed. Some opportunities likely exist to achieve savings for beneficiaries who would otherwise be admitted to skilled nursing facilities for the sole purpose of receiving infusions; savings from moving infusions from other sectors to the home may also be possible under certain circumstances. Home infusion would likely cost the program more if a beneficiary moved from receiving infusions in an outpatient department and required a nurse at the home for all infusions.

For expanded home infusion coverage to realize overall savings for Medicare, any savings from shifting infusion to the home would need to exceed the additional costs to Medicare of home infusion services and supplies, or those that would otherwise have been paid by other insurers or beneficiaries. The cost implications of broader home infusion coverage vary by drug. Thus, a targeted expansion of home infusion coverage focusing on a subset of drugs would have a greater likelihood of savings than a broad expansion. However, we cannot draw conclusions about net savings or costs with the data currently available.

Collecting the data needed for constructing a home infusion payment system would be difficult. Current data on the cost associated with providing home infusion services are very limited; options for additional data might include Medicare payment rates for similar services—such as the rate for a home health visit—or information gleaned from competitive bidding. Alternatively, the feasibility of obtaining data on providers' acquisition costs or manufacturers' sales prices for equipment and supplies could be explored.

In the report, we discuss two approaches for increasing access to home infusion: filling in the gaps in current coverage and setting up a demonstration project for beneficiaries who need infused antibiotics. In general, Medicare has had less ability to monitor care provided in the home than in facility settings and it has been more difficult to create payment systems with incentives for appropriate utilization. While private payers have not reported fraud to be a problem in the home infusion industry, a broad, unmanaged expansion of Medicare FFS coverage could lead to fraudulent actors entering the field. To ensure appropriate utilization of such a benefit, management controls such as prior authorization would likely be needed. The demonstration project could test Medicare's ability to administer a targeted prior authorization policy designed to improve quality of care and reduce costs. A successful program in the specific context of home infusion could be expanded to other candidate components of FFS Medicare.

Chairman HERGER. Thank you.

As you noted in your report and as this subcommittee discussed at a previous hearing, the Medicare benefit has not changed in structure since its inception in 1965.

Can you please explain why the commission felt it was necessary to offer recommendations on how the fee-for-service benefit should be redesigned?

Mr. HACKBARTH. The most important element of any insurance program should be to protect people against the very high cost of illness. And as you well know, Medicare does not include any catastrophic limit on out-of-patient costs. In addition to that, the existing structure of patient cost sharing is quite complicated and very difficult for many beneficiaries to understand. We have this complex web of copayments and co-insurance that can be, frankly, a little bit bewildering to all of us, not to mention to many Medicare beneficiaries.

That lack of catastrophic coverage and the complexity of the benefit's cost sharing creates uncertainty and anxiety among Medicare beneficiaries and we believe contributes to the demand for supplemental insurance as a way of buying protection against this uncertainty.

We think that by redesigning the benefit package along the lines we have described, we could update it and make it more consistent with modern benefit design, reduce uncertainty and more fairly distribute the burden of costs for Medicare beneficiaries.

Chairman HERGER. Thank you.

As someone who represents a rural district, I am well aware of how challenging it can be for some rural providers to remain viable, and I completely agree that we need to make sure that rural beneficiaries have access to quality care while also being responsible to the taxpayers footing the bill for the program.

As Congress has to make tough decisions pertaining to specific payment adjustment policies, can you elaborate on your principles for evaluating special payments with an example of how to apply them?

Mr. HACKBARTH. Sure. So our three principles are that a special payment adjustment should be targeted to isolated providers. By that, we mean a provider that if that provider were to go out of existence, that it would compromise needed access to care for Medicare beneficiaries.

Second, we think that the amount of the adjustment ought to be based on data as opposed to just grabbed out of the air. So an example of that would be if we adjust for low volume, providers have higher costs when they have low volume; MedPAC has recommended in the past that there be a low volume adjustment. But we think that the amount of the adjustment ought to be consistent with how much costs increase when you have low volume, and we don't think that the current low volume adjustment is justified in that way.

The third principle is that wherever possible, we would like the payment adjustment to be an add on to a prospective payment, which retains the incentives for cost consciousness, as opposed to just moving to cost reimbursement, which would eliminate those incentives.

Chairman HERGER. I appreciate the comission's work to figure out which approaches can improve the coordination of care in our too often fragmented health care system. I am interested in the notion of establishing payment policy that rewards good patient outcomes.

In fact, we heard testimony from a private health plan at a previous subcommittee hearing that uses such an approach that providers decide who they want to collaborate with and collectively determine what they need to do to provide high-quality efficient care. Does the commission believe that giving providers the flexibility to determine how best the care for their patient population is a promising approach?

Mr. HACKBARTH. One of the lessons that we draw from the demonstration projects that have been run in CMS on care coordination is that to be successful, a program of care coordination has to be carefully woven into the practice environment where it occurs. It is not possible to achieve good care coordination by imposing it externally. It is not the sort of thing that you can design from a distance and just sort of plug into a local health care delivery system.

Instead, it needs to be more organic and part of the care delivery. So our general approach is to say that Medicare should move away from fee-for-service payment to payment systems that establish both financial and clinical responsibility for a defined population or for an episode of care and then allow providers the flexibility to adapt care coordination to their particular circumstances but hold them accountable for the results, both on quality and cost.

Chairman HERGER. Thank you.

Mr. Stark is now recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman.

Again, Chairman Hackbarth, thank you very much.

In reforming the benefit design, you have got both a cap to protect high out-of-pocket costs and changes to the supplemental insurance, and I have reservations about the Medigap policy which would increase costs for beneficiaries, but I agree that the catastrophic cap would be an improvement.

I am afraid that some people might separate this and do the Medigap policy without the cap. And why do you recommend that both of these policies happen together?

Mr. HACKBARTH. Yes. We, first of all, let me say we do think that they should be done together. And as I said in my opening comment, we think that they are linked. In fact, that one of the reasons that beneficiaries want to have supplemental coverage is because of the inadequacies in the design of the existing Medicare benefit. And so we believe that if we correct those flaws, add catastrophic coverage, make the cost sharing more predictable and understandable, that that will reduce some of the demand for supplemental coverage, and then, in that context, we think it is appropriate to say if the beneficiary continues to want to buy supplemental coverage, they should face at least a portion of the additional costs that imposes on Medicare.

Mr. STARK. In your recommendations, the current cost sharing stays the same in the aggregate. So even though some beneficiaries see costs go up and some will see them go down, the average beneficiary will stay the same.

Now why was this important as a principle?

Mr. HACKBARTH. When we look at the Medicare benefit package and compare it to benefit packages offered in the private market, we don't think that the existing Medicare benefit package is too rich compared to what exists for, say, a privately insured population. In fact, given the population covered, the elderly with higher health care costs, if anything it might be too lean not too rich.

We recognize of course the fiscal constraints that exist, and so we adopted the guiding principle that we ought to not make it richer or leaner, keep it as it is in terms of actuarial value but reallocate the costs.

Mr. STARK. But you have got, with the catastrophic cap, the average liability you say remains the same, but won't there be some will see the cost go down by about 250 and the others up. But, as I understand it, you are going to have a lot more see their costs go up than down. Is there any reason for that?

Mr. HACKBARTH. Well, that is the way——

Mr. STARK. How it comes?

Mr. HACKBARTH [continuing]. That is the way the numbers work. Generally speaking, the beneficiaries who would see their costs go down are those that have very high expenses and benefit from the catastrophic limit. This is what insurance should be doing. This is the first responsibility of a good insurance program.

The beneficiaries who would see their costs go up under our redesign would be beneficiaries who tend to use fewer services especially the beneficiaries that use only Part B services and do not have a hospital admission.

It is important to note, though, that if you look at 1 year, a 1 year snapshot, you have got this array of winners and losers. But for any given beneficiary, the risk of incurring high cost goes up over time. So if you look at the measure of the risk of having a hospital admission in a given year, in any 1 year, the average beneficiary has a one in five risk of being hospitalized. But if you look over a 4-year period, it is one in two; half of all beneficiaries will have at least one hospitalization in a 4-year period.

So having that extra coverage for a catastrophic illness we think makes a lot of sense and, over time, will benefit most beneficiaries.

Mr. STARK. Thanks again for your testimony.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Hackbarth, in your recommendations dealing with additional charge for supplemental insurance, I got to agree with Pete. The commission feels supplemental insurance coverage leads to increased utilization of services.

Can you talk about why you think it is important to address Medicare supplemental coverage and what effects your proposal would have on Medicare spending and beneficiary behavior?

I am of the belief that if a guy thinks he needs extra coverage over and above Medicare, he ought to be able to buy it and not pay a premium. Go ahead.

Mr. HACKBARTH. We share your belief that if a beneficiary thinks that they need supplemental coverage, that they should be free to buy that coverage, and that is why we didn't propose any regulatory restriction on the ability to buy supplemental coverage.

Having said that, the evidence to us is clear that that private decision to buy supplemental coverage increases costs for the Medicare program and the taxpayers. And we think that it is appropriate for the beneficiaries who make that private decision to buy supplemental coverage to face at least a portion of the additional cost that it imposes on taxpayers.

Mr. JOHNSON. You say you think. Do you have empirical data that proves it?

Mr. HACKBARTH. That costs go up with supplemental coverage?

Mr. JOHNSON. Yes.

Mr. HACKBARTH. Yes, we do.

Mr. JOHNSON. And is there any one part of the country where it is more prevalent than another?

Mr. HACKBARTH. That supplemental coverage is more prevalent than others?

Mr. JOHNSON. Yes.

Mr. HACKBARTH. I would be happy to get data on that for you. I don't have the data in my head, Mr. Johnson. I am sure there are variations.

Mr. JOHNSON. Okay. Did the commission look at the health status of the beneficiaries that were involved in that decision?

Mr. HACKBARTH. Yes.

Mr. JOHNSON. And could it be that the beneficiaries are just doing treatment and procedures determined by their doctor based on their health needs instead of just going to the hospital?

Mr. HACKBARTH. We believe that the evidence shows that the increased use in services from supplemental coverage is especially large on discretionary services.

So if you look at the effect of supplemental coverage on hospital admissions, the effect is relatively low because most hospital admissions are not discretionary. There is a much larger increase in services in the areas that are more discretionary.

Mr. JOHNSON. Are there any concerns that if some beneficiaries don't have supplemental coverage that they might put off treatment or a procedure until it is too late when the cost is much higher than it could have been?

Mr. HACKBARTH. We think that when you take into effect, take into account all of the different effects that imposing the supplemental charge on, the charge on supplemental insurance is warranted and will result in lower costs for the Medicare program.

Mr. JOHNSON. How do you account for that? What makes you believe that?

Mr. HACKBARTH. The empirical research that we and others have done.

Mr. JOHNSON. I am wary of that. What happens to beneficiaries if only some of the recommendations are implemented if the additional charge is implemented without making the benefit package better for beneficiaries, and could that result in beneficiaries' dropping their coverage and then having to a pay more for their health care in the long term?

Mr. HACKBARTH. Again, we think that all of these recommendations that we have made on benefit redesign are a package and should be done together, not one without the other. So we would not support the charge on supplemental insurance without the benefit redesign.

Mr. JOHNSON. You know you are charging people for buying extra insurance; that is like putting an extra charge on a gasoline tank because you are buying gasoline. I don't understand that. I think it is wrong, by the way.

Go ahead. I think my time is about expired.

Mr. HACKBARTH. May I respond to that, sir?

Chairman HERGER. Yes.

Mr. HACKBARTH. The difference is that the charge on gasoline—the purchase of gasoline does not increase the cost for taxpayers, the individual decision to buy purchase gasoline. The individual decision to purchase supplemental coverage, the costs of that are not borne by the beneficiary. Most of the costs of that are borne by the taxpayers and that is why we think the charge is warranted in this case.

Mr. JOHNSON. What about not having any health insurance at all? Under your condition, any time we buy health coverage, it is going to raise the cost of health care, according to you.

Mr. HACKBARTH. That is a completely different issue. Here we are talking about——

Mr. JOHNSON. No, it is not. It is insurance.

Mr. HACKBARTH [continuing]. Here we are talking about beneficiaries who are insured by the taxpayers making a private decision that further increases the burden borne by the taxpayers.

Mr. JOHNSON. Okay, thank you, Mr. Chairman.

Chairman HERGER. Mr. Kind is recognized.

Mr. KIND. Thank you, Mr. Chairman, for having this hearing. Chairman Hackbarth it is always good to have you before us and thank you for the work you and MedPAC does in preparing your report every year.

Obviously, as a representative from a large rural district in western Wisconsin, I intend to dial in quickly on what MedPAC is looking at in regards to access to care in rural versus urban areas, and certain incentive payments have been established there. I think it is important that we continue to review that. But also in light of the fact that we are dealing with some pretty tough budgets around here, I am sure the incentive payments for rural providers is something that will be considered in the context of budget discussions.

But your report now is not recommending any type of across-the-board cut as far as rural incentive payments, is that correct?

Mr. HACKBARTH. No, our approach, Mr. Kind, would be to better target adjustments using the criteria that I described earlier: Are the providers isolated? Are the adjustments empirically justified? And do they preserve incentives for cost consciousness?

Mr. KIND. Did you guys do any type of analysis on what the potential impact of some cuts for rural providers might be?

Mr. HACKBARTH. Well, again, our goal is to target as opposed to just cut across the board. And I emphasize that because there seems to be some confusion in the commentary on our report that

I have seen. And what we want to do is target, not just in order to make sure that Medicare dollars are used wisely, but it also has very important implications for the quality of care.

One of the issues that we discuss in our chapter is the relationship between volume of services and quality. And I think you know that there is a well established relationship between volume and quality.

To the extent that Medicare supports many low-volume hospitals and discourage consolidation, not only does that cost Medicare more money, it results in lower quality for rural beneficiaries.

Mr. KIND. Also, Medicare utilization data shows that Medicare use in rural provider settings is substantially higher than in urban settings, and I think approximately 46 percent of all patients in rural hospitals are Medicare beneficiaries versus 31 percent in urban facilities.

Medicare payment costs therefore have a much greater impact obviously in the rural areas than in the urban areas.

In fact, one study shows that 35 percent of all rural hospitals currently operate at a financial loss.

Do you ever look at the margins when you are doing your analysis and preparing your reports?

Mr. HACKBARTH. Yes we do. And included in the chapter is a summary of that analysis. We closely look at the margins for our March report each year, as you know, on payment updates, and we repeat some of that analysis here as well as. And many of these services, especially in the post-acute area, the margins for rural providers, as well as urban providers, are really quite high.

In the case of hospitals, the margins, Medicare margins for rural hospitals are actually higher than the Medicare margins for urban hospitals. Granted, however, that they are negative in both cases for urban and rurals. We base our payment rate recommendations for hospitals, urban and rural alike, on what we refer to as an efficient provider analysis. In fact, that is what we are required to do by statute. And suffice to say that we have concluded that both urban and rural providers can provide high quality care at the existing Medicare rates.

Mr. KIND. Obviously, the 800-pound gorilla in this hearing room today is waiting to see what the Supreme Court is going to do in the Affordable Care Act. I think there are three major revolutions occurring in the health care system that are going to continue regardless of what the Court may decide in the next week or two. One is obviously the HIT build-up, which is long overdue, and that is moving forward now and we need to continue to have that move forward. The other is delivery system reform. We have talked about this before. And the other, ultimately, is the payment reform. We need to keep striving for it so we are getting payments based on value or outcome of care. On that last point, what more can be done in order to accelerate the payment reform in the health care system?

Mr. HACKBARTH. We think there is a lot of good work underway looking at new payment methods, whether it be bundling around hospital admissions or medical homes or accountable care organizations. And we have long supported those efforts.

My biggest concern is the pace of change.

And the problem that we have collectively, all of us, is that to some extent payment reform cannot proceed without delivery system reform. The two are inextricably linked to one another. So I think that the critical question for the Medicare program as well as for private payers is what are the steps that we can take to accelerate the rate of reorganization of our care delivery system?

And that is a big topic in its own right. I think part of that is, frankly, and I know this isn't necessarily welcome advice is that life under fee-for-service Medicare has to get more difficult. Despite the complaints that we often hear from providers about how the payments are too little, the reality is that life under fee-for-service is still very comfortable for a lot of people, and if we want them to migrate to new payment systems, there needs to be consistent pressure on fee for service.

Mr. KIND. I would agree.

Thank you, Mr. Chairman.

Chairman HERGER. The gentleman's time has expired.

Mr. Reichert is recognized for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman, thank you for holding today's hearing.

And I think we all recognize that the Medicare Payment Advisory Commission is important to us and a useful resource for Congress as we move forward to work together to reform the Medicare program, to make sure that it is there for generations to come and to protect those current beneficiaries.

I want to thank you, Mr. Hackbarth, and your fellow 16 commissioners for your work, and I know it is not easy work. But I have noticed some things in some of the documents provided to us, I know that you hold community hearings and try to reach out to beneficiaries in the public as you look at your information. But you talked about analysis of some of the data, you talked about some of the evidence that you have collected.

And I am just wondering in this process that you are presenting today, did you have the opportunity to assemble focus groups or do some polling or tele-town halls or town halls to talk to the beneficiaries?

Mr. HACKBARTH. Yes.

Mr. REICHERT. I think that is important.

And you said yes. So what did you learn from the beneficiaries as you talked about, I think Mr. Johnson's points, to concerns as to whether or not people like to delay or even forgo treatment because of some of the cost increases that he is talking about and the copays for supplemental insurance? And if you could comment on, what are you hearing from the beneficiaries as you look at these changes?

Mr. HACKBARTH. So what we heard in our focus groups on the Medicare benefit package was that, in fact, there is a lot of anxiety among beneficiaries about their ability to afford needed care. And they also find the existing Medicare payment structure, the existing benefit structure, to be quite confusing and the combination of those two things, the fear of high costs and the complexity, are very important factors in their wanting to buy supplemental insurance coverage. And I think we can all relate to that.

Another important finding from our focus groups was that there is a bit of a difference at least between how current Medicare beneficiaries and people who are just before Medicare eligibility look at these issues, so that people who are not quite yet eligible for Medicare and are often insured say through employer-sponsored coverage, they are a little bit more willing to say, look, I am prepared to have some co-payments at the point of service as long as they are understandable and predictable in exchange for a lower premium. They make those trade-offs more readily, whereas current beneficiaries are, frankly, more fearful.

Mr. REICHERT. There is a little fear connected with the current beneficiaries——

Mr. HACKBARTH. Yes. Yes.

Mr. REICHERT [continuing]. Around this change.

Mr. HACKBARTH. Yes.

Mr. REICHERT. And is there work being done to help ease the concerns or——

Mr. HACKBARTH. Well, we think the most important work that can be done is to restructure the benefit package to make it simpler and to provide catastrophic coverage. That is what the focus groups tell us beneficiaries want.

Mr. REICHERT. I was also, just to switch here real quick here, move to the section of the report that refers to care coordination, fee for service, I was a little surprised to learn that in your comments, there is no overwhelming evidence that care coordination saves money and is more efficient. Can you explain that, please?

Mr. HACKBARTH. Yes. So in recent years, CMS has run a substantial number of care coordination demonstrations. There is a variety of different approaches. CBO several months ago did a much discussed summary of the evidence and sort of the bottom line conclusion was that there weren't a whole lot of dramatic clear successes in reducing costs and improving quality.

We did our own examination of those demonstration projects and the results and came away with maybe a slightly different conclusion. What we found is some indication of some things that work, but as we look at the overall picture, it seems to us that what works in care coordination is highly dependent on the context. And as I said in my earlier comment, care coordination to be effective in reducing costs and improving quality needs to be organic, needs to be part of the care delivery system. It can't be readily imposed from the outside in sort of a plug-in module, if you will.

And so the conclusion, the policy conclusion that we draw from that if is if we want good care coordination—and I know we all do—the best approach is to create both clinical and financial accountability for a group of providers, have clear measurements of success, and then give them some room to adapt care coordination approaches to their particular circumstance.

Mr. REICHERT. Thank you, Mr. Chairman.

Chairman HERGER. Mr. Pascrell is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Hackbarth, we did not have a hearing on the March MedPAC report. So I want to take the opportunity to ask a question about it if I may.

As we look toward the end of the year and the need for a physician or other health care, health extenders, I am worried that my colleagues across the aisle hope to offset a big chunk of the cost on the backs of beneficiaries. I am not saying that is what their objective is; I am saying I am concerned about it. And that is totally unacceptable in view of what the whole purpose of the health care act was.

We have many viable offsets. You have been pretty specific about some of them. Can you remind us of the recommendations from the March report with regard to market basket updates? What is the policy justification for these recommendations? And would these recommendations yield a saving?

The MedPAC estimates in March recommendations would save $60 billion over 10 years. So I would like you to answer those three questions with regard to what one of our major objectives with health care reform was all about.

Mr. HACKBARTH. So, in our March report, we had the series of recommendations most of them related to the update, the rate increase for the various provider groups. In the aggregate, as you say, our rough estimate is that if those recommendations in our March report were adopted, they would save roughly $60 billion over about 10 years.

Now I would add the caveat that of course that we don't do the estimates, the official estimates for the Congress, CBO makes those estimates. But that is our rough estimate to the savings.

Mr. PASCRELL. Can you remind us of the recommendations that would bring this about?

Mr. HACKBARTH. Yes. So, as you know, Mr. Pascrell, we make update recommendations for each of the different provider groups, hospital, inpatient, outpatient services, physicians, all of the post-acute providers, skilled nursing facilities, home health agencies, long-term care hospitals and patient rehab hospitals, ESRD providers, across the whole board. In each case, what we do is what we refer to as a payment adequacy analysis where we look at the variety of different type of data on access to care, quality of care, access to capital for providers. There are margins on Medicare business, and that is the foundation, the analytic foundation for the recommendation.

This sort of summarizes the recommendations across the board. None of our update recommendations were higher than 1 percent. We recommended 1 percent for hospital inpatient outpatient services and for dialysis facilities.

All of the others were less than 1 percent or zero, and in a few cases, we recommended rebasing of the rates, which would actually be a reduction in the rates over time. Specifically, we recommended rebasing for skilled nursing facilities and home health agencies.

Mr. PASCRELL. I would recommend, Mr. Chairman, that the members make sure they go back to this March report, which is pretty succinct, I thought more so than usual, and this cost savings is not just a myth, and whether we are talking about CBO numbers or anybody else's numbers; we are talking about real savings. And that is what we need in health care reform, one of the things we need in health care reform.

And I have one other quick question if I may, do you believe that health care reform does indeed move us toward a Medicare program that pays providers based on the quality of their services and not the quantity? Do you think that that is what it actually does? Or will do?

Mr. HACKBARTH. Well, as I said, in response to Mr. Kind, we do believe that there is a lot of important work underway in terms of changing the Medicare payment systems, better reward quality and cost. I am happy to say that much of that work is based on or related to MedPAC recommendations in the past.

So we are encouraged to see that going forward.

Mr. PASCRELL. Mr. Chairman, I would ask you the final question if I may before I stop here.

Chairman HERGER. The gentleman's time has expired.

Mr. PASCRELL. If I may ask a question.

Chairman HERGER. The gentleman's time has expired, but you are welcome to come and visit with me. We will move on.

Mr. PASCRELL. Thank you, Mr. Chair.

Chairman HERGER. Dr. Price is recognized for 5 minutes.

Mr. PRICE. Thank you, Mr. Chairman.

And it is good to see you again, Dr. Hackbarth. We appreciate the information that you provided, and I want to echo Mr. Pascrell's commanding the March 12th report because I think it outlines a lot of things that may or may not result in a higher quality of health care. The decisions that we make here and the decisions that you make have real life consequences out in the real world. Seniors who receive their health care are affected by the things that you recommend and the things that we do.

In response to Mr. Reichert's question to you, have you talked to beneficiaries—you said that you had been in town halls and you talked to beneficiaries—have any of those beneficiaries said that they wanted their life under fee-for-service to get more difficult?

Mr. HACKBARTH. No, I don't think that beneficiaries typically think in those terms. I think that generally speaking, Medicare beneficiaries like the Medicare program, I don't think they think in terms of fee-for-service versus others so much.

Mr. PRICE. But in fact that is what you said wasn't it? You said that "life under fee for service has to get more difficult."

Mr. HACKBARTH. Yes.

Mr. PRICE. Tell me what that means. What does that mean for the patient?

Mr. HACKBARTH. We believe——

Mr. PRICE. What does that mean for the patient?

Mr. HACKBARTH. Better care I believe.

Mr. PRICE. Life getting more difficult means better care?

Mr. HACKBARTH. Life getting more difficult for fee-for-service providers, encourage them, encouraging them to move to new payment methods that are more focused on producing high quality care at a lower cost.

Mr. PRICE. Help me understand this thing. Life getting more difficult, you want life to get more difficult for the folks taking care of the patients?

Mr. HACKBARTH. And open doors for them to new payment methods.

Mr. PRICE. When life gets more difficult for the doctors of this land, how does life get better for the patients of this land?

Mr. HACKBARTH. The key point, Dr. Price, is that our goal is not just to make life more difficult for doctors but also we want to create new opportunities.

Mr. PRICE. So one of your goals is to make life more difficult for doctors I guess I just heard you say.

Mr. HACKBARTH. We think that there needs to be pressure on fee for service to encourage people to move to new payment models that better reward quality while keeping costs down.

Mr. PRICE. I think this is really illuminating. And I appreciate your being candid. I think this is extremely helpful because MedPAC believes that fee for service ought to go away. Right?

Mr. HACKBARTH. Over time, we think——

Mr. PRICE. That we ought not have individual patients being able to find an individual doctor that they trust to say I want, please, for you to provide this service for me and under a fee-for-service model that——

Mr. HACKBARTH. Actually, no, we didn't say that. And I'm glad you raised this. We believe that Medicare beneficiaries should have options for their insurance coverage.

Mr. PRICE. Is fee for service one of those options?

Mr. HACKBARTH. Yes, and there could be plans under Medicare Advantage, for example, that say that what we want to do is offer old style fee-for-service and if there is a market——

Mr. PRICE. In that "life more difficult" arena?

Mr. HACKBARTH. If patients and physicians and other providers choose that, we think that option should be available.

Mr. PRICE. In your March 12th MedPAC report, you say that access, Medicare, new Medicare patients needing access to physicians is becoming more difficult. In fact, your survey found that one in four Medicare patients looking for a new physician were having trouble finding one.

Mr. HACKBARTH. Primary care physician, yes.

Mr. PRICE. Tell me, do you believe that an increased or an out-of-pocket spending limits or—and decreasing the beneficiary cost protections reducing those, does that increase or decrease access to care?

If I take the information from your March report, which says that new Medicare patients are having trouble finding docs, and I take the information from your June report, that says there ought to be a cap and you ought to have copays, how—do you have any data that demonstrates that your recommendation in this report will increase Medicare patients' access to primary care physicians?

Mr. HACKBARTH. We think that the——

Mr. PRICE. I know you think that. Do you have any data?

Mr. HACKBARTH. The response to the problems in access to primary care is to increase payment rates specifically for primary care services.

Mr. HACKBARTH. Multiple reports made it clear that we think that the payment rates for primary care services are too low, and that is a major factor in access problems, not just for Medicare beneficiaries but for all Americans to primary care.

Mr. PRICE. Mr. Chairman, my time has expired, but I think that I would like to follow up with questions with Mr. Hackbarth in writing and encourage others to do the same. Thank you.

Chairman HERGER. Thank you very much.

Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you.

Well, I want to just follow up on this line of inquiry, give you a chance to elaborate. First of all, I didn't hear you say that you wanted to make life more difficult for patients, and I think it—I am inferring from what you say that having a situation where the default is fee for service and rewards volume over value may be more convenient for some providers but is not necessarily the best optimal care and is not necessarily in the best interests of patients.

I don't want you to be trapped into saying because you—I understood you to say you wanted to have some, a little friction so the default isn't what is easiest but necessarily not optimal care. Do you want to elaborate on that a little bit? Did I misunderstand what you were saying?

Mr. HACKBARTH. You are correct, Mr. Blumenauer, in your description. I ran a very large physician group in Boston, 600 physicians, and I feel like I understand physicians pretty well and work pretty well with them. And our group was able to practice very, very high quality medicine, as good as anybody in Boston, a pretty tough market, and do so at a lower cost, and that is because we weren't dependent on fee for service.

We were paid through other means that actually allowed us to better focus resources on the needs of patients, do things in care coordination without worrying about whether they fit a Medicare billing code and deploy resources with one goal in mind, how do we take this pool of resources and get the best quality of care for our patients. What we think is that over time, the whole system would benefit from moving away from fee for service and all of its rigidity toward a system much more focused on value for patients and for the taxpayers who pay the bill.

Mr. BLUMENAUER. And nothing that you have suggested would eliminate the option for people who want to use what for most of the United States is being clear is being outmoded and ineffective, but people could still have fee-for-service options if they wanted to do the old style, reward volume over value.

Mr. HACKBARTH. A consistent theme over the years in our recommendations, and it shows up again in our benefit redesign recommendations, is that we don't want to deny choices. We think that people ought to have choices, including Medicare beneficiaries, but they need to start seeing the cost implications of the choices that they make, and that applies both to patients and providers. That is the only way that we are going to deal with our cost challenges in Medicare and the broader health care system.

Mr. BLUMENAUER. But you are seeking to do this in a holistic fashion.

Mr. HACKBARTH. Right.

Mr. BLUMENAUER. Rather than a blunt instrument. I note with no small amount of irony that some of my Republican friends are all in favor of shifting much higher costs on to the backs of senior recipients and looking for systems that have higher copays, that have higher out-of-pocket expenses, more confusion, if you will, and complexity, but this is fine in the aggregate, but somehow when you are offering things that are more nuanced and fine tuned that somehow we are diving in and suggesting that this is something that is negative or nefarious, and I just, with all due respect, reject that notion.

I have deeply appreciated what MedPAC has done over the years in terms of trying in an unvarnished fashion to give us some useful information. It is Congress that is continually adding complexity. It is Congress that hasn't stepped up for decades, and now we reach a point where it can't continue as it is.

I see my time is about to expire. I was very interested in pursuing the transitional care process in terms of care coordination. I will probably submit something to you in writing on that because we have some legislation we are reintroducing to try to have a transitional care payment in the light of the larger context.

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

Chairman HERGER. Thank you.

Mr. Buchanan is recognized for 5 minutes.

Mr. BUCHANAN. Thank you, Mr. Chairman, for holding this important hearing today.

I represent about 200,000 seniors that rely on Medicare in my district. I want to ensure that seniors have access to quality health care, as all of us do. Millions of Americans are struggling, especially seniors living in our area on fixed incomes. I understand the average income of a Medigap policyholder is less than $30,000 a year. In Florida, we have over 650,000 seniors on Medicare that have a Medigap policy. Medigap is critical to allowing these seniors who live on fixed income to budget the needed care and expect the unexpected medical expenses. Should we be concerned that restricting supplemental coverage could result in skipped doctor visits that are actually needed and could lead to more costly care in the long term?

Mr. HACKBARTH. Well, Mr. Buchanan, again, I want to emphasize that our approach is not to restrict access to supplemental coverage or deny people the option of buying supplemental coverage.

We do think that they should face at least a portion of the cost implications of that choice. When you pay a supplemental insurance premium, you are only paying a small fraction of the added cost to the Medicare program, and so we think that people need to see a bit of that added cost that the taxpayers incur as a result of their decision, but for sure, they ought to retain the choice.

In our chapter on benefit redesign, we present an analysis that shows that if the benefit package is redesigned along the lines that we describe, catastrophic coverage and a restructuring of the copays and some people react to that by reducing their supplemental coverage, in fact, they may be better off financially. And that is because right now a lot of people are buying supplemental coverage out of fear and uncertainty because of the lack of catastrophic coverage and the confusing benefit design. But the amount they pay in for supplemental coverage, they don't get out, again, in benefits. They are overpaying for it. And so they could actually be better off if we have a redesigned benefit package and less comprehensive supplemental coverage.

Mr. BUCHANAN. I just want to ask you, because we have got limited time, a second question. In your report, the commission highlights some serious concerns with the demonstration program that CMS is currently implementing for dual-eligible individuals. I am concerned or I get these concerns expressed to me that CMS is implementing this program with nothing definitive in terms of measurement or some way to compare the outcomes. Should CMS be using some sort of measuring stick to gauge success while helping the people that are at risk in terms of that population?

Mr. HACKBARTH. We think that having a strong measurement system is a very important part of moving toward a new approach for dually eligible beneficiaries. Many of these beneficiaries, as you well know, are really quite vulnerable patients that have either cognitive or physical limitations and have really unique sort of clinical and social service needs, and so we think an important part of this movement needs to be a robust measurement system.

We have limited measures currently for the so-called SNPs, the special needs plans, that serve dually eligible beneficiaries under Medicare Advantage. That measurement system is not robust enough.

The good news is that CMS has engaged the National Quality Forum, which is sort of the national arbiter of quality measurement, to enhance the measurements for the dually eligible population. That is encouraging, but there is more work that needs to be done.

Mr. BUCHANAN. Why haven't they taken a more aggressive approach in terms of actually measuring it because I don't know how you manage it if you can't measure it, you know, from that standpoint.

Mr. HACKBARTH. Well, I think that they are taking an approach to push the measurement ahead. It is just the synchronizing of that with the demonstrations that has us worried. We are worried about really large-scale demonstrations that move too quickly relative to our ability to assess quality in the plans.

Mr. BUCHANAN. Thank you.

I yield back, Mr. Chairman.

Chairman HERGER. Thank you.

Mr. McDermott is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Thank you, Mr. Hackbarth, for coming here and talking to us.

You talked briefly about something I want to expand on, primary care. In about 2 weeks, sometime in the next 2 weeks, the Supreme Court is going to decide whether we have a national plan under the Affordable Care Act. One of the needs is going to be for primary care physicians. Everybody knows that we need half the doctors to be in primary care, but we have only got about a third. Why is that? Because of the compensation. And you had asked the RUC, the Relative Value Update Committee, to do a comprehensive review of the E&M codes. They talked you out of it and came back with a new set of codes for care transition and for chronic care management, and I would like to hear your understanding because clearly, the RUC is where the prices are decided; 87 percent of their recommendations are accepted by MedPAC, and it is dominated by specialists. There is never—the primary care people don't have a chance on that committee.

So I would like to hear you talk about how we are ever going to get it balanced so that a primary care physician can make a decent living in some places and therefore go into that part of medicine, or are we just going to have this same mess until we have real breakdown in the system?

Mr. HACKBARTH. I don't remember ever being talked out of anything by the RUC, just for the record.

Mr. MCDERMOTT. Maybe that is my interpretation. They didn't give you what you asked for.

Mr. HACKBARTH. Yeah, right. Let me make a few points.

One, we have pushed aggressively for a number of years for there to be a significant effort to across the board improve the relative values in the Medicare payment system. What we have said is that CMS is overly dependent on the RUC for determining relative values, and we have urged them for a period of years now to develop alternative sources of information and expertise that can—not necessarily replace the RUC but at least complement what they get from the RUC. We are particularly concerned that estimates of time, the time involved in each of the 7,000 codes are off, and maybe not by a little, but off substantially. Time is the single—time estimate is the single most important factor in determining the relative value. So if the time estimates are off, that is a big, big deal.

The RUC process for estimating these things is they do surveys of physicians in various specialities, and that is the raw material, but often the response rate of these surveys is very limited, a small number of physicians enters the issue of self-interest in the responses. So we think CMS needs to develop alternative databases, for example, on the specific issue of time and we have made——

Mr. MCDERMOTT [continuing]. What prevents you—I would like to stop you right there because I put a bill in saying you should have your own analytic people doing this rather than having the RUC. What is it that prevents you from doing that?

Mr. HACKBARTH. Well, the question is what prevents CMS from doing that.

Mr. MCDERMOTT. Yes.

Mr. HACKBARTH. And it sounds like we are telling them to do the same thing. We think they need to be less dependent on the RUC and have more alternative sources of information to guide their decisions. It sounds like we are together on that issue.

One last point on primary care. We do think that this revaluation could help primary care, but the problems that we face in primary care are so urgent that we need to do something in addition to improving the relative values. Part of that is incorporated in the Patient Protection and Affordable Care Act. There is a bonus for primary care, as you well know. We think that is a constructive step. But it may be that we need to do some additional stopgap measures, for example, payments for the care coordination in addition to looking at the relative——

Mr. MCDERMOTT. Can I make another suggestion? That is make medical school free and require 4 years of primary care in repayment to the country as we do with ROTC officers? If we did that, we would have people in the pipeline coming out trained to do primary care, and we would have them not deeply in debt. It seems to me that is one of the main things that we do not talk about when we talk about payment reform.

Thank you, Mr. Chairman.

Chairman HERGER. Mr. Gerlach is recognized.

Mr. GERLACH. Thank you, Mr. Chairman.

Mr. Hackbarth, I am going to just raise a quick question with you and really rather than you replying now, maybe you might want to get back to me a little bit later because it deals with the March report, not the June report, which is the focus of today's hearing, but I did want to raise this issue with you with the hope that you can provide us with your insight and thoughts on it.

Mr. HACKBARTH. Sure.

Mr. GERLACH. I have a constituent who got 3 days of home health care services, and ultimately the agency billed for that service for a total of $1500, ended up getting reimbursed, however, by CMS for $3,000, even though it was only billed at $1500 because of episodic care regulations as they are currently written. So we wrote to CMS about this issue and, about a month ago, got a response back from Lawrence Wilson, director of the Chronic Care Policy Group, who says basically that in your, MedPAC's, March report shows that Medicare payments for home health agencies to freestanding home health agencies in 2010 were, on average, 19.4 percent higher than the provider's costs. A huge amount of reimbursement above the cost obviously. MedPAC's estimate of Medicare margins for home health agencies in 2012 is estimated to be 13.7 percent. As a result, we, CMS, are working diligently to implement provisions of the Affordable Care Act that would recompute the payment rates for home health care services to ensure they more accurately align with the cost of providing efficient and high quality services.

Do you have any thought at the moment or, again, get back to me after the hearing with a more comprehensive answer as to where in your opinion CMS is with their examination of this issue, such a high reimbursement for services above the costs of the providers, and what can be done to make those reimbursements more accurately reflect the costs that are being charged by these agencies?

Mr. HACKBARTH. Well, I would like to look into the first part of your comment about your particular constituent question and the circumstances there.

On the issue of Medicare margins for home health agencies, I can confirm that our analysis shows that on average, the margins are very, very high, well up in the teens, as the letter says, and therefore, we have recommended a series of changes in the home health payment system. One is to rebase the rates and lower the rates, but also changes to improve the case mix system so the payment for any given home health episode is a function not just of a base rate but also adjustments for the patient's condition and the like. We think there are real problems in those condition-specific adjustments that need to be fixed as well.

Mr. GERLACH. Good. If you can then get back to us on what you view the progress is being made at CMS to do exactly what you are recommending and whether you think it is being done as expeditiously as it should be, given the high rates of return that the agencies are getting in their reimbursements, we would appreciate that response, and I will shoot a letter to you to that effect. If you could get back to us, I would appreciate it.

Mr. HACKBARTH. And part of this issue is in CMS's court.

Mr. GERLACH. Right.

Mr. HACKBARTH. Part of it is in the Congress' court in terms of setting the base rates.

Mr. GERLACH. Okay. Thank you.

Thanks, Mr. Chairman.

Chairman HERGER. Mrs. Black is recognized.

Mrs. BLACK. Thank you, Mr. Chairman. I want to thank you for allowing me to sit on this panel and to be able to ask questions.

Mr. Hackbarth, I want to go back to a question that was being asked just a bit ago about the dual eligible and the financial alignment demonstration program. As you had already indicated that many of these beneficiaries are dealing with complex physical and also cognitive disabilities, if the State chooses to passively enroll these beneficiaries into these new health plans, is it possible that they will see their treatment plans disrupted?

Mr. HACKBARTH. We fear that that is a possibility, and so we think that the demonstrations need to be designed in a way to minimize that risk, and there can be, for example, some transitional steps taken. So if before a State passively enrolls any beneficiary in a plan, there needs to be very clear communication not just with the beneficiary but also with the beneficiary's providers so that there is an opportunity at the front end to say, no, I don't want to be part of this, thank you very much.

Mrs. BLACK. Because these are very fragile individuals for the most part, and a change in the doctor or a change in a hospital or some provider could really negatively affect them.

Mr. HACKBARTH. Yes, and that is part of the reason that we think that the communication needs to be not just to the beneficiary but also to others who may advise the beneficiary, like physicians or family members. We are talking potentially about patients with cognitive limitations that would have real difficulty understanding this. So we think real care needs to be taken before anybody is passively enrolled, which means enrolled without them making an affirmative choice.

Then we also think, even if they elect to go along, that it may be appropriate to include some transitional mechanisms, like including the patient's providers in the health plan's network for at least a period of time to facilitate a smooth transition.

Mrs. BLACK. Will there be an opportunity for them to make that choice, or will they just be forced to go into that program? And secondary to that, is an existing private Medicare Advantage plan able to compete with that transition?

Mr. HACKBARTH. Well, the opportunity for existing Medicare Advantage plans to compete, that will all be a function of how the rules are set up at the State level. These are demonstrations that would vary in their specifics State by State, and so, you know, it needs to be evaluated on that basis.

Mrs. BLACK. Well, I hope that it will be evaluated and allow people to make a choice and to have a choice because that is important that we make sure as we move forward, that we give the beneficiary and their families helping them make that choice a choice in who will be providing those services.

I have one additional question. Some say that these beneficiaries could simply opt out, but as MedPAC has noted before, would this population find it challenging to navigate a process like that, an opt-out process——

Mr. HACKBARTH. Yes. As I said, that is a concern we have, and we think that the communication needs to be beyond just to the beneficiaries. There need to be other people brought into the loop, providers, family members, and there are State agencies that advise beneficiaries. There needs to be a very carefully designed communications plan to make sure that patients are not inadvertently coerced into arrangements that simply won't work for them. Again, we are talking about very vulnerable patients in some instances.

Mrs. BLACK. And then the last question, is there a possibility that the sweeping opt-out mechanism could lead this large demonstration program to resemble more of a waiver program?

Mr. HACKBARTH. Yes, and that is one of our principal concerns. In fact, in a chapter in our June report, we talk about that. The State proposals, as I understand it, now envision in excess of 3 million beneficiaries being moved into these new arrangements. That is, by our reckoning, not a demonstration project but a program change, and we would prefer to see a smaller number in a much more focused way so we don't do inadvertent harm and so we have the means to carefully evaluate how well this effort has worked.

Mrs. BLACK. Well, I thank you because that is just what I am thinking. If it is just a waive, it is a waiver program; otherwise, it is not a demonstration program, and we will not get good information by moving the entire group all at one time.

Mr. HACKBARTH. Right.

Mrs. BLACK. Thank you. I yield back my time.

Chairman HERGER. Thank you.

I want to again thank Mr. Hackbarth for your testimony today. The opportunity to discuss MedPAC's thoughtful analysis and recommendations is of great value to the subcommittee. I appreciate that MedPAC is taking on issues that are important to the viability and sustainability of the Medicare program. Considering the extent of the fiscal challenges facing the Medicare program as well as our country, it is essential that Congress consider all available options. Such a comprehensive review is needed to ensure beneficiaries have access to high quality care through a Medicare program that is on sound financial footing. We must change our current course. We look forward to continuing to work with MedPAC as we carry out that important work.

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, I would ask our witness to respond in a timely manner. With that, the subcommittee is adjourned.

[Whereupon, at 11:22 a.m., the subcommittee was adjourned.]
[Questions for the Record follow:]

Responses to Questions for the Record
Committee on Ways and Means – Health Subcommittee
Hearing on MedPAC June Report
June 19, 2012

Questions from Mr. Brady of Texas

Q. Your report noted that some Medicare Advantage plans do cover the nursing services and supplies associated with home infusion of IVIG for patients with primary immune deficiency disorders. Were you able to determine any cost differential between the various sites of care for those M.A. plans that provided this benefit?

A. *No. We were not able to calculate Medicare Advantage costs because data on plans' utilization and costs at the patient level (the so-called "encounter data") are not currently available.*

Q. Your report seems to express support for the Center for Medicare and Medicaid Services conducting a demonstration project to understand the costs and benefits associated with coverage of the nursing services and supplies associated with home infusion of IVIG for patients with primary immune deficiency disorders. I have introduced H.R. 1845 that would create such a demonstration project. Would you agree that such a demonstration, specific to IVIG treatment, would be beneficial for patients and the Medicare program?

A. *In the report, the Commission discussed the potential for a demonstration program to evaluate whether a home infusion benefit in Medicare improves quality and saves money, compared with the current options beneficiaries face. While the Commission did not rule out the possibility of targeting a demonstration of IVIG for patients with PID, to construct and evaluate a demonstration program focused solely on this population would be challenging. The PID population is small and setting up the demonstration would entail significant administrative costs, making it more difficult to demonstrate savings. Moreover, because the PID population is small, it may be harder to detect statistically significant impacts.*

Q. As non-covered services, Medicare beneficiaries who choose to receive IVIG treatment at home for treatment of primary immune deficiency disorders are not able to use MediGap supplemental insurance to pay for nursing services and supplies associated with their treatment. How much money (out of pocket) would patients be able to save if they could use their MediGap insurance to cover the patient share of costs for those services?

A. *We cannot estimate the reduced out of pocket (OOP) costs to beneficiaries. For the IVIG population, the reduced OOP costs depend on the number of beneficiaries with Medigap coverage, as well as the private provider rates for supplies and nursing. Also, bear in mind that Medigap premiums would increase for all Medigap holders in order to cover these costs. Finally, it would be unprecedented to require Medigap plans to cover non-Medicare covered services.*

Q. Your report specifically noted that out-of-pocket costs for nursing services are a barrier to access for home infusion of IVIG therapy. Why were these costs singled-out as an impediment for this particular treatment? Why is home infusion of IVIG different from other drugs?

A. *Two factors make nursing costs more of an issue for IVIG than some other home infusion drugs like antibiotics. Patients needing IVIG for PID requires a nurse to be present for each administration, which is different from many other home infusion drugs (e.g., antibiotics, parenteral nutrition) where teaching the patient to self-administer is the goal. Also, patients with primary immune disorder (PID) are often not homebound so they do not qualify for the Medicare home health benefit.*

Q. You indicated in your report that MedPAC anticipates minimal woodworking as a result of expanding Medicare coverage of nursing services and supplies of IVIG for patients with primary immune deficiency disorders. Would you please expand on why MedPAC does not believe such woodworking would occur?

A. *Since PID is a rather clinically precise diagnosis, and relatively few individuals receive this diagnosis, it is unlikely that broader Medicare coverage of nursing services and supplies would result in new candidates emerging to access them.*

Question from Ms. Black of Tennessee

Mr. Hackbarth, the duals demonstration project will in many cases remove dual eligibles from their current coverage in Medicaid and Medicare in favor of enrolling them in coordinated plans. However, in the case of Part D, it could remove individuals from the competitive bidding Part D architecture into coverage that is paid exclusively through administered rate setting, which would eschew the discipline that competitive bidding imposes.

Q. Given that some special needs plans under Medicare somehow manage to coordinate Medicare and Medicaid services and still submit competitive Part D bids, is there any reason to suppose that plans in this demonstration could not do the same, if not in the first year, then in years two or three?

A. *The Commission is concerned about this possible feature of the demonstration programs. Specifically, we are concerned that this policy could de-stabilize the Part D prescription drug plan (PDP) market for LIS beneficiaries by affecting the available number of benchmark plans and the amount of the premium subsidy. Dual-eligible beneficiaries are a large portion of the LIS population, and because the proposed scope of the demonstrations is so large and so many dual eligible beneficiaries would be enrolled in plans that did not submit Part D bids, bids would be missing from the LIS benchmark calculation for most or all dual-eligible beneficiaries within a state. Given that some of the plans likely to participate in the demonstrations may already submit Part D bids for other lines of business, CMS should consider whether it is reasonable to expect that they could also submit bids for this program.*

Questions from Mr. Stark of California

Q. Sole Community Hospitals and Mileage Criteria. In order to be eligible for Sole Community Hospital (SCH) status and the special payments that accrue from that status, a hospital must be located at least 35 miles from the nearest like hospital (excluding critical access hospitals). What percentage of SCHs fail to meet that mileage criteria because they are: (1) within 15 miles; (2) between 15 to 25 miles; or (3) between 26 and 35 miles from the nearest like hospital (excluding CAHs)? What percentage are within those mileage limits of either a CAH or a prospective payment hospital?

A. *According to Commission analysis, 38 (9%) Sole Communities Hospitals (SCHs) are within 15 miles of another hospital (either PPS or CAH), 120 (29%) are between 15 and 25 miles, and 169 (40%) are between 25 and 35 miles. Focusing only on SCHs' distance from PPS hospitals, 19 (4%) are within 15 miles, 41 (10%) are between 15 and 25 miles, and 103 (24%) are between 25 and 35 miles.*

Q. The June report sets forth criteria to structure special payments to rural providers, including the criterion that payments should be targeted to low-volume isolated providers. To the extent your data show that some SCHs are within 35 miles of a PPS hospital or CAH, do those hospitals qualify as meeting the criterion of "isolated provider"?

A. *Ultimately, the definition of "isolated" is a matter of judgment and the Congress may choose to consider multiple factors when determining the appropriate criteria, e.g., the type of road or terrain separating two hospitals. The 35 mile threshold was used as a benchmark in the Commission's work since it was originally used to set eligibility for the CAH program.*

Q. Critical Access Hospital Swing Beds. In the June 2005 report, MedPAC found that CAHs receive roughly $1000 in Medicare payments for every post-acute day in a "swing" bed, as compared to payment rates of roughly $300 per day in a skilled nursing facility. Please provide updated information on the difference, if any, between the Medicare payment for a CAH swing bed day as compared to per diem payments in a SNF. Does this payment difference meet the criteria for special payments to rural providers set forth in the June report?

A. *In our June 2012 Report to Congress, we analyzed 2009 payments and cost data and found that CAHs received an average of approximately $1,315 per day for SNF care. Rural SNFs paid under the SNF PPS received an average of about $390 per day. This resulted in over $800 million in additional payments from Medicare in 2009. We expect that amount to grow to $900 million by 2011. These special payments may not meet the Commission's criteria for special payments, since they may not be targeted to isolated providers. For example, 16% of CAHs are within 15 miles of other hospitals. In addition, cost-based payments maintain lower incentives for cost control that prospective payment.*

Q. Benefit Redesign – Combined Parts A and B Deductible. The illustrative benefit redesign contains a $500 combined deductible, but the Commission did not take a definitive stance on separate or combined deductibles in the recommendations. Why did the Commission decide not to address this issue?

A. *A deductible is a basic component of insurance design; having a deductible enables insurance providers to keep premiums and cost sharing to affordable levels. In the June 2012 Report to Congress, the Commission viewed it as necessary to include a deductible in its revised FFS benefit design and concluded that while the deductible needed to be included, it could be either separate or combined. On the one hand, combining the Parts A and B deductibles would allow Medicare to more closely resemble insurance offerings in the private market. On the other, a combined deductible has the potential to result in higher out of pocket (OOP) expenses early in the benefit year for some beneficiaries, which may be burdensome.*

The Commission recommended the Congress direct the Secretary to develop a benefit design within the guidelines the Commission outlined. This would include the final structure of the deductible(s). The Commission also recommended giving the Secretary authority to modify certain elements of the benefit design, which could over time lead to changes in the beneficiary's OOP spending and reduce the burden of the deductible. This provision does not diminish congressional authority; if the Congress disagreed with the Secretary's proposed actions, it could act to stop the changes.

Questions from Mr. Thompson of California

Q: I have heard concerns from my district on some of the duals demo projects, specifically as they relate to passive enrollment. I have concerns that passive enrollment could limit options for care. In your view, how should CMS evaluate passive enrollment proposal in the dual demo plans from the states? How should they evaluate the interaction between the states' proposals and currently active Medicare Advantage plans? In your testimony, you mention "intelligent assignment" of beneficiaries. Could you explain what intelligent assignment is and how it would work?

A. *CMS proposes to use passive enrollment with an opt-out provision for the capitated model demonstrations. Under this enrollment strategy, beneficiaries will be assigned to a health plan through intelligent assignment unless the beneficiaries opt out of the demonstrations or proactively select a health plan. Intelligent assignment refers to the process of matching a beneficiary to a health plan based on information about a beneficiary's care needs (such as which heath plan has most of the beneficiary's providers in-network), rather than through random assignment.*

Since it may not be possible in all cases to perfectly match a beneficiary's needs to a plan's design or provider network, there are several protections the Commission believes should be in place to best ensure that beneficiaries are not harmed in the assignment process. This includes *conducting outreach to beneficiaries' current providers, to make sure they are aware of the upcoming change to their patients' Medicare and Medicaid services.*

Plans should be required to contact beneficiaries and assess their care needs shortly after enrollment, so the plans can develop and implement a care plan for each enrollee. In the event that a plan's provider networks do not include a beneficiary's current providers, the Commission believes plans should be required to arrange care with beneficiaries' existing providers during a transition period.

In addition, it is important that beneficiaries be passively enrolled into high-quality plans. Doing so gives the demonstration plans a better chance of improving care for the dual-eligible beneficiaries relative to FFS.

Lastly, even if all precautions and measures are taken, there will still be some beneficiaries that will be passively enrolled into a demonstration plan and will not wish to remain there. The Commission holds that all beneficiaries should be notified in advance of passive enrollment and given the opportunity to opt out at multiple points in the process.

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[Public Submissions for the Record follows:]

American Registry of Radiologic Technologists

The American Registry of Radiologic Technologists (ARRT), American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the Society of Radiology Physician Extenders (SRPE) submit to the House Ways and Means Subcommittee on Health this statement for the record related to the June 19, 2012 hearing on the Medicare Payment Advisory Commission's (MedPAC's) June 2012 Report to Congress.

As recognized by the MedPAC report, the Medicare fee-for-service (FFS) benefit package has not been substantially altered since the program was created in 1965. Nonetheless, since that time medical technology and the practice of medicine has changed considerably. As MedPAC notes, "the rigid statutory parameters give Medicare's program managers little flexibility to change its benefit design in response, even as other insurers change their benefit packages."

We commend MedPAC for exploring efforts to reform the design of the Medicare FFS benefit package to protect beneficiaries and improve the efficiency of the program. As MedPAC recognizes, the quality of care as well as its cost-effectiveness may be improved materially if the care is coordinated among providers and the providers have access to the best, most efficient tools to care for their patients.

Consistent with these efforts, we believe that Congress should recognize additional categories of non-physician practitioners that provide, high quality, cost effective care. There are many instances where the only way to satisfy the increasing demand for health care services is to rely on highly skilled non-physician practitioners. Mid-level practitioners, as part of a health care team, often can make a marked improvement in the quality of care provided to patient. This is particularly true in the field of radiology, where the entire community reached a consensus on the need to create a mid-level professional – the radiologist assistant (RA). An RA is an advanced-level radiographer who assists, but does not replace, the radiologist in the diagnostic imaging environment. The RA profession was created in response to an increased demand and need for complex medical imaging services and a shortage of radiologists. All stakeholders in the radiology community – radiologists, technologists, and certifying bodies – collaborated to develop a comprehensive, advanced education and training program for radiographers so that they could expertly and safely perform radiologic assessments and procedures (excluding interpretations) that traditionally were performed by radiologist.

An RA has completed a vigorous academic program that includes a nationally-recognized curriculum, as well as a clinical preceptorship with a radiologist. The RA educational program is required to award a baccalaureate degree, at a minimum, and must educate students to perform diagnostic imaging and interventional radiology procedures within the RA's scope of practice. Today, 12 universities offer education and supervised clinical training for the RA. Twenty-nine (29) states license or certify RAs. In addition, an RA must pass a nationally-recognized certification examination. An RA may be certified by ARRT as a registered radiologist assistant (RRA) or by the Certification Board for Radiology Practitioner Assistants as a radiology practitioner assistant (RPA).[1] RAs always practice under the on-site supervision of a radiologist.

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[1] The term "RA" should be interpreted to include RRAs and RPAs. The primary difference between RRAs and RPAs is the certification body. Both certification organizations require the individual to be a certified radiographer, complete an advanced educational program

Private insurers have shaped their benefit packages to include services performed by RAs, thereby recognizing the important role of RAs in providing high quality, efficient medical imaging services beyond what a general radiographer can provide. While the private sector swiftly recognized the value of RAs, the Medicare program has not kept pace. Currently, Medicare erroneously applies the same level of physician supervision to procedures performed by an RA that it applies to procedures performed by a general radiographer. This ignores the RA's advanced education and training, and is inconsistent with the scope of practice established for RAs by many states' laws. The Centers for Medicare & Medicaid Services (CMS) requires "personal" supervision (a physician must be physically present in the room during the procedure) for services that many states (as well as ACR, ASRT, SRPE and ARRT) have determined can be safely and effectively performed by an RA under "direct" supervision (a physician must be present and immediately available to furnish assistance and direction throughout the procedure but does not need to be present in the room when the procedure is performed). As a result, there are unnecessary delays in scheduling and performing diagnostic and interventional procedures for Medicare beneficiaries, reduced access to quality care for beneficiaries (particularly in rural and underserved areas), inefficient radiology practices and departments, and higher costs to the Medicare program. We believe that it is past time for Medicare beneficiaries to have the same opportunity to benefit fully from the services that RAs provide.

Thus, the entire medical imaging community, including ACR, ASRT, SRPE and ARRT, support the Medicare Access to Radiology Care Act of 2011 (H.R. 3032), which was introduced by Representatives Dave Reichert (R-WA), Bill Pascrell (D-NJ), Pete Olson (R-TX), and Jim Matheson (D-UT). The bill is currently cosponsored by a bipartisan group of 31 Representatives. It would update the Medicare benefit package to include services furnished by RAs in those states where RAs are recognized by the state scope of practice laws. Thus, where a state law provides that RAs are subject to the "direct" supervision of a radiologist for certain procedures, the Medicare program would apply that supervision standard as well for RA services provided in that state. Radiologists would continue to bill the Medicare program for RA services, but the services performed by RAs would be reimbursed at a lower rate than that of radiologists. This would enable Medicare to realize savings and would ensure that there is no adverse impact on the federal budget.

If H.R. 3032 is enacted into law, radiologists would be available for more complex procedures, urgent cases, consultations with referring physicians, and imaging study interpretations. Medicare beneficiaries would benefit from improved quality of care, efficient services and timely access to imaging procedures. This, we believe, would be a good policy that is totally consistent with MedPAC's recommendations for the future of the Medicare program.

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specific to the radiologist assistant's knowledge and skill level (including a clinical preceptorship with radiologists), and pass a comprehensive examination.

Council for Affordable Health Insurance

WRITTEN STATEMENT OF

THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE

SUBMITTED FOR THE RECORD

FOR A HEARING HELD ON

JUNE 19, 2012

BY THE SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

Mr. Chairman and Members of the Subcommittee,

Thank you for the opportunity to provide written comments on the Medicare Payment Advisory Commission (MedPAC) recommendations to redesign the traditional fee-for-service Medicare benefits package, released on June 15, 2012 in its annual report to the Congress. Federal health policymakers face extraordinary challenges, but perhaps none more important than the issue of developing a plan for the future of Medicare that reflects the importance for the long-term success or failure of ensuring that beneficiaries receive appropriate and quality care for their dollars.

Who We Are

The Council for Affordable Health Insurance (CAHI) is a national research and advocacy organization devoted to market-based health care reforms that preserve freedom of choice for individuals and encourage a competitive health insurance market. CAHI members include health insurers, physicians, actuaries, agents and small business owners. Our member companies are active in the Medicare Supplement, individual, small group, health savings account, and senior markets.

Since 1992, CAHI and its members have worked with various states' departments of insurance and legislatures, the National Association of Insurance Commissioners (NAIC), the Society of Actuaries and the American Academy of Actuaries on health care reform issues. For the past 20 years, we have reviewed the Medicare program and ways to improve and sustain the safety net program for future generations. We have asked experts from our Medicare Working Group, Senior Issues Committee, Health Care Reform Working Group, and Research and Policy Committee about their expectations for sustaining the Medicare and Medigap programs. We have looked at short-term solutions, long-term solutions and federal and state budget solutions for both the over-age and under-age 65 markets.

CAHI Concerns

CAHI's experts have reviewed the MedPAC recommendations to redesign the Medicare benefits package. **CAHI's members have serious concerns with the recommendation for imposing a surcharge on Medicare supplement insurance policies.**

Due to federal budget deficit issues, there are several Congressional proposals that reform Medicare and Medigap insurance by instituting some cost-sharing incentives for Medicare beneficiaries as a way to rein in health care spending. Some of the proposals include raising the Medicare Part B premium from 25 percent to 35 percent, altering the Medigap deductibles and copayments and raising the Medicare eligibility age. Many of these recommendations CAHI fully supports.

However, CAHI's members believe that simply broadly changing cost-sharing will not necessarily produce reductions in unnecessary care, and may have a negative impact on overall Medicare spending if beneficiaries delay necessary care and drive up long-term costs. CAHI's members feel strongly that the Congress needs to make targeted changes to the Medicare program that take into account incentives for both providers and beneficiaries to seek cost-effective care.

Medigap and Cost-Sharing

According to America's Health Insurance Plans (AHIP), 9.7 million people have Medigap plans as of 2011. Surveys have consistently shown that seniors are happy with their Medigap coverage. Medicare beneficiaries purchase supplemental coverage to make their health care costs more predictable. They budget their out-of-pocket spending through the purchase of Medigap.

CAHI cautions that as a society, we need to tread lightly as we move forward with Medicare benefit reform because such changes in the program, particularly to the Medigap program, could increase out-of-pocket exposure that could be devastating to an aging population that has very limited income to begin with. MedPAC's benefit design recommendations may increase out-of-pocket spending for more than 50% of those enrolled in private fee-for-service Medicare, which is sure to be unpopular and politically untenable.

CAHI believes that the rationale behind proposals to change cost-sharing for Medicare beneficiaries is flawed. Most proposals that modify cost-sharing for Medicare and/or Medigap beneficiaries rely on the conclusions from the RAND Health Insurance Experiment (HIE) that was conducted in 1971 and funded by the Department of Health, Education, and Welfare (now the Department of Health and Human Services). The RAND HIE was a 15-year, multimillion-dollar effort that to this day remains the largest health policy study in U.S. history. While the study has provided the nation with concrete utilization data, **it only looked at the under-age 65 market and not the Medicare population**. This is an important distinction because the utilization for the under-age 65 market is quite different from that of the over-age 65 market.

The main issue at hand is that **there is little *empirical* evidence of the demand-side approach of focusing on the beneficiary incentives and behavior for the over-age 65 population**. We are well aware of the price sensitivity of medical consumption for the under-age 65 population due to the RAND HIE – which, despite becoming the standard of policy research for looking at the impact of beneficiary cost-sharing and health insurance benefit design, is more than forty years old.

In fact, over the past few decades, the Congress has primarily looked at controlling the Medicare program cost growth on the supply side – focusing on provider reimbursement rate reductions rather than looking at the demand side – which would focus on instituting higher patient consumption and price sensitivity in medical spending/consumption. According to the March 2012 American Academy of Actuaries issue brief, *Revising Medicare's Fee-For-Service Benefit Structure*:

> *"[a] comprehensive package of reforms to improve Medicare sustainability also should consider better aligning incentives on the beneficiary side. To accomplish this, there have been calls to update the program's traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and to address other issues related to beneficiary incentives. Such changes could deal with some of the shortcomings of the current benefit structure, including its lack of a cost-sharing maximum, and could help encourage Medicare beneficiaries to seek more cost-effective care."*

Exacerbating the demand side is the amazing changes in health care delivery, such as the availability of life saving prescription drugs, diagnostic tools and less need for invasive surgery due to technological advances. Beneficiary demand for these services has increased as they have become more readily available in the marketplace and have produced better patient outcomes. Such demand has increased utilization and therefore costs to the Medicare program.

What is the best way to get Medicare beneficiaries to control their health spending? Is the right answer to impose incentives for providers and/or beneficiaries to control their health spending? Is it to put limitations on Medigap insurers and/or beneficiaries either through cost-sharing requirements like deductibles and copayments or levy a subsidy (like 20 percent surcharge MedPAC proposes) on private insurance or a Part B premium rate increase? How much of an impact will a subsidy have on Medicare program spending? What are the unintended consequences to a vulnerable and aging population if you do?

Unintended Consequences

The American Academy of Actuaries explores these questions in their *Revising Medicare's Fee-For-Service Benefit Structure* issue brief, concluding,

> *"Reducing the share of costs that Medigap plans can cover would shift costs at the point of service to beneficiaries, increasing the incentives to seek more cost-effective care and avoid unnecessary care. This has the potential to lower both Medicare and beneficiary costs, but the extent to which costs would decline is unclear. Changes in the rules governing Medigap plans should be structured carefully to avoid unintended consequences."*

Self-Selection

CAHI believes that Medicare supplemental plans now attract a poorer risk group and that this has exacerbated Medicare spending over time as Medicare Advantage plans have become more attractive due to benefit design. In turn, this has created higher utilization in these plans as well. Benefit changes designed to decrease utilization will not necessarily recoup a presumed subsidy in this group, but instead may simply shift costs to seniors who choose supplemental coverage because of their higher health care needs. The forced design of Medigap plans with its integration with Medicare has likely created still further utilization increases. But so do the continual price controls used by the federal government (e.g., the RBRVS, APCs and DRGs) as well.

Where Do We Go From Here?

Our actuaries advise us that Medicare over the past 46 years has contributed to raising the quality of life for the elderly. Without changes to the program, however, Medicare will require resources that are likely to severely pressure the health care system and potentially other sectors such as education, public infrastructure or defense. Without timely action, strain on the federal budget is likely to grow substantially in the coming years, threatening funding of many programs outside of Medicare.

Alternatively, or in combination with squeezing funding of other national programs, Congress may continue to increase payments to providers under Medicare by less than inflation would warrant, as is being discussed currently and as has been done in the past to some extent. But this approach will likely lead to diminished access to care for seniors over time.

Hence we believe there is an urgent need for serious national debate before changes are made to the Medicare benefit structure. However, the focus should not be on short-term fixes to a long-term problem. There are many lessons that can be learned from the private sector. We need to determine which ones might be of help.

If we don't proceed with caution, our actuaries warn us that Medicare will become more like Medicaid relative to access over time if the fee schedules become more like those of Medicaid. Controlling spending in the name of efficiency will mirror that of Medicaid. Further, Medigap plan beneficiaries are enrolled in Medigap plans to make their cost-sharing more predictable, if not more affordable. A surcharge, for example, does not accomplish the task of solving Medicare's utilization and cost issues.

Conclusion

CAHI members feel strongly that the focus needs to be on reducing Medicare spending by making targeted changes to the Medicare program that change incentives for both providers and beneficiaries to seek cost-effective care. Simply broadly changing cost-sharing will not achieve this goal and could exacerbate existing spending problems.

Integrated Health Care Coalition

Integrated Health Care Coalition

July 2, 2012

The Honorable Wally Herger
House Committee on Ways and Means
Subcommittee on Health
1102 Longworth HOB
Washington, DC 20515

Dear Chairman Herger:

On behalf of the Integrated Health Care Coalition (IHCC), representing integrated health systems across the United States, we thank you for the opportunity to provide the following comments on your Subcommittee's Hearing on the Medicare Payment Advisory Commission's (MedPAC) June 2012 Report to Congress. Specifically, our comments are related to Chapters 2, 3 and 5 that address issues of importance to IHCC members who deal with the provision of integrated care for the patients we serve in urban, suburban and rural communities on a daily basis.

As members of the IHCC and nationally-recognized leaders in healthcare reform, we strongly support the federal government's nearly two decades worth of policies that foster integration and innovation. One of these measures, E&M code payment to hospital outpatient providers, is vital to those of us leading in this arena. Allowing integration between physicians and hospitals on the outpatient and inpatient settings with the payment incentives that HOPD allows is simply recognition of current pattern and practice of medical care. To do otherwise would be to take a giant step backwards in delivery system reform and care coordination. We, therefore, strongly recommend that Congress continue the HOPD program as it meets the recommendations of this June 2012 MedPAC report to provide the flexibility for providers to choose the right tools for their populations and thus support, facilitate and permit the innovations that will improve care..

As context, in April 2000, the Health Care Financing Administration (HCFA, now Center for Medicare & Medicaid Services) published the final rule to create incentives for physicians and hospitals to work together to provide better care for beneficiaries. These incentives led to the creation of a hospital outpatient provider based billing system that rewards those who have developed clinical integration sharing common medical information and coordination and integration of medical services. And we believe that many of the processes started then by CMS in this area, should be concluded via appropriate federal rulemaking and congressional oversight.

Most importantly from a policy-only perspective and as we have communicated with the Congress in prior statements, we believe that the results of these HOPD payments have shown better outcomes for Medicare beneficiaries when they receive medical care in systems that are integrated.

We sincerely appreciate this opportunity to provide comment to the Committee, and look forward to our ongoing conversations in this matter to preserve, promote and protect the patients we serve.

Submitted on behalf of the IHCC,

J. James Rohack MD
Co-chair IHCC,
Director, Scott & White Center for Healthcare Policy

Current Member Organizations of the IHCC:

Scott & White Healthcare (Texas)
Henry Ford Health System (Michigan)
Lahey Clinic (Massachusetts)
Billings Clinic (Montana)
Cleveland Clinic (Ohio)
University of Michigan Health System (Michigan)
Munson Healthcare (Michigan)
Bassett Healthcare Network (New York)
Trinity Mother Frances Hospitals and Clinics (Texas)
Indiana University Health (Indiana)
Baylor Health Care System(Texas)
Montefiore Medical Center (New York)
New York Presbyterian (New York)
Asante (Oregon)
Geisinger (Pennsylvania)
Catholic Health Partners (Ohio)
Summa Health System (Ohio)
University of Utah Health Care (Utah)
Essentia Health (Minnesota)

Attach: (IHCC response to MedPAC March 2012 report, February 13, 2012 letter to Congress from IHCC

Medicaid Health Plans of America

Statement for the Record

Hearing on “MedPAC’s June Report to Congress”

June 19, 2012

Subcommittee on Health
House Committee on Ways and Means

Thomas L. Johnson

President & CEO

Medicaid Health Plans of America

Chairman Herger, Ranking Member Stark, and other distinguished members of the Subcommittee on Health of the House Committee on Ways and Means, I am submitting this Statement for the Record on behalf of the Medicaid Health Plans of America (MHPA) for the Hearing on the Medicare Payment Advisory Commission's (MedPAC) June Report to Congress conducted by the Subcommittee on June 19, 2012. My comments are focused on the chapter of the June report entitled "Care coordination programs for dual-eligible beneficiaries" and specific concerns raised by MedPAC about the integrated care demonstration programs that CMS is developing and implementing with states.

MHPA is the leading association solely focused on representing the common interests of Medicaid health plans. Our 113 member plans serve more than 14 million beneficiaries in 34 states and the District of Columbia. MHPA represents both non-profit and for-profit plans, ranging from large multi-state insurance corporations to small community-based plans. We believe that Medicaid managed care has proven to be a highly successful model for coordinating care for low-income and culturally diverse populations and our plans are eager to expand this model to include dual eligible beneficiaries, whom CMS now refers to as "Medicare-Medicaid enrollees."

MHPA strongly supports the unprecedented efforts of the U.S. Department of Health and Human Services (HHS) to strengthen health care services and improve the quality of life for close to 10 million Americans dually eligible for both Medicaid and Medicare. We also believe that the Capitated Financial Alignment Demonstration (CFAD) initiative is an integral part of the overall strategy of HHS for better integrating care and improving health outcomes for Medicare-Medicaid enrollees (MMEs).

In its June 2012 report, MedPAC expressed support for the goals of both the capitated and managed fee-for-service (FFS) demonstrations being undertaken by CMS and recognized the potential to learn from them about improving the quality of care and reducing Medicare spending. MedPAC also acknowledged that the current FFS

Medicare and Medicaid systems have conflicting incentives that can discourage care coordination and lead to poor outcomes and higher spending.

MHPA in fact believes the existing payment silos and fragmented FFS delivery systems are failing Medicare-Medicaid enrollees and are fiscally unsustainable for both the federal and state governments. According to an analysis by the Urban Institute, the combined cost of Medicare and Medicaid care for this population in 2007 exceeded total Medicare expenditures for all other Medicare beneficiaries, a group four times as large.

Today, less than 10% of Medicare-Medicaid enrollees receive Medicaid coverage through Medicaid managed care plans, while only about 120,000 are in programs that fully integrate Medicare and Medicaid services. The vast majority are left to navigate two separate health systems and obtain other social supports with little or no care coordination. Most of their health care and related services – primary, acute, prescription drugs, long-term care, behavioral health, and social supports – are delivered separately. Few if any of their providers have access to claims data or complete health records. According to a recent CMS study, over a quarter of hospital admissions for Medicare-Medicaid enrollees could have been avoided by prevention of the condition causing hospitalization, or treatment in a less costly or more appropriate setting.

Medicare-Medicaid enrollees are sicker and poorer than the general Medicare or Medicaid populations. According to reports done by the Kaiser Commission on Medicaid during the last several years, 86% of Medicare-Medicaid enrollees in 2008 had annual incomes below 150% of the federal poverty level, compared to 22% of non-dual Medicare beneficiaries. Almost half have difficulty with a least one instrumental activity of daily living, or ADL (such as dressing or bathing). They are three times more likely to have a disability and have higher rates of diabetes, pulmonary disease, strokes. Alzheimer's disease, and mental illness. The population served by Medicare and Medicaid most in need of care coordination currently has the least access.

As noted in MedPACs June report, as of 2011, Medicaid-Medicare enrollees represented just 15% of the Medicaid population, but accounted for 40% of total Medicaid spending. In Medicare, they represented 18% of Medicare FFS enrollment, but about 27% of total FFS spending. Total federal and state spending on this population now exceeds $300 billion. Almost two-thirds of Medicaid spending for this population is for long-term care. While nursing home care is a Medicaid entitlement benefit for individuals meeting state income eligibility criteria, in most states access to home and community-based services, which is an optional service, is generally more restricted. An Urban Institute analysis of 2007 data also showed that total per capita Medicare and Medicaid spending on Medicare-Medicaid enrollees averaged $29,868, more than four times per capita spending on other Medicare beneficiaries. As a society, we can and must do a better job of providing elderly and disabled Medicare-Medicaid enrollees higher quality and more cost-effective health care.

Scope of Demonstrations

In its report, MedPAC raised concerns about the scope of the integrated care demonstrations CMS is developing and implementing with states. Specifically, MedPAC believes the scope of the demonstrations are too large for an approach that hasn't been proven and that inclusion of most Medicare-Medicaid enrollees will make it difficult to compare outcomes with a FFS population. We do not share these concerns.

Through the Medicare-Medicaid Coordination Office (MMCO), and in partnership with the Center for Medicare and Medicaid Innovation (CMMI), HHS is seeking to better integrate Medicare and Medicaid services, to align administrative requirements, quality measures and consumer protections, and to improve health outcomes for Medicare-Medicaid enrollees. The capitated demonstrations represent one of two models MMCO is testing – three-way contracts between CMS, states and health plans will provide a single, blended capitation payment to fully cover all Medicare and Medicaid services, including prescription drugs and long-term care services and supports.

Under this model, person-centered plans and interdisciplinary teams of providers will be used to provide the most appropriate set of services in the most appropriate settings, which will allow more Medicare-Medicaid enrollees to receive care in their homes and communities. Health plans will also be expected to coordinate non-medical supports offered through separate programs and providers. Payment incentives will be shifted away from volume of services to quality of care as outcome measurements are put in place to assess performance, including new measures for evaluating the quality of long-term care. In addition, incentives for payers and providers to cost-shift between the two programs will be eliminated by making a single entity accountable for costs across all services.

MHPA believes that the demonstrations should include as many Medicare-Medicaid enrollees as possible. Participation will allow each beneficiary to receive a baseline health risk assessment and further risk appraisals, a person-centered care plan, and coordinated Medicare and Medicaid services. We feel strongly that Medicare-Medicaid enrollees should not be forced to forego care coordination in demonstration states and reject the notion that the status quo is adequately meeting the health care needs of this population. We also note that while the 20 states proposing capitated demonstrations hope to include just over 2 million individuals in integrated care plans by 2014, another 1.2 million Medicare-Medicaid enrollees in these states will not be served through the demonstrations, at least immediately. In addition, each participant will have the opportunity to "opt out" of a demonstration, so every state will continue to maintain a FFS population, which can serve as a control group for comparison.

Plan Experience

MedPAC also expressed concern about whether health plans that may be selected by states to participate in demonstrations have sufficient experience working with different subgroups of Medicare-Medicaid enrollees and sufficient capacity to deliver a full range of Medicare and Medicaid services.

Medicaid health plans have developed an infrastructure for care coordination, access and quality improvement that results in improved outcomes for beneficiaries. This includes information systems capable of integrating large volumes of information used to identify members in need and programs such as utilization management, disease management, and health risk appraisals, as well as care management personnel dedicated to coordinating health and other services for members.

Medicaid managed care health plans are accredited by The National Committee for Quality Assurance (NCQA) and URAC, which evaluate them on rigorous standards relating to network management, access, quality and beneficiary rights. Medicaid health plans report on care quality using standard Healthcare Effectiveness Data and Information Set (HEDIS) metrics that enable states to evaluate quality improvement over time. For example, in 2011, Colorado health plans improved in 17 of 24 performance measures required by the state, addressing topics ranging from chronic disease medication monitoring to increasing use of prenatal care monitoring. Some states also use Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to evaluate health plan performance and beneficiaries' satisfaction. In its June 2011 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) noted that data from the 2010 CAHPS survey showed that Medicaid enrollees gave their plans higher marks than patients in privately insured or Medicare plans. No such comprehensive quality measures or surveys exist in FFS Medicaid.

Health plans serving the Medicaid population already serve large numbers of elderly and disabled persons. MHPA member companies operate Medicare Advantage plans serving close to 4.7 million Medicare recipients. Another 567,000 Medicare beneficiaries are enrolled in their Medicare Special Needs Plans, with three quarters participating in Dual Eligible-Special Needs Plans, or D-SNPs. MACPAC's March 2012 report to Congress report also included an analysis of Medicaid Statistical Information System (MSIS) data that showed that approximately 2.6 million disabled persons were already enrolled in comprehensive, risk-based Medicaid managed care plans as of 2008.

Our plans understand that under the capitated demonstration program they will be held to high performance standards. They expect no less, but welcome the challenge of applying experience and experience acquired by serving low-income, culturally diverse populations in Medicaid to improve the quality of care for Medicare-Medicaid enrollees.

MMCO has given states the flexibility to contract with plans they believe are best given their experience with the aged, blind, and disabled (ABD) population and their local insurance markets. MHPA believes this flexibility is an important aspect of the CFAD program.

Passive Enrollment

While acknowledging that low beneficiary enrollment is a barrier to expansion of integrated care programs, MedPAC questions whether states have the capacity to assign Medicare-Medicaid enrollees to plans that will can best meet their needs and whether every plan will provide high-quality care and appropriate care management models.

CMS is allowing states to use passive enrollment for their capitated integrated care demonstrations, but is also requiring them to allow individuals to opt out of the integrated program either prior to enrollment or anytime afterward. MHPA recognizes that many Medicare-Medicaid enrollees have complex medical and behavioral conditions and agrees that states should be careful to ensure that participating health plans have sufficient capacity to meet the particular needs of every included subgroup and that rates paid to plans are sufficient to cover the cost of all necessary services. MHPA also strongly believes that extensive outreach and education will be required to ensure that Medicare-Medicaid enrollees are fully aware of their options and rights. However, we also believe that once a person chooses to enroll, a state should generally be able to require participation for some reasonable period of time before enrollees can make an informed decision about whether to stay in the plan, switch to another plan, or opt back into the FFS system.

We also think states and plans should be able to provide additional supports and services beyond those already available through Medicare and Medicaid as incentives for participation, as well as non-nominal incentives such as coupons for over-the-counter drugs to encourage enrollees' participation in care management activities or to reward desired behaviors (e.g., getting screening tests).

Pharmacy benefits are a critical aspect of care management and we believe must be included in the integrated demonstration plans, as they currently are, in order for them to work. MMCO has been careful to ensure Part D protections apply to pharmacy benefits within the demonstration, and that savings attributable to Part D are retained in the Part D benefit and not the demonstration. Part D-covered pharmaceuticals provided within the demonstrations will not be subject to Medicaid formularies or the Medicaid Drug Rebate Program.

In closing, we believe that the integrated care demonstrations will greatly improve outcomes for Medicare-Medicaid enrollees. We know that this population is more likely to be institutionalized and is subject to higher rates of hospitalization and re-admissions, as well as emergency room visits. Many lack family support to help them navigate between programs and providers. Without a major change in policy, this population will continue to get sicker and will continue to drive a disproportionately high share of Medicaid and Medicare spending.

Thank you for the opportunity to submit a Statement for the Record on behalf of MHPA.

Medicare Rights Center

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TESTIMONY

on the Medicare Payment Advisory Commission's (MedPAC) June Report to the Congress

to the
United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Tuesday, June 19, 2012
Submitted July 3, 2012

SUBMITTED BY:

JOE BAKER, PRESIDENT
For inquiries, please contact Krystal Knight: kknight@medicarerights.org

Introduction

The Medicare Rights Center is a national, nonprofit beneficiary service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives. Through our direct work with Medicare beneficiaries, their caregivers, providers and families, we have specific insights into the impact on beneficiaries of changes to the Medicare program. In this testimony, we will address the recommendations in the June 2012 Medicare Payment Advisory Commission (MedPAC) report to Congress regarding reforms to the Medicare benefit design and proposals to provide better care for individuals with both Medicare and Medicaid, also referred to as dual eligibles.

Each year, through our consumer helpline, we are able to speak with nearly 15,000 people with Medicare as they navigate their health insurance, appeal coverage denials and try to determine which coverage best suits their health needs. We are also an appointed consumer group member of the National Association of Insurance Commissioner's (NAIC) Senior Issues Task Force statutory Patient Protection and Affordable Care Act Subgroup.

The Proposed Benefit Redesign

In its report, MedPAC suggests reforming the current Medicare benefit design to create a combined deductible for Part A and Part B services, replace coinsurances with standardized copayments, institute a limit on beneficiaries' out-of-pocket spending, and add a surcharge to insurance that supplements Medicare benefits, including both individually purchased Medigap plans and retiree plans.

Many of the proposed changes are promising, and we agree that Medicare could be improved by a simplified plan design, more predictable cost sharing, and the institution of a cap on beneficiaries' out-of-pocket liabilities. The current fee-for-service (FFS) plan structure, including different deductibles for Part A and Part B services, a coinsurance for most Part B services and copay for most Part A services, and no limit on out-of-pocket costs, can be cumbersome to navigate, difficult to effectively financially plan for and costly to beneficiaries. Several of the MedPAC recommendations address these concerns, and we are encouraged to see them; however, we are concerned that some of these recommendations achieve savings by shifting costs to beneficiaries and risk deterring utilization of medically necessary services.

We strongly support the implementation of a catastrophic cap that does not change beneficiaries' aggregate cost-sharing liability. However, we do not support a surcharge on supplemental policies, which would increase costs to Medicare beneficiaries, who are already burdened with some of the highest expenditures of any insured population. While some beneficiaries will decide that they do not desire to purchase supplementary insurance if there is an out-of-pocket cap, others will continue to purchase Medigaps or continue enrollment in retiree plans to reduce the unpredictable nature of cost-sharing, because the supplemental insurance provides other benefits the individual values, or because the beneficiary is comfortable in a plan they have been enrolled in for a long time. We do not support a surcharge on these supplementary insurance products, which would increase beneficiaries' costs.

We are also concerned by MedPAC's rational for recommending the surcharge on supplementary coverage. MedPAC argues that supplemental insurance leads to increased utilization of Medicare services and that a surcharge on supplemental insurance recoups some of the costs associated with increased utilization. As MedPAC acknowledges, increased cost-sharing is a blunt instrument for reducing utilization and is likely to reduce utilization of necessary care as much as unnecessary care.

Furthermore, MedPAC states that "as currently structured, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that the service is ineffective" and that comprehensive supplementary coverage "reduces incentives to weigh . . . decisions about the use of care." These statements mischaracterize current supplemental insurance policies and the people who have them. First, Medicare does not cover services that are not medically reasonable and necessary; Medigaps rely on Medicare's determination that the care meets the criteria for coverage. Many retiree plans also defer to Medicare's medical necessity determination, though some make an independent assessment. Second, MedPAC acknowledges that the "selection effect" of individuals with predictably high health care costs, those who are sicker and therefore more likely to purchase supplemental coverage, "is also partly responsible for the higher spending observed among those with supplemental coverage." (Page 17.) Rather than a license to overuse unnecessary services, supplementary insurance provides Medicare beneficiaries, half of whom live on fixed annual incomes under $25,000, with needed protection from irregular and unpredictable high out-of-pocket costs.

We support the recommendation against increasing beneficiaries' aggregate cost sharing liability. Changing the cost sharing design, as proposed, to combine the Part A and Part B deductibles, replace coinsurance with copays that vary by type of service and provider, and authorize the Secretary to alter or eliminate cost sharing based on the value of services, has the potential to increase predictability for beneficiaries and incentivize utilization of high value care. However, we have three concerns related to these changes. First, a combination of Part A and Part B deductibles will, as noted in the report, result in "the majority of beneficiaries in a given year—[seeing] an increase in their deductible amount." (Page 12.) Therefore, the combined deductible is unacceptable because it shifts costs to beneficiaries and reduces utilization of both necessary and unnecessary services. Second, the categorization of high value and low value services, and setting variable copays in relation to this categorization, must be transparent, evidence-based, and clear to consumers so they can make informed decisions. Because Medicare does not cover treatment that is not medically necessary, even "low value" services should not have prohibitively high cost sharing. Third, if the Secretary is given authority to adjust copayments based on value information, the authority should be limited to reducing copays for services during the plan year. Any changes that would increase cost sharing for particular services, should be implemented only at specified intervals (e.g., annually) with adequate notice to beneficiaries so they may protect against the increase or change their behavior appropriately. Indeed, adequate education and notice to beneficiaries will be crucial to avoid costly surprises and beneficiary confusion. Notice and comment rulemaking, as suggested, is not sufficient to adequately inform affected beneficiaries.

Care Coordination in Fee-For-Service Medicare

The MedPAC report concludes that the Medicare demonstration projects related to care coordination in FFS Medicare "demonstrate the limitation of taking a specific care coordination intervention and inserting it into the Medicare FFS system when the delivery system has not been reorganized to accommodate and wrap around the intervention" and that "payment reforms that fundamentally change the incentives to provide more care offer the most promise for care coordination." However, MedPAC notes that as comprehensive reforms may be years away, "policies to encourage care coordination within the FFS system may be an interim step." We support the Center for Medicare and Medicaid Innovation (CMMI) initiatives to implement and evaluate care coordination models in FFS Medicare, including the development of health homes and accountable care organizations.

Care Coordination Programs for Dual Eligible Beneficiaries

The MedPAC report evaluates two models of care coordination for dual eligible and currently enrolling beneficiaries, and the report comments on the CMS demonstrations on integrated care programs. The Medicare Rights Center supports efforts to improve health care access and quality for dual eligible beneficiaries.

We believe that CMS's demonstration projects offer a unique opportunity to address the numerous and complex problems faced by dual eligible beneficiaries. In their analysis of the CMS demonstration projects, MedPAC raises important concerns, but we support the goals of the project and believe it contains substantial promise to evaluate different models of care coordination for some of the most vulnerable and costly beneficiaries. We agree that the demonstrations provide "opportunities to test how to encourage care coordination, improve quality of care and reduce spending by reducing some of the conflicting incentives between Medicare and Medicaid." (Page 86.)

MedPAC's concerns—the scope of some of the demonstration projects, plan experience and implementation expertise, passive enrollment, and oversight—are legitimate and require careful consideration. Several of these concerns have been addressed in the notice and comment periods the States are required to engage in prior to submission to CMS, or in the CMS approval process. For example, New York's initial proposal involved the majority of dual eligible individuals in the state but has since been reduced in size. Similarly, several proposals exclude, or carve out, individuals who are enrolled in other coordinated-care models, like PACE programs, health homes or accountable care organizations. Others focus on a sub-population of dual eligible beneficiaries, for example, Massachusetts's proposal focuses only on individuals with Medicare under age 65. A balance must be struck between ensuring that these projects are true demonstrations and ensuring that large enough populations participate in order to create efficient systems and perform adequate evaluations.

The report points out that large scale demonstration projects also make dismantling failed projects difficult. For this reason, we urge CMS to require that the "opt-out" option in all of these plans continue to be a robust and realistic option for individuals who choose to remain in FFS Medicare and Medicaid. This concern also underscores the need for careful monitoring of these demonstration projects and flexibility from the states when failures are identified within the demonstration.

Demonstration projects that seek to move beneficiaries into fully capitated managed care plans raise concerns regarding programmatic experience and network adequacy. MedPAC points out that only about 20 plans are currently capitated and at risk for beneficiaries' full Medicare and Medicaid costs. Though they lack this fully captitated experience, most Medicare Advantage plans and Medicaid Managed Care plan providers do have experience serving dual eligible; however, they have not done so in a coordinated and comprehensive fashion. Indeed, no entity has experience serving large dual eligible populations in a seamless and coordinated manner, because it has never been successfully done. Dual Eligible-Special Needs Plans, even Fully Integrated Dual Eligible-Special Needs Plans continue to have in-network doctors who do not accept Medicaid, and there has been no explicit standard to which these plans are held with regard to minimum standards of care coordination. If these demonstration projects move forward, CMS must work closely with states to ensure that these fully capitated plans have adequate provider networks for Medicare, Medicaid, long term care services and prescription medications. Moreover, robust state and Federal oversight is needed to guarantee that the coordination promised in these demonstrations is realized. We agree that plan participation standards must be transparent, and plans with insufficient quality assurance, provider networks and capacity should not be permitted to participate.

The opportunity to create contracts between plans, CMS and the respective States, which protect beneficiaries, are cost effective and include evidence supported practices from various programs, will allow for innovation. Furthermore, beneficiary and other stakeholder involvement will help to ensure that proposed systems can meet the diverse needs of dual eligible individuals. This effort will require states to work with the Federal government and stakeholders with experience in both the Medicare and Medicaid programs. While it is a praiseworthy goal for these demonstrations to include beneficiary protections from the Medicare and Medicaid program, it also requires an exhaustive knowledge of both programs, not only legally but also practically.

Enrollment practices, including proposed passive enrollment, marketing and education, and potential lock-in periods are vitally important. If states and CMS use passive enrollment systems, finding that the systems do not violate Medicare law that promises freedom of choice, they must be, as MedPAC states "intelligent." This means that States must enroll beneficiaries into plans which meet their specific needs based on the specific services the beneficiary uses. For example an "intelligent" assignment system that only looks at long term care providers, but does not consider the beneficiary's prescription medication needs, may result in an enrollment that leaves the beneficiary worse off. Moreover, random assignment into a plan, regardless of whether it is fully capitated, defeats the broader goals of coordination and better care for dual eligible beneficiaries. We support models which use passive enrollment, if at all, only as a last resort for individuals who do not select a plan after education and guidance with a trained neutral advisor. We agree that it "may be difficult for some dual eligible beneficiaries to be informed about their choices," and are hopeful that thoughtful consideration from CMS, the states, beneficiaries, advocates and plan sponsors can devise strategies for effective communication during enrollment and after.

We are encouraged by CMS's indication that beneficiaries will be able to change plans throughout the year, and we urge CMS to reject or require adjustment to proposals that include "lock-in" provisions. We further urge CMS to reject proposals with elements similar to lock-in, where leaving private insurance plans is permitted only after a certain number of months or a limited number of times. We urge CMS and MedPAC to continue to carefully review these proposals to ensure that the demonstrations have the best chance of bringing about cost-effective improvements to the access and quality of care to which dual eligible beneficiaries are entitled.

NAIC

June 28, 2012

Congressman Wally Herger, Chair
Congressman Pete Stark, Ranking Member
SubCommittee on Health of the
Committee on Ways and Means in the House of Representatives

The Honorable Chairman Herger:

Our organizations represent millions of Medicare beneficiaries. Each of us is an appointed consumer group member of the NAIC's Senior Issues Task Force statutory PPACA Subgroup. organized to make recommendations to the Secretary in regard to adding cost sharing to Medigap plans C and F as required by Section 3210 of the Affordable Care Act. We are very concerned about proposals that would make Medicare beneficiaries pay higher out-of-pocket costs and the misperception that seniors don't have enough "skin in the game."

We are very concerned about the MedPAC testimony at the recent Subcommittee hearing. The MedPAC testimony and report proposes a tax on the supplemental benefits Medicare beneficiaries buy as financial protection against the sudden, unpredictable, and unlimited medical costs that remain after Medicare pays its portion of covered costs. Medicare beneficiaries already pay a substantial amount of their annual incomes on direct and indirect medical care costs, and most of those costs will continue to rise even if all of recommendations in the MedPAC report were enacted.

For instance, beneficiaries pay premiums for their Medicare Part B and D benefits, in addition to their supplemental coverage, whether they buy it individually or it's a shared expense with their former employer. They are also responsible for their share of prescription drug costs, and other expenses that are not covered by Medicare at all such as dental, vision, hearing, and long-term care. Half of Medicare beneficiaries spent at least $3,138 in all out-of-pocket costs for their health care expenses, representing 17% of their $22,000 annual income.[1] About 10% of all Medicare beneficiaries spent as much as $7,861 annually on all health care expenses.

The calculations in the MedPAC report create averages to make their case for "winners," who would pay less than they do today, and "losers," who would pay more with a $5,000 annual out of pocket cap for each individual beneficiary, along with other proposed changes. Since these costs are applied to individual beneficiaries, couples would potentially be exposed to double those annual out of pocket amounts, potentially wrecking havoc on family budgets.

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[1] See: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/Setting-the-Record-Straight-about-Medicare-fact-sheet-AARP-ppi-health.pdf

Unfortunately, most Medicare beneficiaries cannot accurately determine whether they are likely to be one of the "winners" or "losers" under these proposed changes and subsequently exposed to less cost or more cost than they incur today. As Medicare beneficiaries age they have a much greater risk of being one of the "losers" who will pay more. As a population with low tolerance for risk, those who can afford supplemental benefits, even with an applied tax, are likely to continue to retain or seek out supplemental benefits. Those who can't afford it are more likely to delay care until it become unavoidable and more expensive.

The report states: "many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, *regardless of whether there is evidence that the service is ineffective or, conversely, whether it might prevent a hospitalization.*" Under federal law, Medigap policies pay covered benefits only after Medicare determines them to be medical necessary and pays for Medicare-covered services. To protect consumers, Medigap policies cannot impose their own medical necessity determination, and therefore Medigap policies have no influence on whether or where care is received. Employer-based supplemental benefits also only pay after Medicare has approved and paid, and only if that covered service is also covered by the employer-based plan.

A $5,000 out of pocket maximum, $10,000 for couples, is a larger amount than most annual Medigap premiums. An out-of-pocket cost this large could be incurred in a single expensive medical event. Beneficiaries purchase Medigap policies, and take employer based benefits, precisely because they provide a predictable premium cost each month that can be budgeted against existing income, and because they don't know when they will experience a medical event or how much money they will be obligated to pay if they don't have supplemental coverage.

When unpredictable medical costs occur without this coverage many people tap into existing assets to pay those medical bills, thus often reducing the earning capacity of their remaining assets. Recent news reports note an upsurge in debt held by people over age 65 since the recession in 2008, and a reduction of almost of third of their net worth due to plummeting home equity and investment earnings.

No study yet presented to the NAIC subgroup has been able to connect the assumed higher utilization of Medicare covered services by Medicare beneficiaries with supplemental benefits with medical care services that were ***not*** medically necessary. As one study notes, the effect of supplemental insurance cannot be clearly distinguished from unobserved personal characteristics associated with higher medical spending[2] Another suggests that people tend to purchase Medigap policies because they expect they might need more health care and have had comprehensive insurance coverage before becoming eligible for Medicare.[3]

Attached to this letter is one sent jointly with the Center for Medicare Advocacy and the Medicare Rights Center in March to each MedPAC commissioner, in response to their draft recommendations for MedPAC's June 15th report.

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[2] Cost sharing effects on spending and outcomes, Schwartz, Katherine, Ph.D., Robert Wood Johnson Research Synthesis Report No. 20, December 2010

[3] See: http://www.eief.it/files/2012/02/wp-03-incentive-and-selection-effects-of-medigap-insurance-on-inpatient-care.pdf

In that letter we referenced the NAIC Discussion Paper "Medicare Supplement Insurance First Dollar Coverage and Cost Shares" that presents information relative to other proposals for increased cost sharing for Medicare beneficiaries.[4]

We urge members of the Subcommittee to balance the information presented by MedPAC with the information contained in these other documents by those of us who work with Medicare beneficiaries on a daily basis and understand their needs and their fears.

Sincerely,

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[4] See:
http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf

March 21, 2012

Commissioner
Medicare Payment Advisory Committee
Individual address

Subject: Medicare and First Dollar Coverage

Dear Commissioner:

Our organizations represent millions of Medicare beneficiaries. Each of us is an appointed consumer group member of the NAIC's Senior Issues Task Force statutory PPACA Subgroup. We have been following MedPAC's discussions of first dollar coverage and the assumed effect on Medicare costs. We are very concerned about proposals that would make beneficiaries pay higher out of pocket costs, and the misperception that seniors don't have enough "skin in the game." We believe that seniors, more than any other population, are very aware of the high cost of medical care and fearful of the impact those costs may have on their retirement income and savings. Those who have supplemental benefits through their former employment or through a Medigap are grateful that they can limit the open-ended cost of their Medicare benefits. By paying a fixed monthly premium they can budget for and limit health care expenses that might otherwise seriously affect their daily living expenses and savings. Rural beneficiaries in particular are much more likely to have supplemental benefits because their access to other forms of Medicare coverage is very limited or nonexistent.

Supplemental benefits pay only after Medicare has approved and paid for covered services. By law Medicare pays first and supplemental benefits pay afterwards. After the selection of a primary care physician, beneficiaries rarely have the option to second guess the medical services ordered by their doctor or the provider of those services. They therefore have little opportunity, knowledge, or skill in choosing between a "low value" service and one of higher value. Those medically necessary decisions are made by their doctor and confirmed by Medicare when payment is made.

We are attaching the NAIC Discussion Paper "Medicare Supplement Insurance First Dollar Coverage and Cost Shares" for your review. The discussion paper is a consensus document by regulators, industry representatives and consumer groups that seeks to make federal policymakers aware of potential negative and unintended consequences of some of the changes to Medicare and supplemental coverage that are being considered.

We hope you find this information helpful and each of us would be happy to speak with you if you have any questions or are concerned about how beneficiaries will react to mandatory higher out-of-pocket costs for their medical care, or higher premiums based solely on the insurance they buy.

Sincerely,

Bonnie Burns, California Health Advocates
David Lipschutz, Center for Medicare Advocacy
Ilene Stein, Medicare Rights Center

National Home Infusion Association

The National Home Infusion Association (NHIA), a national membership association for clinicians, managers and organizations providing infusion therapy services to patients in home care and outpatient settings, submits to the House Ways and Means Subcommittee on Health this statement for the record related to the June 19, 2012 hearing on the Medicare Payment Advisory Commission's (MedPAC's) June 2012 Report to Congress.

NHIA appreciates that members of Congress,[1] the Government Accountability Office (GAO)[2] and MedPAC have focused recent efforts on exploring comprehensive Medicare fee-for-service coverage of home infusion therapy. We also appreciate the time MedPAC afforded us in presenting how home infusion therapy providers administer high quality, cost effective care. However, we believe that MedPAC report is flawed in several important respects, particularly:

- MedPAC does not fully describe the important role of infusion pharmacists;
- It fails to address the hardships on patients and potential dangers to patients that are due to having to receive infusion services in an institutional setting;
- It erroneously concludes that the savings from a home infusion therapy benefit would be diminished by additional costs associated with the "woodwork effect;"
- It mistakenly assumes that hospital DRG payments preclude any opportunity for savings from a home infusion therapy benefit following patients' discharges from the hospital; and
- It dismisses the decades-long experience of private commercial plans and Medicare Advantage plans that illustrate that a significant number of patients can avoid hospitalization due to the availability of infusion therapy in the home setting.

Most significantly, we believe that the MedPAC report is flawed because it does not recommend a demonstration to evaluate a comprehensive Medicare home infusion therapy benefit. A demonstration conducted by the Centers for Medicare & Medicaid Services (CMS) would provide policymakers with the data needed to fully assess the costs and benefits of a Medicare home infusion benefit. As discussed in more detail below, we believe that a properly designed demonstration would address unanswered questions related to a home infusion benefit and could provide CMS and policymakers with information and guidance that would be helpful to the Medicare program generally.

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[1] The Medicare Home Infusion Therapy Coverage Act of 2011 (H.R. 2195/S. 1203) was introduced on June 15, 2011 in the House of Representatives by Representative Eliot Engel (D-NY) and in the Senate by Senator Olympia Snowe (R-ME).

[2] United States Government Accountability Office, Home Infusion Therapy: Differences between Medicare and Private Insurers' Coverage, June 2010 (GAO-10-426).

The MedPAC Report Does Not Reflect the Professional Services Furnished by Infusion Pharmacists and Does Not Adequately Acknowledge the Variability of the Duration of Nursing Services Required for Home Infusion Therapy.

A multidisciplinary team of healthcare professionals is needed to furnish safe and effective infusion therapies in the home setting. The healthcare professionals involved in providing home infusion therapy services include infusion pharmacists, the prescribing physician, infusion nurses, and when appropriate a nutrition support dietician. Unfortunately, the MedPAC report does not acknowledge the important services furnished by infusion pharmacists.

Infusion Pharmacists Provide Essential Ongoing Services to Patients Who Receive Home Infusion Therapy.

Notably, the MedPAC report fails to recognize that infusion pharmacists provide essential professional services and appropriate clinical interventions throughout the course of a patient's home infusion therapy. Infusion pharmacists coordinate and facilitate safe and appropriate care in the home setting by collaborating with the prescribing physician and infusion nurse, as well as by serving as a resource to these health care professionals as well as the patient and the caregiver. In addition, infusion pharmacists perform specialized routine clinical interventions to maximize a patient's health outcomes and to mitigate potential adverse reactions, such as:

- Developing and implementing the patient care plan;
- Compounding medications in compliance with the US Pharmacopeia 797 regulated sterile compounding procedures;
- Dispensing infusion medications and equipment;
- Conducting ongoing patient assessments, clinical monitoring and treatment plan oversight, including lab and medication profile monitoring;
- Adjusting dosage based on drug levels and pharmacokinetic drug elimination rates;
- Providing on-call services 24 hours/7 days per week; and
- Performing patient discharge services.

It is imperative that any discussion of a comprehensive Medicare benefit for home infusion therapy recognize the broad clinical responsibilities of infusion pharmacists. Their central, active and ongoing role in patient care activities significantly exceeds the activities involved in the retail/mail order pharmacy dispensing of oral and topical medications. The current Part D dispensing fee was explicitly designed as a retail pharmacy dispensing fee. Due to the higher level of care coordination and extensive ongoing clinical oversight involved with infusion therapy, this dispensing fee clearly is insufficient to cover the costs associated with alternate site infusion therapy drug dispensing. Thus, we believe that it is entirely misleading for MedPAC to state that "[t]raditional fee-for-service (FFS) Medicare general covers some or all components of home infusion depending on the circumstances."

Most Intravenous Medications May Be Safely and Effectively Administered Without the Physical Presence of a Nurse.

Nursing services, while important, are not the only and often are not even the primary professional services provided to infusion patients. Most infusion patients require nursing services. However, the duration of nursing services required to safely and effectively administer home infusion therapy varies depending on the drug being administered and the characteristics of an individual patient and his or her caregiver. For example, as the MedPAC report notes, home infusions of antibiotics may be safely administered independently by a patient or his caregiver. A nurse may be involved in educating the patient and caregiver on how to administer an antibiotic independently. Generally, home nursing visits for a patient on antibiotic therapy occur once or twice weekly depending on the clinical lab monitoring that is required and the ongoing maintenance of the vascular access device.

MedPAC cited a single example in its report of an infusion provider that sends a nurse to provide each administration of the infusion drug. This does happen from time to time, due to limited drug stability or administration issues particular to the medications, but it occurs very infrequently and should not be the basis for policies pertaining to home infusion.

The MedPAC Report Fails to Address the Hardships on Patients and Potential Dangers to Patients Resulting From Having to Receive Infusion Services in an Institutional Setting.

The MedPAC report does not reflect adequate consideration of the increased danger and added expense of complications associated with extended hospital stays for Medicare-aged patients. It is well-established that extending the length of a hospitalization significantly increases the risk of hospital-acquired infections and other complications and adverse outcomes associated with institutionalized care. In addition, there is considerable literature that indicates that vascular devices with direct access to the bloodstream increase the risk of acquiring MRSA or other difficult and costly infections. Also, transitioning patients' care to other institutions, such as skilled nursing facilities (SNFs), extends the risk of morbidity and mortality.

We believe that absent evidence to the contrary, the general principles related to hospital-acquired infections are applicable to infusion therapy. MedPAC suggests that "the literature has not compared infection rates among patients receiving infusions in the home versus other settings." While we believe there is substantial evidence that infections are far more frequent in institutional settings than in the home, a demonstration project could provide data that specifically compares the health outcomes and complications experienced by patients that receive infusion therapy in different health care settings.

Despite the section of the report entitled "Medicare beneficiary experience," we do not believe that MedPAC staff actually spoke with infusion patients, regardless of their payer type. Similarly, we do not believe that MedPAC staff spoke with disease advocacy organizations, such as the American Diabetes Association, the AARP, and disability organizations such as the American Association of People with Disabilities. Rather, the MedPAC report indicates that "Interviews of discharge planners, providers, and physicians provide insight into Medicare beneficiaries' experience accessing home infusion services."

However, we believe that the patient experience with home infusion therapy is one of the most important motivations for Congress to act to improve coverage for home infusion. Consultations with patients and their families would make clear, we believe, how the availability of home infusion can keep families together during stressful episodes of illness and how home care can be the most appropriate, economical and convenient option for patients with serious mobility issues. Soliciting patients' perspectives would be consistent with the current focus on "patient-centered care." We have attached a Wall Street Journal article from 2008 as well as a compilation of patient experiences to illustrate this point.

MedPAC's Concern that Savings Would Be Reduced by the "Woodwork Effect" is Unwarranted and Can Be Mitigated by Utilization Controls, Such As Prior Authorization.

We disagree with MedPAC's concern that the savings to the Medicare program would be diminished by additional costs associated with the woodwork effect (i.e., providing Medicare coverage of home infusion therapy would cause more beneficiaries to use intravenous drugs who otherwise would have been treated with other therapies). The MedPAC report references the potential costs of the woodwork effect several times despite recognizing that (1) patient demand would not increase utilization because patients do not generally seek out IV drugs, and (2) physicians would not increase utilization since there are inherent risks with IV medication, and therefore, they will not take prescribing decisions lightly. The report cites one study that suggested that there may be over-prescribing of infusion drugs when oral medications may be sufficient, but it did not explore why the physicians ordered infusion drugs. In addition, MedPAC's concern regarding the woodwork effect is contrary to evidence in the GAO's 2010 report on home infusion therapy, which suggests that the home infusion therapy benefit "is largely free from inappropriate utilization and problems in quality of care."[3]

We believe that patients will benefit from an alternative "woodwork effect" that may result from Medicare coverage of a comprehensive home infusion therapy benefit. Physicians often limit the medications that they prescribe to beneficiaries based on what is covered by Medicare. Thus, a Medicare fee-for-service beneficiary is often prescribed an oral medication that is covered by Medicare as incident to a physician's service, even if an infusion drug would be more appropriate for the particular patient. We believe that patients will benefit if physicians have the opportunity to prescribe the most clinically appropriate drug, regardless of whether it is

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[3] United States Government Accountability Office, Home Infusion Therapy: Differences between Medicare and Private Insurers' Coverage, June 2010 (GAO-10-426), page 26.

in oral or infusion form. This scenario would increase patients' access to clinically appropriate drugs and would improve the quality of care furnished to Medicare beneficiaries.

We believe the threat of the woodwork effect would be minimized if Medicare adopts proper guidelines that reflect the private sector's payer guidelines for home infusion therapy, and if physicians engage in appropriate prescribing patterns supported by home infusion therapy provider verification of each prescription. The MedPAC report acknowledges that prior authorization has worked well in the private sector and with Medicare Advantage (MA) plans, and indicates that the plans, physicians and providers did not generally perceive it as overly burdensome. It is worth noting that the legislation pending in Congress to establish comprehensive coverage of home infusion therapy (H.R. 2195, S. 1203) would authorize prior authorization and other mechanisms to ensure the proper use of infusion therapy in the home. As discussed below, we believe that implementing a targeted prior authorization program for home infusion therapy would address MedPAC's concern regarding increased utilization and could very well benefit the entire Medicare program.

MedPAC Mistakenly Assumed that Hospital DRG Payments Prevent Any Opportunity for Savings from a Home Infusion Benefit Following Patients' Discharges from the Hospital.

The MedPAC report incorrectly assumes that hospital DRG payments preclude any opportunity for savings on home infusion following patients' discharges from the hospital. The report emphasizes that since Medicare makes DRG payments for hospital stays, Medicare payments are unaffected by shorter hospitalizations except in a few instances. However, the report fails to acknowledge that Medicare currently makes more than one payment for infusion therapy services for most beneficiaries.

Most hospitalized Medicare beneficiaries receiving infusion services are discharged from the hospital to a SNF, hospital outpatient department or a physician's office where they continue to receive needed infusion services. As a result, in addition to DRG payments to hospitals, Medicare currently is paying SNFs, hospital outpatient departments and physician's offices for infusion services. In many cases, Medicare coverage of home infusion therapy would be a cost effective alternative to these settings, and is certainly a more convenient one for the patients.

The MedPAC Report Improperly Dismisses the Experiences of Private Commercial Plans and MA Plans which Illustrate that (1) Patients Have Avoided Hospitalizations By Receiving Home Infusion Therapy Services; and (2) Fraud and Abuse Has Not Been an Issue.

Most private commercial plans and most or all MA plans cover home infusion therapy. The actual experiences of these plans indicate that there are infusion patients who avoid hospitalizations altogether due to the availability and receipt of home infusion therapy services. In contrast to the first-hand experiences of the private commercial plans and MA plans, the MedPAC report notes that several commentators, including hospital discharge planners and physicians, believe that there would be very few instances where the availability of home infusion therapy could result in avoided hospitalizations for Medicare beneficiaries.

We believe that MedPAC should defer to the actual experiences of the private commercial plans and the MA plans when evaluating the potential for avoiding hospital stays since home care has not been an option for Medicare beneficiaries due to a lack of coverage of home infusion therapy. In addition, our members' experiences indicate that a significant number of their non-Medicare home care patients never need or receive inpatient hospital care (ranging from 5% to 30%, depending on the particular infusion drug). We believe that the prospect of savings due to avoided hospitalizations should be an issue addressed through a demonstration.

The MedPAC report also acknowledges that the private commercial plans and MA plans did not report that fraud and abuse was more prevalent in the area of home infusion therapy than in any other type of service. Nonetheless, MedPAC concludes that an unmanaged expansion of a Medicare fee-for-service benefit could lead to fraudulent actors entering the field. We are unclear why a new home infusion therapy benefit would be unmanaged. We believe that any benefit that is poorly managed has the potential for fraud and all Medicare benefits should be well managed. Proper utilization controls, such as prior authorization, could help mitigate this concern. These controls are specifically provided for in the infusion coverage legislation cited above and which is currently pending before Congress. Thus, we do not believe that a new home infusion therapy benefit would have a higher risk for fraud and abuse than any other Medicare benefit.

The MedPAC Report Fails to Recommend that CMS Conduct a Demonstration on a Home Infusion Therapy Benefit to Enable Policymakers to Thoroughly Assess the Costs and Benefits of the Therapy.

We agree with the MedPAC report that more information is needed to thoroughly evaluate the costs and benefits of a comprehensive home infusion therapy benefit. As noted by MedPAC, more information is needed related to several key areas, such as the selection of patients, possible savings and appropriate payment levels for a Medicare benefit. We believe that the absence of these data as well as some of the issues highlighted above strongly supports the need for CMS to conduct a demonstration.

As mentioned throughout this statement, we believe that several of the concerns raised in the MedPAC report can be addressed by proper utilization controls that have worked well in the private sector and for MA plans, including prior authorization. Section 1834(a)(15) of the Social Security Act authorizes the Secretary to use prior authorization practices for certain items of durable medical equipment, and thus the concept is not entirely new to Medicare Part B. The MedPAC report acknowledges that if it developed a targeted prior authorization program for a home infusion therapy demonstration, it could be a useful tool for home infusion as well as other areas and could benefit the Medicare program as a whole.

We believe that CMS should invest in developing a targeted prior authorization program for a demonstration regarding home infusion therapy coverage. The narrow focus of the program will enable CMS to gain experience with implementing prior authorization for a limited number of beneficiaries. CMS can refine the prior authorization program based on the demonstration, and can begin applying it to other areas. While it may be a challenge for CMS to implement management controls within the Medicare fee-for-service program, we believe that the investment in a prior authorization program will benefit providers, beneficiaries and the Medicare program.

A request that CMS conduct a demonstration on a home infusion therapy benefit is not akin to when the Medicare program is asked to evaluate a new type of therapy. Rather, home infusion therapy is covered widely by virtually all payers other than Medicare fee-for-service. Thus, the issue is how to translate this widespread coverage into a form that can work within the Medicare program. We believe that a properly designed demonstration project would improve the Medicare program and would significantly benefit Medicare beneficiaries.

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National PACE Association

Statement of the National PACE Association
Before the House Ways and Means Committee
Hearing on the Medicare Payment Advisory Commission Report
June 19, 2012

The National PACE Association (NPA) is pleased to submit the following statement for the record in response to the Medicare Payment Advisory Commission (MedPAC) report issued June 15, 2012. NPA applauds Congress and the Commission for its efforts to develop common-sense, sustainable policy solutions that ensure the integrity of the Medicare program. Moreover, NPA appreciates MedPAC's interest in and support of Programs of All-inclusive Care for the Elderly (PACE), particularly its recommendations for expanding the program, developing outcome measures, and ensuring that Medicare payment accurately reflects the costs of caring for a high-need, medically complex population.

Our comments focus mostly on MedPAC's recommendation on payment, as changes to the PACE payment methodology must be carefully balanced to protect the viability of the PACE model.

MedPAC's first recommendation is that Congress direct the Secretary to improve the Medicare Advantage risk-adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Commission goes on to suggest that PACE providers be paid based on the MA payment system for setting county benchmarks and quality bonuses.

While NPA understands and appreciates MedPAC's aim to place all Medicare managed care options on a consistent payment platform through the use of the same county benchmarks, we have concerns that this recommendation does not recognize the unique needs of the frail elderly served by the PACE program and does not address inadequacies in the current risk adjustment methodology.

To begin, MedPAC bases its recommendation on an analysis concluding that PACE payments are, on average, 17 percent greater than fee-for-service costs. We are concerned, however, that the commission is not using an appropriate comparison group. Specifically it is not clear that MedPAC compared payments to PACE to Medicare fee-for-service expenditures for a nursing home level of care population.

PACE exclusively serves the frailest subset of Medicare beneficiaries, older adults requiring nursing home level of care. The vast majority of individuals enrolled in PACE have low incomes, significant disabilities and chronic illnesses, and are dependent on others to help them with at least three basic activities of daily living, such as eating, bathing, transferring, toileting and dressing. About half of our program enrollees have some form of dementia. Approximately 90 percent of PACE participants are 65 years of age or older, averaging 81 years of age, 30 percent of whom are age 85 or older. It is unclear whether the Commission's comparison group reflects the significant needs of typical PACE participants -- those at a nursing home level of care living in the community.

We are also concerned that the comparison does not address inadequacies in the current risk adjustment methodology. As noted in Chapter 4, MedPAC states that the CMS-HCC model does not fully account for severity of illness and interaction of multiple illnesses. It goes on to suggest that, "Because of these shortcomings of the CMS–HCC model, there is a potential for MA plans to benefit financially if they have a relatively healthy beneficiary profile or to be disadvantaged if they have a sicker beneficiary profile. This is especially relevant to plans that specialize in managing the care for the sickest beneficiaries, such as special needs plans (SNPs) and plans in the Program of All-Inclusive Care for the Elderly (PACE) because payments may not be adequately adjusted to effectively provide care."

While the Commission acknowledges the shortcomings in the HCC model, it suggests that the frailty adjustor applied to PACE payments makes up for this difference and that, in the aggregate, "17 percent is a reasonable estimate" by which Medicare payments to PACE exceed spending in FFS. Unfortunately, the Commission offers no data to support this assertion, nor does it offer data that the relative impact of "overpayment" for some participants is sufficient to offset "underpayment" for other participants.

To more fully understand this issue, NPA respectfully requests the opportunity to review MedPAC's data and analysis to ensure that the true costs of providing care to this frail, high need population have been adequately captured

In closing, NPA greatly appreciates the Commission's work and its support for the PACE model. We look forward to continuing to work together to expand the PACE model and to ensure that beneficiaries continue to receive the high quality, integrated care provided by PACE organizations.

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National Rural Health Association

NRHA

NATIONAL RURAL HEALTH ASSOCIATION

MedPAC Rural Report Woefully Incomplete

The National Rural Health Association (NRHA) strongly contests the June 15 MedPAC Report to Congress that infers access to health care by rural patients and inadequacy of reimbursement rates for rural providers is no longer a concern. **Access to health care by rural patients and inadequacy of reimbursements for rural providers continue to plague rural America.**

Experts Agree Access to Health Care by Rural Medicare Patients Continues to Plague Rural Areas:

- "Rural Americans are more likely to suffer from chronic health conditions such as diabetes, heart problems and cancer, and face greater difficulty getting quality healthcare than their urban counterparts." UnitedHealth Center for Health & Reform Modernization
- "77 percent of rural U.S. counties are defined as health professional shortage areas (HPSAs). Furthermore, 164 rural counties throughout the country lack any primary care physician." Rural Health Research Center
- "(R)ural areas have higher rates of poverty, chronic disease, and uninsurance, and millions of rural Americans have limited access to a primary health care provider."[1]HHS 2011 Report
- "Health care access and health status are a particular concern in rural areas, where the population is older, has lower education and income levels, and is more likely to be living in medically underserved areas than is the case in urban areas…Rural (nonmetro) residents have higher rates of age-adjusted mortality, disability, and chronic disease that their urban (metro) counterparts". USDA

MedPAC Reports Conclusions on Access Contradict Experts:

- MedPAC Assertion: "Equitable access does not necessarily mean equal travel times for all services. Small rural communities are expected to have fewer physicians per capita."

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[1] See also: Radley and Schoen, "Geographic Variation in Access to Care — The Relationship with Quality", The New England Journal of Medicine, June 13, 2012.

  - Rural Response: While rural communities may be expected to have fewer physicians overall, there is no reason that rural areas should be subjected to fewer providers per capita simply because they are isolated.

- MedPAC Assertion: Rural beneficiares do not have an access to care problem because utilization of care rates are comparable to urban areas.

  - Rural Response: Rural beneficiaries have similar utilization rates because of an access to care crisis and they must travel to urban settings for care. MedPAC admits this: "Service volumes for rural patients, who have few local physicians per capita, is maintained in part by patients traveling to urban areas for some of their care." (MedPAC report p. 117.) That's like saying a vegetarian can survive at McDonald's as long as they eat somewhere else.

- MedPAC Assertion: Fewer providers in rural areas does not equate to an access to care concern for rural patients (because the volume of visits by beneficiaries between urban and rural patients is comparable), MedPAC assumes there is no access concerns.

  - Rural Response: If beneficiary visits are equivalent but there are fewer providers, logic dictates that there would be more strain on the system.

  - Recent census data shows that approximately 25% of the population lives in rural America while only 10% of physicians practice there.

Rural Hospitals provide quality, cost-effective care:

- Medicare utilization data shows that rural hospitals treat significantly more Medicare beneficiaries than do urban facilities. Approximately 46% of all patients in rural hospitals are Medicare beneficiaries, compared to 31% in urban facilities.

- Given rural hospital's Medicare patient share and uninsurance rates, it is no surprise that rural hospital's total margins are much worse than urban facilities. One study by Sano Capital Group showed that 35 percent of all rural hospitals currently operate at a financial loss. These facilities must depend on charitable contributions, system subsidization, or local taxes to make up the difference.

- Notwithstanding MedPAC's conclusion that rural payment policies do not contain sufficient cost controls, Medicare payments for all rural residents are 3.7 percent less per beneficiary than their urban counterparts, according to a recent iVantage Health Analytics study.

- Medicare makes up a significant amount of the payment rural structure but not its entirety. Costs must be contained because private and self-payers may pay on different schedules and as a good overall business model.

- Rural hospitals provide approximately 18% of all patient care yet receive only 13.5% of all Medicare payments according to a study by the Sano Capitol Group.

- Medicare Dependent Hospitals' (MDHs)—one type of rural hospital designation—financial margins would degrade considerably without the designation's accompanying payment methodology.
    - Without hospital-specific payments, MDH margins in 2009 would have been a negative 12.6 percent.
    - Without transitional outpatient payments, margins for hospitals receiving those payments in 2009 would have been a negative 16.2 percent.
- Cuts to rural hospitals also hurt rural economies. A closed rural hospital can mean as much as a 20 percent loss of revenue in the local economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate. Even if a hospital doesn't close, reduced services compromise local access to care and job loss in the community.

These congressionally established rural payment programs for hospitals are not 'bonus' or 'special' payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country.

National Senior Citizens Law Center

NSCLC
National Senior Citizens Law Center
PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on Medicare Payment Advisory Commission's (MedPAC)
June Report to Congress
June 19, 2012

Mr. Chairman and Members of the Committee:

The National Senior Citizens Law Center (NSCLC) appreciates the opportunity to submit this statement for the record on the recommendations in the June 2012 Medicare Payment Advisory Commission (MedPAC) report to Congress. NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation and counseling of local advocates. NSCLC supports the goal of ensuring that Medicare-Medicaid enrollees (dual eligible individuals) have seamless access to high quality health care.

In the June Report, the Commission discusses the Centers for Medicare and Medicaid Services' (CMS) efforts to collaborate with states to develop integrated care programs for dual eligible individuals. As part of this effort, CMS awarded 15 states contracts of up to $1 million to design a program that covers primary, acute, long-term care and behavioral health. NSCLC supports the demonstration. We hope that states will use the opportunity presented by the demonstration to develop innovative, person-centered systems of care. As advocates for low-income older adults, we are committed to ensuring the demonstrations include strong consumer protections. NSCLC is pleased to see the Commission call attention to concerns regarding ensuring beneficiary protections in the demonstration, and we share the Commission's concerns.

As the report notes, an implementation date of January 1, 2013 gives CMS and the states a short period of time to prepare for implementation and to resolve several demonstration issues-including project scope, plan standards, and passive enrollment-that could have negative effects on dual-eligible beneficiaries' access to and quality of care. We are pleased to see that several states have decided on a later implementation date. Time is needed to work out the many details that must be in place for individuals to safely transition into new systems. There are far too many key areas where CMS and the states have not yet decided on direction.

Scope of the demonstration:

The Commission questions whether the large scope of many of the demonstration proposals is in the best interest of the beneficiary. With many states proposing to enroll most or all of the dual-eligible beneficiaries in the state, the proposals appear to be large-scale program changes rather than true demonstrations. Not only does the large scale call into question the characterization of those proposals as a "demonstrations," but it introduces a host of issues jeopardizing quality care, such as: plan capacity, beneficiary access, and ability to evaluate the demonstrations.

For example, in California, the state seeks authority to transition close to 700,000 duals into capitated managed care plans in year one and all of its 1.1 million dual eligible individuals by 2015. Los Angeles County, which was selected for the demonstration's first phase, will transition all of its dual eligibles, over 350,000 individuals, into one of two health plans in 2013. If the plans fail to meet beneficiaries' needs, it would be very difficult to transition so many individuals with complex care needs out of the demonstration, further complicating access to providers and care management plans.

The California example also demonstrates why the Commission's concern that the demonstrations are not going to be evaluated properly is well founded. As the Commission points out, if most or all of a state's dual eligible beneficiaries are enrolled in the demonstration, there is not a sufficient sample of comparable beneficiaries in Medicare fee-for-service to be able to test whether the demonstration improved care and reduced cost. NSCLC agrees with the Commission that proposals to use a pre/post demonstration study design are not as strong as studying an intrastate control group. NSCLC recommends that CMS require each state to maintain a clearly identifiable, size-appropriate control group, and that the agency disfavor proposals that include all of the dual eligible individuals in a state or metropolitan areas.

Plan Experience:

The Commission draws attention to the lack of experience participating plans have with the dual eligible population, and the need for information from CMS and states on how both will ensure that beneficiaries receive the care they need, given that lack of plan experience. We add to the Commission's concern the fact that few plans have any experience providing the long term services and supports (LTSS) that will be part of the demonstrations.

In the California example, Los Angeles County proposes to enroll all of its dual eligible individuals into one of two health plans. One plan was recently sanctioned for Medicare access problems, and the other recently received a CMS compliance notice for poor quality.[1] Combined, the two plans currently serve just 7,000 dual eligible

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[1] National Senior Citizens Law Center, Assessing the Quality of California Dual Eligible Demonstration Health Plans, available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Plan-Ratings-Report-May-2012.pdf.

individuals in their Dual Eligible Special Needs Plans (D-SNPs).[2] Neither plan has any experience providing LTSS. The California proposal validates the Commission's doubt that all health plans participating in the capitated model have the experience and capacity necessary to care for large numbers of vulnerable individuals.[3]

Underscoring its concern regarding plan experience, the Commission highlights the following areas where additional information is needed from CMS and the states:

- Will plans participating in the demonstration be able to establish provider networks and provider payment rates that encourage high-quality care and care coordination for services?
- How will CMS and states balance having plans available to participate in the demonstration, with selecting plans with enough experience for a reasonable expectation of success?
- What standards will plans participating in the capitated model need to meet? How much will these standards change during negotiations between the state and plans?
- How will plans be selected for participation?
- What role will quality rankings play in selecting plans in each state?

NSCLC hopes that CMS and the states will have clear answers and a plan for all of Commission's questions before any demonstration proposal is approved. NSCLC recommends that CMS and the states require plans to demonstrate in advance that they have expertise in serving all beneficiaries in the demonstration. Plans that are unable to specify how they will care for specific sub-populations should not be included for participation. This will require plans to develop appropriate provider networks, and will require plans to establish systems to vigorously monitor network capacity. CMS and the states should allow time for network development before implementing a demonstration.

In addition, we appreciate the Commission's call for CMS and states to designate resources for monitoring beneficiary experience in the plans. Currently it is not clear that CMS and states will dedicate sufficient resources for oversight and monitoring.

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[2] Health Net, MQR #7a–Attachment 5 in *California's Dual Eligible Demonstration Request for Solutions - Los Angeles County Application* at 289-91 (February 29, 2012) ("*Health Net Medicare Disclosures*"), available at *www.dhcs.ca.gov/provgovpart/ Documents/Duals/RFS%20Applications/Health%20Net%20LA%20County%20Large%20Format.pdf.*

[3] MedPAC Report to Congress: Medicare and the Health Care Delivery System (June 2012) at 82.

Passive Enrollment:

NSCLC has consistently argued that enrollment should be based on a voluntary system in which dual eligibles must "opt in" to the integration model. An "opt-in" enrollment system honors the autonomy and independence of the individual by preserving for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries.

Instead of this voluntary system, CMS and states propose to use passive enrollment with an opt-out mechanism. The Commission raised the concern—which we share-- that in a passive enrollment system every state may not have the resources and information it needs to make intelligent assignments. Moreover, passive enrollment assumes that plans will have the capacity to meet the needs of all the dual eligibles who are enrolled and, as the Commission noted, there are questions about whether every health plan will offer high-quality care and care management models appropriate to all enrollees.

Although we continue to object to passive enrollment, NSCLC commends CMS for its decision not to allow states to "lock in" individuals into plans on the Medicare side of enrollment. However, despite CMS' position, several states continue to propose to lock individuals into a plan. As noted above, the Commission expressed concerns that plans may not be able to meet the complex needs of all the duals eligibles whom they enroll. Those concerns highlight why it is critically important that CMS maintain its prohibition on lock-ins so that individuals who cannot be served in a plan can promptly disenroll in order to get the care they need. Although the Commission only addressed the Medicare side of the enrollment issue, NSCLC believes that disenrollment from managed care for both Medicare and Medicaid services must be a continuing option for any dual eligible individual in a demonstration plan.

NSCLC appreciates the Commission's attention to the demonstrations, and values CMS' effort to better coordinate care for dual eligibles. Thank you for the opportunity to submit our views on this report. If you have any additional questions, please contact Fay Gordon at (202) 683-1992 or fgordon@nsclc.org.

The Center for Fiscal Equity

Comments for the Record
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
Hearing on MPAC's June Report to Congress
June 21, 2012, 10:00 AM
by Michael G. Bindner
The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic. Regular reports are an excellent occasion to review issues which have arisen throughout the year. This is one area where much has arisen. As always, we will leave it to the listed witnesses to address the report contents and offer additional thoughts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact Sheet

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Committee on Ways and Means
Subcommittee on Health
Hearing on MPAC's June Report to Congress
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